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

DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

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Quarterly Report - Implementation Plan for Westchester Medical Center

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

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.a.iii	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services	Completed
2.a.iv	Create a medical village using existing hospital infrastructure	Completed
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.a.ii	Behavioral health community crisis stabilization services	Completed
3.c.i	Evidence-based strategies for disease management in high risk/affected populations (adults only)	Completed
3.d.iii	Implementation of evidence-based medicine guidelines for asthma management	Completed
4.b.i	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	Completed
4.b.ii	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer	Completed

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report (Baseline)

Instructions :

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

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	41,834,599	44,581,933	72,094,581	63,839,476	41,834,599	264,185,188
Cost of Project Implementation & Administration	**21,190,419**	**28,252,186**	**30,305,477**	**28,721,128**	**22,858,150**	**131,327,360**
Cost of Project implementation	20,353,727	27,360,547	28,863,585	27,444,338	22,021,458	126,043,655
Cost of Administration	836,692	891,639	1,441,892	1,276,790	836,692	5,283,705
Revenue Loss	**4,183,460**	**4,458,193**	**7,209,458**	**6,383,948**	**4,183,460**	**26,418,519**
Internal PPS Provider Bonus Payments	**0**	**3,250,887**	**26,006,159**	**35,059,257**	**32,123,006**	**96,439,309**
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	**0**
Other	**0**	**1,000,000**	**4,000,000**	**4,000,000**	**1,000,000**	**10,000,000**
Innovation Pool	0	1,000,000	4,000,000	4,000,000	1,000,000	10,000,000
Total Expenditures	**25,373,879**	**36,961,266**	**67,521,094**	**74,164,333**	**60,164,616**	**264,185,188**
Undistributed Revenue	**16,460,720**	**7,620,667**	**4,573,487**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

NYS Confidentiality – High

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IPQR Module 1.2 - PPS Budget Report (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
41,834,599	264,185,188	21,549,667	243,900,256

Budget Items	DY1 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**15,760,460**	**18,884,932**	**2,305,487**	**10.88%**	**112,442,428**	**85.62%**
Cost of Project implementation	15,258,466					
Cost of Administration	501,994					
Revenue Loss	**1,400,000**	**1,400,000**	**2,783,460**	**66.53%**	**25,018,519**	**94.70%**
Internal PPS Provider Bonus Payments	**0**	**0**	**0**		**96,439,309**	**100.00%**
Cost of non-covered services	**0**	**0**	**0**		**0**	
Other	**0**	**0**	**0**		**10,000,000**	**100.00%**
Innovation Pool	0					
Total Expenditures	**17,160,460**	**20,284,932**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.3 - PPS Flow of Funds (Baseline)

Instructions :

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

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

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	41,834,599	44,581,933	72,094,581	63,839,476	41,834,599	264,185,188
Practitioner - Primary Care Provider (PCP)	1,177,516	1,880,031	5,227,049	6,241,324	4,879,035	19,404,955
Practitioner - Non-Primary Care Provider (PCP)	9,700	379,422	1,997,186	2,449,841	1,766,150	6,602,299
Hospital	8,456,571	10,062,920	27,055,208	31,419,357	26,626,726	103,620,782
Clinic	229,625	928,908	4,007,835	5,175,345	3,332,301	13,674,014
Case Management / Health Home	0	327,562	2,220,431	2,854,148	2,348,610	7,750,751
Mental Health	268,500	1,356,962	2,775,531	3,180,348	2,598,610	10,179,951
Substance Abuse	0	232,544	1,580,308	2,032,963	1,676,150	5,521,965
Nursing Home	0	20,000	80,000	80,000	20,000	200,000
Pharmacy	0	10,000	40,000	40,000	10,000	100,000
Hospice	0	10,000	40,000	40,000	10,000	100,000
Community Based Organizations	298,313	1,257,027	1,562,133	1,639,195	982,460	5,739,128
All Other	0	0	0	0	0	0
PPS PMO	14,933,654	20,495,891	20,935,413	19,011,812	15,914,573	91,291,343
Total Funds Distributed	**25,373,879**	**36,961,267**	**67,521,094**	**74,164,333**	**60,164,615**	**264,185,188**
Undistributed Revenue	**16,460,720**	**7,620,666**	**4,573,487**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.4 - PPS Flow of Funds (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
41,834,599	264,185,188	21,549,667	243,900,256

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.i	2.a.iii	2.a.iv	2.b.iv	2.d.i	3.a.i	3.a.ii	3.c.i	3.d.iii	4.b.i	4.b.ii		
Practitioner - Primary Care Provider (PCP)	87,223	87,223	83.02	3.37	0	3.15	.24	2.82	0	2.19	2.28	1.68	1.25	1,090,293	19,317,732
Practitioner - Non-Primary Care Provider (PCP)	726,992	726,992	24.3	1.75	0	1.64	.13	1.47	66.86	1.14	1.18	.87	.65	-717,292	5,875,307
Hospital	298,035	298,035	6.05	0	0	0	0	0	93.95	0	0	0	0	8,158,536	103,322,747
Clinic	25,096	25,096	90.18	1.95	0	1.82	.14	1.63	0	1.27	1.32	.97	.72	204,529	13,648,918
Case Management / Health Home	78,627	78,627	9.52	.62	0	.58	.04	.52	87.35	.41	.42	.31	.23	-78,627	7,672,124
Mental Health	309,582	309,582	8.76	.16	0	.15	.01	.13	90.44	.1	.11	.08	.06	-41,082	9,870,369
Substance Abuse	282,691	282,691	.95	0	0	0	0	0	99.05	0	0	0	0	-282,691	5,239,274
Nursing Home	13,305	13,305	100	0	0	0	0	0	0	0	0	0	0	-13,305	186,695
Pharmacy	29	29	100	0	0	0	0	0	0	0	0	0	0	-29	99,971
Hospice	4,255	4,255	100	0	0	0	0	0	0	0	0	0	0	-4,255	95,745
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0	0	0	298,313	5,739,128
All Other	682,983	3,807,455	33.65	1.04	0	.97	.07	.87	61.11	.68	.7	.52	.39	-3,807,455	-3,807,455
PPS PMO	14,651,642	14,651,642	19.68	16.19	0	15.11	0	13.53	0	10.53	10.92	8.04	6	282,012	76,639,701
Total Funds Distributed	**17,160,460**	**20,284,932**													

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Module 1.4, Funds Flow Q3 reporting, requires the PPS to designate numeric values for amount of funds disbursed by provider type; and within provider type, indicate percent of funds disbursed by project. WMCHealth PPS makes payments to organizations (e.g. Legal Entity w/ Tax ID #), not to individual providers. In almost all cases, organizations include providers of multiple types. Since the reporting guidelines did not provide for reporting at the organization level, our PPS had to allocate payments down to the provider level (NPI/MMIS when available) and then aggregate these to the prescribed provider types required in Module 1.4.

Our payments to organizations can be for one project or may span several projects; we do not make individual payments to organizations per project. Therefore, we needed to determine a way of allocating funds flow not only by provider type but by project within provider type as required in Module 1.4.

Here is our methodology, summarized:

For the very few organizations with only one provider type, we allocated the payment (funds disbursed) to percent spent by project as follows: for the projects the organization participated in for Q3, we summed their associated project valuations as determined by NYSDOH and created a weighting factor to allocate funds across each project. The weighting factor, or percent for allocation by project, is determined by the individual project valuation divided by the sum of all project valuations that the organization participated in.

In most cases where an organization includes providers of multiple types, we evenly allocated the payment among all those providers and then calculated percent spent by project as described above. For organizations with no associated provider types, payments were included in the ALL OTHER category.

As per email dated 1/15/2016: "This reporting will ensure that the funds reported within the 12 defined Provider Type categories represents only funds distributed to PPS network partners." With respect to any funds retained by the PPS Lead organization, "The PPS will have the ability to appropriately reflect these funds as PPS retained funds once the PPS Lead Provider Type is available in IPP." Therefore since Funds Flow Items – "All Other" row per the "Total Amount Disbursed" column automatically includes amounts from prior quarters (including amounts for funds other than payments to providers), the "Total Amount Disbursed" as well as the total amounts for Benchmarks / "Undistributed Revenue YTD" and "Undistributed Revenue Total" are not calculating as they should. These amounts, "Undistributed Revenue YTD" and "Undistributed Revenue Total" should agree with the similar information requested and highlighted on IPQR Module 1.2 – PPS Budget Report (Quarterly)."

As per remediation guidance, emailed 03/01/16 for Q3, and the addition of the "PPS PMO" row, we allocated the funds retained by the PPS using the methodology described above.

Module Review Status

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

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IPQR Module 1.5 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	In Progress	Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1. Budgets for meeting "early" DSRIP deliverables for DY1 approved by the Finance Committee.	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Funds Flow and Distribution Plan for "early" funds signed off by the Finance Committee and shared with participating partners.	Completed	See Task.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Budgets for meeting the remainder of DSRIP deliverables for DY1 approved by the Finance Committee.	In Progress	See Task.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Funds Flow and Distribution Plan for remaining funds signed off by the Finance Committee and shared with participating partners.	In Progress	See Task.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Plan for annual updates.	On Hold	See Task.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - IA Monitoring

Instructions :

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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1. Identify standing committees.	Completed	This task completed; see upload meeting minutes in Milestone #1.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Transition Executive Committee (EC) from Planning EC to Operational EC; confirm member appointments.	Completed	This task completed; see uploads.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 4. In partnership with other PPSs in the region and the PHIP plan for the Hudson Region DSRIP Clinical Committee (HRDCC).	Completed	See Task.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Solicit and appoint members of the: Nominating Committee, Finance Committee, IT Committee, Workforce Committee and Quality Steering Committee.	Completed	Update as Required by IA: • Finance, Workforce and Nominating Committees will continue to present monthly committee reports to the Executive Committee • Quality Steering and IT Committees are being finalized and will begin monthly reports to the Executive Committee	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Establish project-oriented workgroups of the WMC PPS Quality Committee.	Completed	Update as Required by IA: July, 2015 update: Chairs of the WMC PPS Quality Steering	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		Committee and each of 8 Project Quality Advisory committees (PQAC) have been proposed and submitted to the Nominating Committee for approval. Participant organizations have been asked to submit names of those interested in PQAC participation and project management office (PMO) staff are working with PQAC chairs to schedule first meetings. The Hudson Region DSRIP Public Health Council (HRDPHC) has convened to begin planning and oversight of 4bi (Tobacco cessation). The Quality Steering Committee will provide clinical oversight of project 2ai, the PQAC for Behavioral Health will provide clinical guidance for projects 3ai and 3aii, two Medical Village projects will have local clinical governance and there will be PQAC for each of the following: 2aiii, 2biv, 2di, 3ci, 3diii, 4bii. For each project the designated quality committee will review target vs achieved milestones, numbers of activated patients and engaged providers, DSRIP quality performance measures applicable to each project (as data becomes available) and will consider developing additional metrics to gage project success.							
Task Step 2. Convene the WMC PPS Quality Committee.	Completed	See Task.	08/08/2015	09/30/2015	08/08/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Develop meeting schedules, identify staff support, and draft charter for each Committee and Workgroup.	Completed	See Task.	08/08/2015	12/31/2015	08/08/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1. Draft charters for Executive Committees.	Completed	This task completed; see uploads.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Establish process to communicate updates to PAC members.	Completed	We are producing quarterly newsletters in addition to posting updates on our website. We are in process of planning our second annual PAC Summit meeting.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Incorporate Executive Committee	Completed	Update as Required by IA: • Finance, IT, Workforce, and Quality Steering Committee	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
feedback into final charter documents.		charters,which includes details concerning committee by-laws and policies, have been finalized and are awaiting committee approval.							
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Draft and obtain review/feedback on Master Services Agreement (MSA) and exhibits, which will describe legal terms and conditions of WMC PPS participant relationships; document PPS governance structure, policies and services agreements with PPS Project Management Office (PMO).	Completed	This task completed; see uploads.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Send MSA to WMC PPS participants; host webinar to review.	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Finalize MSA and execute with PPS participants.	Completed	See Task.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Draft schedules that describe obligations of WMC PPS Participants.	Completed	Update as Required by IA: • A member of the Executive Committee will chair each governing committee and will monitor the status of each committee. • We have begun the design of an Executive Committee dashboard that will provide for each meeting status of the PPS implementation, minutes from Committee meetings, as well as Provider Status (e.g. MSA signed) etc. This should be completed by end of second quarter.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task	Completed	See Task.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 1. WMC PPS customizes Salesforce to support IDS network; establish provider type, geographic, and other categories.									
Task Step 2. Convene Quality Committee and planning groups for local deployment councils.	In Progress	See Task.	11/05/2015	06/30/2016	11/05/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3. Conduct Focus groups with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	Completed	Update as Required by IA: Our PPS is currently planning the following DY1 activities to engage public and non-provider organizations as a result of activities related to the Community Engagement Advisory Quality Committee; Hudson Region DSRIP Public Health Council; and NYSARC; and Focus groups to engage community members in our hot spots. Our initial Focus groups are scheduled for October-December in one hot spot and will complete as indicated in 2.a.i. by Q4 of DY1. However, we plan additional Focus groups in at least 2 other hot spots through DY2 Q1. We are also participating in the White Plains Wellness Week in September.	10/27/2015	12/31/2015	10/27/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Identify gaps in organization types (including public and non-provider, CBOs) by crosswalking exisitng network to needs identified in CNA .	In Progress	See Task.	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. PPS holds webinars and conference calls to convene committees and workgroups that include CBO participation.	Completed	Additional Information, which also addresses IA comments on Inclusion of CBOs: • Identify CBOs willing to participate in network through the Community Engagement Advisory Quality Committee and facilitate completion of Master Services Agreement (MSA) for those who have not yet done. • Develop CBO payment arrangements based on applicable projects and other initiatives; Roles and Responsibilities will be delineated in each MSA Schedule B. • Templates for Schedule B's are currently in development.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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		• Upon DOH reopening PPS network, pursue additional CBOs to join WMC network							
Task Step 2. Execute MSA with some PPS Participants and/or service contracts between PMO and CBOs as appropriate.	In Progress	• 250 MSAs were sent on May 14th, 2015. As of July 27th, we have received 156 MSAs, including 27 from CBOs.	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Completed	Agency Coordination Plan.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task Step 1. Convene Hudson Region DSRIP Public Health Council (HRDPHC) including participation by all three Hudson Valley PPS with local departments of health, mental health and social services. HRDPHC will be a forum for ensuring LGU input into the work of DSRIP PPSs in the Hudson Valley.	Completed	Additional Information as Required by IA: Our PPS has had an ongoing relationship with local public agencies since last July 2014; we continue to meet quarterly with our LGUs through the regional network meeting (our next meeting is Aug 27; this includes DOH, DOMH and DSS; all 8 counties invited). We also have representation of state and local agencies on our HVDPHC including NYSQuitline, American Cancer, etc (see upload for this Task for participant list and planned activities). Each group participates based on ongoing agreements for action items that should be decided by end of DY1, Q3. We anticipate contracts with CBOs and LGUs as described in Milestone #6.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Establish Webinars and conference calls as the main forum for convening committees and workgroups that agencies will participate on and for presentations about the DSRIP program and PPS- specific projects, goals and progress. Continue quarterly in- person meetings with LGUs in the region via the Hudson Valley Region Health Officers Network.	Completed	Next meeting HVHRON August 27, 2015	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Include training on use of MIX into agency coordination plan; as appropriate,	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
committees and workgroups will set up group sites on the MIX (currently the HRDPHC tobacco cessation group has a site.) All committee members will be offered MIX training.									
Task Step 4. Agency coordination plan will include enrolment of LGUs into Salesforce (SF) which will allow our PPS to track which agency (and other) organizations are participating in our PPS and assure all meetings and minutes are tracked and made available to participants.	Completed	See Task.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #8 Finalize workforce communication and engagement plan	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1. Workforce Committee identifies workforce communication goals, objectives, key themes and target audiences.	In Progress	See Task.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2. Develop preliminary training strategy (e.g., scale, timing, scope, methodologies, content and cultural competency considerations) as defined in Milestone 5 of the Workforce Strategy.	In Progress	See Task.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3. Identify cultural diversity and literacy training needs through the following sources: the Cultural Competency Survey results from our CNA results, current needs assessment surveys of our partners, focus groups with Medicaid residents and the uninsured as well as input from our "subject matter experts (SME)" from health and behavioral health care provider s and CBOs. This SME advisement will come from members of our Community Engagement Quality Advisory Committee and local deployment councils that	In Progress	Additional Step/Task as Required by IA.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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will include area workers and union representatives.									
Task Step 4. Develop a web-based educational model(s), which will utilize the results of the information gathered in Step 3 above, for partners in our network/region with an expert academic partner, to raise awareness of the regional health disparities and the cultural diversity of the population.	In Progress	Additional Step/Task as Required by IA.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Collect information of existing and planned training programs and resources, via surveys with our partners, including their capacity to expand and support PPS workforce training needs as identified in the gap analysis.	In Progress	We began collecting this information through our Workforce Survey as part of our Current State Assessment.	09/08/2015	12/31/2016	09/08/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6. Workforce Committee and stakeholders develop training schedules and communication plans that engage all levels of the workforce; once agreement is reached schedules and plans approved by workforce governance.	Not Started	See Task.	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7. The Workforce Committee with the assistance of the IT Committee develops a platform for required quarterly reports and for tracking program offerings and participation and develops mechanism to measure training effectiveness in relation to goals once strategy and plan implemented.	Not Started	See Task.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. CBOs will be represented on our PAC	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and recruited to participate on the Project Advisory Quality Committees, the HRDPHC, local deployment councils, and focus groups/community engagement sessions.									
Task Step 2. The PMO will establish webinars and conferece calls as the main forum for convening committees and workgroups and sharing presentations about PPS-projects, goals and progress to gather feedback on project delivery.	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. WMC PPS will finalize partnership agreements or contracts with CBOs as outline in Milestone #6.	In Progress	See Task.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	violad	Other	21_MDL0203_1_3_20160114101208_20161026_Q3_All_Committee_Meeting_Schedule.xlsx	Updated Meeting Schedule Template for Executive Committee and Sub-committees, Q3.	01/14/2016 10:12 AM
	violad	Other	21_MDL0203_1_3_20160114100909_20151015_Q3_Governance_Executive_Committee_Template_FINAL.xlsx	Updated Committee template to reflect changes for Q3 approved by Nominating and Executive Committees.	01/14/2016 10:09 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	violad	Other	21_MDL0203_1_3_20160114100058_2016111_Quality_Committee_Meeting_Schedules_01112016.xlsx	Meeting Schedule Template for Quality Advisory Committee meetings	01/14/2016 10:00 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	violad	Other	21_MDL0203_1_3_20160114100002_2016113_Project_Advisory_Quality_Committee_Charters_ALL.pdf	Workbook containing all Quality Advisory Committee Charters	01/14/2016 10:00 AM
	violad	Other	21_MDL0203_1_3_20160114095904_2016113_ALL_Project_Advisory_Quality_Committee_Membership.xlsx	Workbook containing all Quality Advisory Committee Member Rosters	01/14/2016 09:59 AM
	violad	Other	21_MDL0203_1_3_20160111152811_20151008_Governance_Organizational_Chart.pptx	Clinical Governance Structure Chart	01/11/2016 03:28 PM
Establish governance structure reporting and monitoring processes	violad	Other	21_MDL0203_1_3_20160111154413_WMCHealth_PPS_Governance_Structure_Reporting_and_Monitoring_Protocol.pdf	Governance & Committee Structure Reporting & Monitoring Document	01/11/2016 03:44 PM
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	violad	Other	21_MDL0203_1_3_20160111154852_20151123_Public_Sector_Agency_Template.xlsx	Public Sector Agency Template	01/11/2016 03:48 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	Yes there have been updates to Milestone #1. We have uploaded a Governance Committee template to reflect new membership approved by the Nominating and Executive Committees during Q3. We also uploaded a Meeting Schedule Template to reflect Executive and Sub-Committee meetings for Q3.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	As per guidance for Domain 1 Milestone reporting, for this Milestone we are submitting an organization chart for clinical governance; the Quality Steering Committee (QSC) and Project Advisory Quality Committees (AQC) list of members, approved Charters, and a Meeting Schedule Template that includes all meetings for the QSC and Project AQC.
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	As required, we are uploading a Governance & Committee Structure Reporting and Monitoring Document to substantiate successful completion of this Milestone.
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.)	To substantiate our successful completion of this milestone we have submitted the following required supporting documentation, the Public Sector Agency Template.
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	
Milestone #2	Pass & Complete	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Complete	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Fail	The documentation submitted was insufficient to demonstrate completion of the milestone. The Westchester County Department of Community Mental Health contract was not available for the IA to review.
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	

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IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

1. Recruitment and active ongoing participation and engagement by participant leadership. The care delivery transformation envisioned under DSRIP requires not only significant stakeholder input but active, ongoing and engaged provider, community based organization, payer and patient representative leadership. We recognize that Committee and PAC members have significant obligations outside of the PPS and have limited time to devote to PPS activities outside of DSRIP. We will schedule meetings in advance so participants have a line of sight to plan their calendars, will develop meeting agendas and employ principles of disciplined meeting facilitation to ensure meetings are productive and will seek to limit time commitments required. We will also utilize one PPS Quality Committee (instead of 11 different project quality committees) with functional workgroups and tiger team taskforces as necessary.
2. Cross-discipline expertise required to successfully implement projects. While our executive governance structure calls for specific Committees to ensure the PPS is in compliance with State and Federal DSRIP obligations through delegated monitoring of reporting obligations, we recognize that implementation of projects will only be successful if decisions related to clinical protocols, workforce training, IT systems, value based contracting, etc., are not made in siloes and cross-functional teams come together to develop project specific implementation plans. As such, we have developed a governance structure that allows flexibility to bring together both ad hoc and ongoing workgroups and will be developing a cross-functional approach by DY1 Q2.
3. Execution of Master Services Agreement and detailed schedule attachments. Given the size and diversity of provider types involved in our PPS, developing and negotiating the Master Services Agreement and funding schedules among the PPS Participants within an expedited timeframe will be a significant undertaking. Each of our Participants has different capabilities, resources and interests. Our Executive Committee will approve the terms sheet upon which the MSA is based and will be reviewing the draft MSA in the first quarter, followed by review by the larger PAC. We will be deploying detailed, individualized attachments on a rolling basis against a prioritized schedule informed by stage of DSRIP project development and individual Participant site commitments made to provider speed and scale during the application development.
4. Alignment across multiple PPSs in the region. Given that our PPS spans eight counties and that there are other PPSs that overlap with our region, several of our Participants are involved in more than one PPS and will face both competing demands on their time for governance activities and potentially unaligned protocols and project implementation approaches. To minimize this burden on Participants, we are actively collaborating with the other PPSs in our region and have established a Regional Clinical Council that will align protocols to the extent possible on overlapping projects and will seek to reduce additional demands on time by clinical leaders in the region.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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Our governance structure is the backbone of our DSRIP accountability and will have significant, substantive overlap with all DSRIP work streams. Representatives from our PPS partner network will be called on to participate in a wide range of Committees and Workgroups that will have responsibility for protocols and policy development. All participants will, through the MSA and as a condition of PPS DSRIP participation, agree to adhere to policies and procedures that impact IT, workforce, funds flow, financial sustainability, cultural competency, practitioner engagement, clinical integration, population health management, performance monitoring, and community engagement.

Specific to the success of the Executive Committee and its governing Committees, there is a critical dependency on the IT systems and communications work streams that will assure accurate collection and monitoring of key performance, workforce and financial metrics. The WMC PPS will rely upon existing and new IT systems for communications purposes including webinars and conference calls, and portals for sharing of results.

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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
Chair PPS Executive Committee & SVP Westchester Medical Center	Anthony Mahler, WMC	Represent WMC, lead applicant and fiduciary. Lead review and adoption of policies by EC; ensure ongoing monitoring by EC and accountability.
Executive Director of Center for Regional Healthcare Innovation	June Keenan, WMC PMO	Responsible for overseeing DSRIP program management, including compliance with governance protocols and Participant contracts and overall DSRIP operations.
Medical Director, Center for Regional Healthcare Innovation	Janet Sullivan, MD, WMC PMO	Operational oversight of clinical and quality processes, including deployment of protocols and metrics (as developed and adopted through governance process).
VP Operations, Center for Regional Healthcare Innovation	Peg Moran, WMC PMO	Operational oversight of business, operations and finance protocols.
SVP and Deputy General Counsel	Beth Davis, WMC	Lead responsibility for development of policies and procedures and participant contracting documents (will work with outside counsel and Participant representatives).
SVP Financial Operations	John Morgan, WMC	Lead responsibility for financial oversight.
SVP, Internal Audit & Compliance	Patricia Arial, WMC	Lead responsibility for audit and compliance.
PPS Executive Committee Members	Multiple providers and provider types [Provided upon request; avail on PPS website]	Governing body of the PPS, in effect the Board of the PAC. Responsible for adopting terms sheet, policies and procedures, committee charters, etc. and well as populating committees. Responsible for transparency and accountability.
PPS PAC Members	[Provided upon request; avail on PPS website]	Participation in Committees and Workgroups, participation in PAC meetings, input and feedback on draft documents, adherence to participation agreements.

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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		
Project Advisory Quality Steering Committee Members / Chairs	Chair quality committees for specific projects	Clincial protocols and oversight of individual project plans
External Stakeholders		
Regional Clinical Council Members	Multiple Providers and Provider Types	Overarching protocol and metrics direction on projects that are common to more than one PPS in the region
Regional Public Health Council Members	Multiple Providers and Provider Types	Overarching direction on projects that are common to more than one PPS in the region and assuring communication with LGU and CBOs

IPQR Module 2.7 - IT Expectations

Instructions :

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

The Governance work stream is heavily dependent on the shared IT infrastructure that underpins the success of an integrated delivery system aimed at improving population health. Governance, including the Executive, Clinical, Workforce, and IT committees, encompasses oversight and accountability for PPS performance, and as such relies on metrics and reporting enabled by the IT and Systems that we put in place. Key components of the IT & Systems work stream including data sharing and interoperability, patient identification, data-driven change, and performance reporting are key to providing the governance structure with insight into the progress and performance of individual network partners, and the PPS overall. This reporting will enable the governance structure to identify areas of programmatic success and importantly, areas of risk so as to enable timely course correction.

WMC PPS's approach to meeting our IT requirements includes the investment in a robust customer relations database to support the management if network partners related to their program participation and reporting, as well as administrative functions such as contracting. This platform will be used to the extent possible to track submission of Domain 1 metrics to WMC PPS. The IT committee will identify and communicate opportunities identified through the current state assessment to utilize IT to improve the process and outcomes of care, as well as the risks and impacts of IT-driven change to network practices. Each of the PPS Committees will play a role in supporting the connections of network providers to the local HIE (QE) SHIN-NY and the adoption of interoperable health IT platforms, including EHRs that meet MU standards.

To support the improvement of population health and establishment of value-based contracting, the ultimate objectives of DSRIP, WMC PPS will make use of IT systems to manage our attributed population, as well as the "total" population – unattributed patients who receive care from our network or who are simply part of our communities. First, we will leverage the potential of NYS DOH's MAPP portal for management of attributed members including enrollment, gaps in care, utilization and outcomes analysis, and performance reporting. Next, we will create a road map to establishing a platform that supports robust health analytics including the integration of data from multiple sources. Finally, we recognize that the increased role of IT and associated data and reports will require the development of new competencies. Accordingly, our IT requirements include the creation of a strategy to train clinical and non-clinical segments of the workforce to use IT effectively to improve the quality of health care in our region.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

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Success will be measured by the occurrence of meetings of the Executive Committee, Finance Committee, Quality Steering Committee, IT Committee, and Workforce Committee at a frequency in accordance with the applicable charter and documentation of meetings through meeting agendas and meeting notes. In addition, PPS operational policies and procedures (as detailed above) will be developed, adopted and implemented.

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Executive Committee adopts Finance Committee charter.	Completed	This Task completed; see upload.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Appoint members to operational Finance Committee (transitioning from planning Finance Committee) and establish regular meeting schedule.	Completed	This Task completed; see upload.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Define the Roles and Responsibilities of the WMC (PPS Lead organization) and PMO (Center for Regional Healthcare Innovation) finance .	Completed	Additional Information as Required by IA: • WMC PPS CFO-John Morgan, SVP, Financial Operations (refer to table), co-chairs PPS Finance Committee and is a member of the Executive Committee • WMC CFO is responsible for the annual PPS budget, funds flow, financial reporting and oversees the Center for Regional Healthcare Innovation PMO's fiscal operations.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4. Develop financial structure chart/document and present to Executive Committee for sign off.	Completed	See Task.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4a. PMO will provide quarterly financial managment reports to the Finance Committee through Governance Dashboard. Finance	Completed	Additional Step/Task Required by IA: Governance Dashboard under development; anticipated completion September 30, 2015. Update: Exec Committee	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Committee reports will also be provided to the Executive Committee.		reiewed template for dashboard at their September meeting. Anticipated completion of dashboard is scheduled for 12/31/2015 as per our development team.							
Task Step 5. In order to monitor fiscal operations , the PPS will implement internal controls including; monitoring of the RFP process; distribution of funds including those for vendor payables; reconciliation of accounts and variance analysis for actual vs. budgeted revenue and expense categories.	Completed	See Task.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5a. Document and implement initial financial controls and reporting structure (including naming auditor), recognizing that financial oversight will evolve with broader program implementation and further guidance from DOH.	Completed	Additional Step/Task Required by IA.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5b. WMC will revise and/or implement additional internal controls as deemed necessary.	Completed	Additional Step/Task Required by IA.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5c. WMC will provide ongoing training to PPS providers via webinars.	Completed	Additional Step/Task Required by IA. First training webinars held in April on MSA.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	In Progress	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 1. Identify core PMO and WMC staff to support ongoing financial health assessment monitoring.									
Task Step 2. Establish Financial Assessment and Restructuring Workgroup of the Finance Committee (as discussed in DSRIP application).	In Progress	See Task.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Review financial health data compiled from survey distributed during DSRIP planning phase; identify and address information gaps and conduct assessment of any new (or added since initial network lists) providers utilizing existing tool and process.	In Progress	Additional Information as Required by IA: The PPS will evaluate the fiscal metrics of PPS Partners on an annual basis. These metrics include: cash on hand, current ratio, payer mix, liquidity of assets, debt-to-asset ratio, and preparedness to implement a value-based payment structure on an annual basis.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Identify financially frail and potentially financially frail (those who exhibit certain risk factors) and review status with Finance Committee.	In Progress	See Task.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Develop procedure for ongoing (annual) monitoring of financial fragility status of identified providers and the impact on service delivery for Medicaid beneficiaries, with updates to Finance Committee and Executive Committee at regular intervals as determined by Finance Committee.	In Progress	See Task.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6. Subsequent quarterly reports will track plans to address financial status of providers.	In Progress	See Task.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4a. Identified financially fragile PPS partners will submit quarterly fiscal reports for WMC PPS monitoring	In Progress	Additional Step/Task as required by IA.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4b. Based on submitted financial metrics, make funds available for financially fragile PPS Partners	In Progress	Additional Step/Task as required by IA.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Review New York State Social Services Law 363-d with Counsel.	Completed	Additional Information as Required by IA: • The PPS CFO, John Morgan, is a member of the PPS Executive Committee and Co-Chair of the PPS Finance Committee. In this role, Mr. Morgan will be informed of compliance activities and will actively participate in the evaluation and recommendation of compliance activities. Patricia Ariel, Chief Compliance Officer for Westchester Medical Center (WMC), will serve as our PPS Compliance Officer and will have a matrixed oversight of PPS leadership, including CRHI, with regard to DSRIP compliance. As part of the Compliance Plan, and to ensure that PPS network members are complying with the requirements of NYS Social Services Law 363-d, which include the requirements of the code of conduct, network members will be required to submit to the PPS Compliance Officer a copy of their submitted annual OMIG certification.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Update WMC PPS's compliance plan as needed to be consistent with NYS Social Services Law 363-d and update Executive Committee.	Completed	Additional Information as Required by IA: • The WMC PPS Lead will be including community stakeholders and governmental agencies, who make up the Executive Committee, in order to meet all requirements under NYS Social Services Law 363-d. • PPS will involve community stakeholders (provider agencies, trade orgs), and government agencies (DOH, OMH, LGUs), as appropriate based on provider compliance findings.	10/13/2015	12/31/2015	10/13/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Implement monitoring protocols and annual compliance plan review procedure.	Completed	See Task.	11/10/2015	12/31/2015	11/10/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task	Completed	See Task.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Step 1. Review final State value-based payment roadmap with Finance and Executive Committees.									
Task Step 2. Establish Value-Based Payment Task Force (note, previously referred to as Financial Sustainability Taskforce in DSRIP Application; further guidance on financial sustainability workstream expectations from DOH led to modification).	In Progress	See Task.	09/15/2015	03/31/2016	09/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Conduct current state assessment of value-based payment across all WMC PPS Participants.	In Progress	See Task.	09/15/2015	03/31/2016	09/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3a. WMC PPS will conduct an electronic survey of PPS Partner's fiscal operations including their readiness to implement a Value Based Payments model.	In Progress	Additional Information/Step required by IA.	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Continue value-based payment models and strategies discussions with the Hudson Valley's three largest Medicaid Managed Care Plans that began during the planning phase (note, Hudson Health Plan, the largest plan in the region, serves on the WMC PPS Executive Committee).	In Progress	See Task.	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. WMC PPS will provide education and support on VBP arrangements; we will make this training available through our annual Summit and more locally through the local deployment councils.	In Progress	Additional Information/Step required by IA. Summit date, November 5, 2015	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3	YES

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Task Step 1. Review baseline assessment of Participants' value-based payment arrangements (and capabilities).	In Progress	See Task.	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2. Conduct gap assessment to achieving stated goal of 90% within five years.	In Progress	See Task.	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3. PPS Draft VBP Plan, including MCO strategy, distributed for stakeholder feedback.	In Progress	See Task.	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4. Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee.	In Progress	See Task.	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5. PPS will provide updates on implementation of VBP plan.	In Progress	See Task.	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize PPS finance structure, including reporting structure	violad	Other	21_MDL0303_1_3_20160122104309_WMCHealth_PPS_Finance_Committee_Presentation_11_17_2015_Financial_Structure_Related_ONLY.pptx	Organization Charts	01/22/2016 10:43 AM
	violad	Other	21_MDL0303_1_3_20160120145514_WMC_PPS_Executive_Committee_6-25-15_minutes.doc	Executive Committee Meeting Minutes Approving Finance Committee Members	01/20/2016 02:55 PM
	nbajaj	Other	21_MDL0303_1_3_20160119103520_4_Copy_of_20151008_Finance_Committee_Meeting_Schedule_11.17.15.xlsx	Finance committee Meeting Schedule Template.	01/19/2016 10:35 AM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	nbajaj	Documentation/Certification	21_MDL0303_1_3_20160119104744_1_View_-_2015_OMIG_Certification_Federal_Deficit_Reduction_Act_2005.pdf	Copy of 2015 Certification Confirmation, Federal Deficit Reduction Act	01/19/2016 10:47 AM
	nbajaj	Documentation/Certification	21_MDL0303_1_3_20160119104655_1_View_-_2015_OMIG_Cert._NYS_Mandatory_Provider_Compliance_Program.pdf	Copy of 2015 Certification Confirmation, NYS Mandatory	01/19/2016 10:46 AM
	nbajaj	Documentation/Certification	21_MDL0303_1_3_20160119104613_1_View_-_2014_OMIG_Certification_WMC.pdf	Copy of 2014 Certification Confirmation from OMIG	01/19/2016 10:46 AM
	nbajaj	Other	21_MDL0303_1_3_20160119104429_1_View_-_20151130_WMC_DSRIP_Compliance_Manual_-_Final_Draft_Clean_Version.docx	WMC PPS Compliance Plan Document	01/19/2016 10:44 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	We have uploaded supporting documentation to substantiate completion of this milestone: Organization Charts for the governing body and each subcommittee detailing the finance structure and list of members; evidence of PPS Board approval of Finance committee; and a Meeting Schedule Template.
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	We have uploaded supporting documentation to substantiate completion of this Milestone, including: WMCHealth PPS Compliance Plan; a copy of the certification confirmation (2014 & 2015). We are currently conducting a risk assessment to identify those areas of risk that will comprise our annual work plan.
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	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

Milestone Review Status

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

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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. Because our PPS spans eight counties, we recognize it may not be feasible or desirable to enter into value-based contracts on behalf of all Participants; we anticipate setting up new or supporting entities to enable appropriate contracting arrangements with local MCOs. We recognize that local circumstances and needs may prevent a singular approach to sustainability and some arrangements may be acceptable in one region but not another; this may also be driven by the presence of MCOs in some, but not all, PPS counties. The entities will also carry forward the responsibility of sustaining outcomes after the conclusion of the Program.
2. Value-based reimbursement is designed to shift the basis of reimbursement from volume to value by incorporating incentives to improve financial & clinical performance. Simply changing incentives is not sufficient to achieve sustainable transformation. Culture change, substantial investment in information technology infrastructure, data mining/business intelligence tools, workforce training, process redesign and care model transformation and adoption of population health orientation requires significant time. This is particularly a challenge for safety net providers who care for a disproportionate percentage of Medicaid and uninsured patients. To ensure fragile safety net providers will achieve a path of financial sustainability and transition to VBP models, our PPS will create an innovation pool to which PPS Participants may apply for funding to enable their transition and mitigate potential losses/financial challenges when transitioning away from their existing business model. The Finance Committee will develop criteria and an application process for the distribution of funds.
3. The state of readiness for payment reform across our PPS Participants varies greatly. In order for value-based reimbursement to be successful, providers must have the right infrastructure in place, cultural alignment and must becoming willing to embrace at least a degree of risk. As our PPS endeavors to advance clinical integration and clinical care redesign to promote accountability for cost, quality and value in a robust and sustainable care network, we will be evaluating provider readiness, leveraging DSRIP to build shared infrastructure, and building strong alliances providers supported by a strong technical assistance program through the PMO.
4. Our PPS began an active dialogue with regional Medicaid plans during the DSRIP planning process and, understanding the critical importance of MCO involvement, ensured MCO representation on our Executive Committee and as part of our clinical program planning. We will continue to work with MCOs through our VBP Task Force and as partners in our governance process.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Financial Sustainability is in many ways the "end game" of the DSRIP transformation effort and, as such, has a critical interdependency with all operational and clinical performance workstreams. In particular, there are clear linkages with: Governance, Performance Reporting,

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Finance/Budgeting, IT, Clinician Engagement, and Population Health / Clinical Integration.

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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
Executive VP for Financial Planning and Managed Care	Mark Fersko, WMC	Responsible for value-based contracting strategy and managed care operations. Co-chair of Value-Based Payment taskforce. Will have executive responsibility for final Value Vision and Action Plan and for establishing value-based contracts on behalf of WMC.
SVP Financial Operations & Co-Chair WMC PPS Finance Committee	John Morgan, WMC	Responsible for financial operations and DSRIP funds flow. Co-chair of PPS Finance Committee, responsible for oversight of the annual financial health assessment policies and protocols as well as annual deployment, development of Value Vision and Action Plan (through the Committee's Value-Based Payment Task Force), and accountability for financial sustainability workstreams (including compliance review).
SVP Strategic Planning & Chair WMC PPS Executive Committee	Anthony Mahler, WMC	Chair of Executive Committee. Committee is responsible for final approval and adoption of financial health assessment policies and protocols; Value Vision and Action Plan, governance responsibility in monitoring of progress against plan and institution of course correction when necessary, and ensuring accountability for all financial requirements related to DSRIP.
SVP, Executive Director, Center for Regional Healthcare Innovation	June Keenan, PMO	Lead responsibility for DSRIP program for PPS lead WMC
VP Operations, Center for Regional Healthcare Innovation (CRHI)	Peg Moran, PMO	Executive responsibility for CRHI (which acts as PPS program management office) operations and hiring and management of financial staff.
PPS Executive Committee Members	Multiple Providers	Governing Body of the PPS.
Co-Chair Finance Committee	Lindsay Farrell, CEO Open Door Medical Center	Co-chair of PPS Finance Committee, responsible for oversight of the annual financial health assessment policies and protocols as well as annual deployment, development of Value Vision and Action Plan (through the Committee's Value-Based Payment Task Force), and accountability for financial sustainability workstreams (including compliance review).
SVP Audit & Compliance	Patricia Ariel, WMC	Oversight of development and implementation of the compliance plan for both WMC (PPS lead) and related compliance

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		requirements of the PPS as they are defined. Responsible for reports and updates to the Finance and Executive Committees.
SVP & Deputy General Council	Beth Davis, WMC	Oversight of legal contracts, including detailed provider schedule attachments to the WMC PPS DSRIP Master Services Agreement, which detail funds flow to providers and related provider-level requirements. Responsible for oversight of value-based contracting related to DSRIP.
Value-Based Payment Taskforce Members (roster will be available on request)	PPS Value-Based Taskforce	Responsible for development of value-based payment roadmap and creation of Value Vision & Action Plan.
PPS Finance Committee	Multiple Providers	Advises and reports to the PPS Executive Committee on recommendations for PPS budgeting, funds flow allocation, and provider financial assessments.

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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		
CFOs and Managed Care Contracting executives at PPS Participant organizations	Financial and contracting oversight at PPS Participants	Responsible for contributing to PPS VBP baseline assessment and ultimately ensuring transition to Value Based Payment contracts in their respective organizations. Will be asked to review and provide feedback to Value Vision & Action Plan.
Senior Director, Finance and Administration, CRHI	Joseph Liberatore, PMO	Senior Director has overarching responsibility for budget and financial reporting.
Senior Director, IDS, CRHI	Helene Kopal, PMO	Responsible for IT infrastructure and generating of reports
WMC PPS Quality Committee	PPS Quality Committee	Responsible for clinical protocol establishment and quality monitoring, which will ultimately demonstrate value to market place and facilitate feasibility of value-based payment and reporting to support VBP
External Stakeholders		
Regional Medicaid Managed Care Organizations and other payers	Payers responsible for contracting with providers	Participation in Value-Based Payment strategies and options discussions, review and feedback into the WMC PPS Value Vision & Action Plan, responsibilities related to implementing the PPSs value based strategy, the contracting process, and implementation / administration of executed value based agreements.
New York State Department of Health	Manages Medicaid program, regulates Medicaid reimbursement, defines DSRIP program requirements	The PPS Lead and PPS finance function has responsibility for the overall administration of DSRIP reporting to DOH and the funds flow process. DOH also has ability to support regulatory waiver requests that will facilitate Value-Based Payment and to setting policies for Medicaid program transition to VBP in five years.
External Auditor	Responsible for 3rd party external compliance audit	External audit function

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IPQR Module 3.7 - IT Expectations

Instructions :

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

IT Systems and Processes impact every other organizational workstream, especially the Financial Sustainability workstream and provide the infrastructure for Population Health Management and DSRIP projects data analysis and reporting. IT support will also enable tracking and reporting of financial health of Partner organizations, value-based contracting in the PPS, infrastructure deployment, training requirements and impact on outcomes.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

The WMC PMO will monitor and advance the Financial Sustainability Workstream through a combination of PMO staff, senior WMC finance and compliance executives at WMC, PPS Finance Committee and Value-Based Payment Task Force reporting to the PPS Executive Committee.

IPQR Module 3.9 - IA Monitoring

Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1. Establish a Community Engagement Quality Advisory Committee.	Completed	This committee also serves as Advisory Quality Committee for 2.d.i; see upload list of members.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.	Completed	Need PHI data attribution from NYSDOH	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3. Identify cultural competency and health literacy champions within the local deployment groups established as part of Clinical Governance who are responsible for patient and provider engagement. These Champions will communicate cultural competency strategy and plans to our provider network and report back to the WMC Quality Committee and Workforce Committee.	Completed	Will also work through Community Engagement Quality Advisory Committee.	09/30/2015	12/31/2015	09/30/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Using information from the Cultural Competency Survey distributed to providers during our CNA and mapped against the results of Step 1, we will conduct a gap assessment of cultural and linguistic capabilities of providers. We will also be able to compare access issues identified from the Consumer survey with provider services identified as part of our project plans to identify key factors that must be addressed to improve access.	Completed	Detailed provider survey will be finished DY1, Q4	11/05/2015	12/31/2015	11/05/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5. Conduct initial Focus groups with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	Completed	See Task.	10/27/2015	12/31/2015	10/27/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6. Establish Cultural Competency/Health Literacy workgroup as a subset of the Workforce Committee to oversee identification of evidence-based clinical training that takes into consideration disease risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest	Completed	See Task.	10/06/2015	12/31/2015	10/06/2015	12/31/2015	12/31/2015	DY1 Q3	

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approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee, who in turn will share these standards/approaches with the Hudson Region DSRIP Clinical Council to coordinate with the other 2 PPSs in the region.									
Task Step 7. Include within the Workforce Assessment and Strategy the need to engage our PPS network in identifying best practices for dealing with disparities that should be shared with providers and community groups, especially for vulnerable sub populations.	Completed	See Task.	10/06/2015	12/31/2015	10/06/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8. Obtain Executive Committee approval of Proposed Strategy.	Completed	See Task.	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 9. Begin identification of appropriate and meaningful measures to monitor ongoing impact of the WMC PPS Cultural Competency Strategy.	Completed	See Task.	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 10. Establish mechanism to evaluate interventions and processes included in the approved Strategy by utilizing a Plan-Do-Study-Act (PDSA) cycle. The Community Engagement Quality Advisory Committee as well as the WMC PPS Quality Committee will evaluate and advise on the results.	Completed	Additional Step/Task required by IA.	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 11. Solicit ongoing feedback on the various structures, processes and interventions that are part of the Strategy through brief interviews and surveys of key community partners and consumers through the local deployment councils.	Completed	Additional Step/Task required by IA.	09/30/2015	12/31/2015	09/30/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2	In Progress	This milestone must be completed by 6/30/2016. Cultural	10/15/2015	06/30/2016	10/15/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).		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							
Task Step 1. Define a current state training need based on Steps 1, 2 and 5 of the cultural competency/health literacy strategy above.	In Progress	See Task.	10/15/2015	03/31/2016	10/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. In collaboration with partners identified in the Workforce Training plan, including CBOs, providers, unions and New York Medical College, and incorporating findings from Steps 3 and 4 from the above milestone, the PPS PMO will either develop or subcontract to vendors training that will address disparities identified as part of our current state training needs assessment.	Not Started	See Task.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3. Obtain Executive Committee approval of Proposed Training Strategy.	Not Started	See Task.	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4. Develop content for material and online modules after Step 6 in the above milestone for providers in the region to raise awareness of regional health disparities.	In Progress	See Task.	11/05/2015	06/30/2016	11/05/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5. Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation.	In Progress	See Task.	11/05/2015	06/30/2016	11/05/2015	06/30/2016	06/30/2016	DY2 Q1	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	violad	Other	21_MDL0403_1_3_20160116105244_CC-HL_TrainingSchedulefor_Reporting2015Dec.xlsx	Cultural Competency Health Literacy Training Schedule Template	01/16/2016 10:52 AM
	violad	Other	21_MDL0403_1_3_20160116105201_CC-HL_MtgSceduleforReporting2015Dec.xlsx	Cultural Competency Health Literacy Meeting Schedule Template	01/16/2016 10:52 AM
	violad	Other	21_MDL0403_1_3_20160116105049_12152015__CCHL_Strategy_Document_FINAL.pdf	Cultural Competency Health Literacy Strategy Document approved by Executive Committee December 15, 2015	01/16/2016 10:50 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	We have successfully completed Milestone 1 as reflected in our uploads: Cultural Competency and Health Literacy Strategy Document approved by the Executive Committee; a Meetings Template detailing our activity in the community; and our Training Template identifying the training and informational materials we have created and distributed for the benefit of our Project Managers, Quality Advisory Committees and/or PAC members.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	

Milestone Review Status

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

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Our PPS may have difficulty in getting frontline workers and key stakeholders to support cultural competency training requirements because they are perceived as additional/burdensome. To mitigate this risk we have included union representation on our Workforce Committee. We have also included champions for Cultural Competency/Health Literacy as part of our local deployment. This will also allow communication with network partners so that all PPS training requirements can be planned for and assessed with respect to workforce impact. Staffing may be a concern for providers who will need to screen for BH disorders or Patient Activation. To mitigate this we will provide training through outreach cooperatives which will include PCP and staff training supported with implementation toolkits that facilitate culturally competent use of assessment tools (PHQ2, SBIRT, PAM). There is also limited baseline knowledge of organizational performance due to lack of data and insufficient numbers of culturally and/or linguistically trained staff. To mitigate this risk we have come up with a Workforce Strategy to train and hire additional staff.

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.)

Our Cultural Competency and Health Literacy strategies are largely dependent on Finance and Workforce work streams. We have integrated our CC/HL budget into the Workforce Budget and a member of the Finance Committee is represented on the Workforce team. There are also direct links between training components of our CC/HL strategy that need to be coordinated and assessed for impact on workforce. To do this we have integrated the elements of our CC/HL strategy in parallel with the Workforce training requirements. In addition our Workforce Plan includes recruitment of bilingual health educators, medical interpreters and staff to fill gaps identified in our initial assessment of staffing as part of our CNA conducted last November. This will be updated when our CC/HL current state assessment is completed. Our strategy is also dependent on Clinical Integration; we have integrated champions who will coordinate with the WMC PPS Quality Committee.

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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
WMC PPS Cultural Competency & Health Literacy Lead	Deborah Viola, PhD, VP & Director Health Services Research & Data Analytics (PMO)	Identification of Health Disparities and overall assessments, and content development related to training on disparities.
WMC IDS/IT development	Helene Koppel, Sr Director, IDS (PMO)	Responsibility for IT systems related to workforce and cultural competency/health literacy training, monitoring and reporting.
Training Vendor	New York Medical College, School of Health Sciences and Practice	Training modules and possible certificates.
WMC PPS Workforce Project Lead	Barbara Hill, Director, Community Workforce Transformation (PMO)	Dedicated project manager who will lead WMC PPS's workforce strategy design, development, implementation, and monitoring.

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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		
WMC PPS, Workforce Committee (refer to Workforce Strategy section for complete listing)	Works with Workforce Project Lead	Committee of key stakeholders who meet regularly to inform, guide, and review the development and implementation of the WMC PPS's workforce plan and implementation.
WMC PPS Community Engagement Quality Committee: WMC Community & Cultural Affairs, Open Door Family Health Center, Maternal Infant Services Network, Sarah Lawrence College, Lower Hudson Valley Perinatal Network, Gateway Community Industries, Catholic Charities Community Serv. Orange Co., Program Design & Dev. , Mental Health Assoc. Ulster, Family of Woodstock, Mental Health Assoc. Orange Co., New American Workforce, Planned Parenthood Mid-Hudson Valley, African American Men of Westchester	Works with Workforce Project Lead - Will provide information on patient/family experiences in their organizations and in the community	Committee of key stakeholders who meet regularly to inform, guide, and review the development and implementation of the WMC PPS's cultural competency and health literacy strategy and coordinates with the PPS's patient engagement strategies for Project 2.d.i
External Stakeholders		
County Health, Mental Health and Social Services departments	Local county stakeholders who provide input and feedback on community needs	Community needs assessment
NAMI of Rockland County - (National Alliance on Mental Illness)	PPS partner & stakeholder	Family and Patient advisement re: cultural competence and health literacy

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IPQR Module 4.7 - IT Expectations

Instructions :

Please clearly describe how the development of shared IT infrastructure across the PPS will support the development and implementation of your cultural competency / health literacy strategy and the achievement of the milestones described above.

IT Systems impact every other organizational workstream because of the need for data and reporting in the DSRIP program. Since our CC/HL strategy is dependent on Workforce, we will rely upon new IT systems, including new uses of IT which will require retraining of existing staff, training for new or redeployed staff, and new sets of skills for many partner employees across the PPS. We will rely upon IT for tracking and reporting of training requirements and impact on outcomes.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

Success of the Cultural Competency and Health Literacy workstream will be measured principally through the timely achievement of project milestones. To track progress against milestones in accordance with quarterly reporting to the DOH, we will deploy project management software to document deliverables, tasks, resources, timing, dependencies, and other critical success factors. Project management capabilities will also include proactive monitoring for early identification of possible slippage of due dates enabling the team to correct course as necessary. Integral to achieving outcomes is our relationship with the local county departments of health, mental health and social services and our partnering with them to update their community health and mental health needs assessments.

IPQR Module 4.9 - IA Monitoring

Instructions :

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Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1. WMC PPS convenes stakeholders (RHIO, network providers, WMC project teams, others) to develop assessment components including technical and functional information.	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Issue RFP to identify and engage vendor to conduct assessment.	Completed	See Task.	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3. Establish IT governance structure.	Completed	See Task.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4. Under the direction of WMC PPS, vendor creates assessment tool, survey and analytic plan.	In Progress	Additional Information as Required by IA: Under the direction of WMC PPS Sr. Dir, IDS Operations, vendor creates assessment tools, survey, and analytic plan.	09/15/2015	03/31/2016	09/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5. Vendor surveys WMC PPS network on current state.	In Progress	Additional Information as Required by IA: Vendor surveys WMC PPS network on current state using a combination of electronic questionnaires, site-visits, and interviews. EMRs, existing and planned RHIO connections, technical needs, and capabilities will be part of assessment.	10/06/2015	03/31/2016	10/06/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6. Vendor analyzes and tabulates results	Not Started	See Task.	01/12/2016	03/31/2016	01/12/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and creates a current state assessment report.									
Task Step 7. WMC PPS reconvenes IT governance group to share results and develop strategy for closing gaps.	Not Started	See Task.	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7a. WMC PPS reconvenes IT governance group to budget for closing gaps and achieving interoperability.	Not Started	Additional Step/Task required by IA.	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Milestone #2 Develop an IT Change Management Strategy.	Not Started	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1. Based on results of current state assessment (milestone above), identify opportunities for IT-driven change in partner practices, e.g. data sharing.	Not Started	See Task.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2. IT Committee, working through the PMO, assesses impact, risks, and effectiveness of IT changes and alignment with projects.	Not Started	Additional Information as Required by IA: The IT committee, chaired by WMC CIO, working through the PMO, assesses the impact, risks and effectiveness of IT changes and alignment with projects. The IT committee also includes executive representation by the RHIO (QE).	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3. Obtain Executive Committee Board approval of change management strategy.	Not Started	See Task.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
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;	06/01/2015	12/31/2016	06/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).							
Task Step 1. Establish IT governance structure.	Completed	See Task.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. WMC PPS creates plan for the development of platforms to share administrative, milestone, and project information with network partners. These platforms will also support the establishment and tracking of data sharing agreements.	Completed	See Task.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Implement interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	Completed	Additional Information as Required by IA: WMC PPS working with WMC IT department, consultants, and other stakeholders, creates functional requirements for data platform enabling secure storage, management, and analysis of program data. Functionality includes a "web form" or other tool to enable network partners to report programmatic activity to the PPS.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4. Create plan for procuring and implementing platforms to capture patient-reported data (e.g., PAM, community resource referrals, others), including hardware needs and mobile deployment.	Completed	Additional Information as Required by IA: WMC PPS deploys data platform following pilot testing and training with 2 network partners. Deployment will include procedures for providing programmatic data to WMC PPS.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5. Create PPS-wide data sharing roadmap.	In Progress	See Task.	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6. Create plan to deploy MAPP functionality using dashboards, enrollment information, and other data as made available by NYS.	In Progress	See Task.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 7. WMC PPS in coordination with QE, establishes plan to connect network partners to RHIO.	In Progress	See Task.	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 8. Create roadmap for data sharing and reporting using platform to support population health analytics.	Not Started	Additional Specificity as Required by IA: WMC PPS creates process to ensure the establishment of data sharing agreements between the PPS and partners, vendors, consultants, and others as necessary, as well as between network partners and the RHIO and other stakeholders as appropriate. This includes an internal process to track agreement activity, as well as the incorporation of DSRIP program data sharing agreements in the WMC PPS contracting process.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5a. WMC PPS, working with the IT Committee, creates a PPS wide data sharing roadmap based on the results of and gaps identified in the current state assessment (M/S #1), in effect a plan to "close the gaps". Areas of focus will include: i) RHIO connectivity, ii) the use of direct mail, and iii) secure access to performance data provided by the PPS incorporating metrics sourced from the MAPP portal as well as the reporting of data through the tool described in Step 4.	In Progress	Additional Step/Task required by IA. Date changed to take into consideration end date Step 8.	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Not Started	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.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1. WMC PPS, with feedback from the local deployment councils, adapts tools for member engagement to be culturally and linguistically appropriate for isolated communities.	Not Started	See Task.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2. WMC PPS and QE identify appropriate measures to monitor RHIO consent.	Not Started	See Task.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task	Not Started	See Task.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3. Based on current state assessment (milestone #1), PPS reviews and identifies technology, workflow and other barriers to engaging members and obtaining consent to share data on the RHIO.									
Task Step 4. The PPS will rely upon cultural competency and health literacy champions within the local deployment groups established as part of Clinical Governance to communicate cultural competency strategy and plans to our provider network and report back to the WMC Quality Committee and Workforce Committee.	Not Started	See Task.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5. Obtain Executive Committee approval of QE engagement plan.	Not Started	See Task.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 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.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1. Submit NYS_SSP Workbooks, Set 1.	Completed	See Task.	07/01/2015	10/31/2015	07/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Submit NYS_SSP Workbooks, Set 2.	Completed	See Task.	11/01/2015	01/31/2016	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Submit NYS_SSP Workbooks, Set 3.	Not Started	See Task.	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Step 4. Submit NYS_SSP Workbooks, Set 4.	Not Started	Additional Information as Required by IA: Under the direction of WMC Security Officer, establish PPS-wide protocols for protected data. Protocols will be adapted from WMC's existing security assessments and interventions which address training, risk analysis and mitigation. Physical and building security, identification and authentication, protocols for devices, data integrity, emergency, and break the glass and other contingencies will also be adapted.	05/01/2016	07/31/2016	05/01/2016	07/31/2016	09/30/2016	DY2 Q2	
Task Step 5. Develop plan for ongoing security and	Not Started	See Task.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
testing throughout PPS network.									
Task Step 6. Obtain PPS Executive Committee approval for data security and confidentiality plan.	In Progress	See Task.	08/18/2015	12/31/2016	08/18/2015	12/31/2016	12/31/2016	DY2 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	violad	Other	21_MDL0503_1_3_20160315110004_Contact_Information.docx	As per remediation, Contact Info file	03/15/2016 11:00 AM
	violad	Other	21_MDL0503_1_3_20160315105824_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PS_Family)_R.docx	SSP Workbook, PS Family	03/15/2016 10:58 AM
	violad	Other	21_MDL0503_1_3_20160315105732_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PE_Family)_R.docx	SSP Workbook, PE Family	03/15/2016 10:57 AM
	violad	Other	21_MDL0503_1_3_20160315105625_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(IR_Family)_R.docx	SSP Workbook, IR Family	03/15/2016 10:56 AM
	violad	Other	21_MDL0503_1_3_20160315105512_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AU_Family)_R.docx	SSP Workbook, AU Family	03/15/2016 10:55 AM
	violad	Other	21_MDL0503_1_3_20160315105415_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AT_Family)_R.docx	SSP Workbook, AT Family	03/15/2016 10:54 AM

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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.	As per guidance and requirements, we are submitting the second set of SSP Workbooks. As per remediation, we are resubmitting the second set of SSP workbooks. We have also included a separate file containing additional contact information.

Milestone Review Status

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

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The WMC PPS is a partnership of diverse network participants and stakeholders. While we view this as a necessity and strength in establishing an integrated delivery system of care, we expect it to present challenges around IT systems. We encompass a range of provider types, a variety of EMR systems (or none at all), technology capabilities and data literacy, and other factors. This diversity has the potential to impact each of the IT milestones-- governance, data sharing, and data security and confidentiality. Because IT underpins all 11 of our projects in some way, each project may in turn be affected as well.

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.)

1. Governance. Representatives from partner organizations will be called upon to participate in the IT teams described above as well as facilitate the adoption of approved policies and procedures. The PPS Board will need to approve [or comment on] IT-related strategies and plans as described above.
2. Practitioner Engagement. PE is heavily dependent on IT Systems and Processes, specifically the ability to generate reports that are meaningful to physicians. Successful population health management strategies will require effective practitioner engagement both to change practices and provide data.
3. Funds Flow. As the tool for several key DSRIP milestones including PCMH achievement, data sharing, and performance reporting, IT adoption and use will be a key factor in contracting and funds flow. It is expected that funds to partners will be tied in part to the adoption of IT.
4. Workforce. New IT systems, including new uses of IT will require retraining of existing staff, training for new or redeployed staff, and in fact a new set of skills for many partner employees across the PPS. The IT team will work closely with the Workforce leads to ensure the creation and sustainability of the knowledge, skills, roles, and positions necessary to support a technology-enabled integrated delivery system.
5. General Interdependence with IT of all other workstreams. As a "cross-cutting" workstream, IT Systems and Processes are integral to the success of all other DSRIP workstreams because of the heavy reliance on information management. Clearly, performance monitoring will require the implementation and use of automated systems and effective reporting. Workforce statistics and metrics will need to be captured and tracked to assess and report the impact of the projects. Finance, budgets, and funds flow likewise all will rely on the ability to capture, analyze and report on program and organizational data.

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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
IT Systems and Processes Lead	Helene Kopal, Sr Director, Integrated Delivery Systems, WMC PMO	Overall responsibility for IT System & Processes Milestone Completion; Overall responsibility for IDS (2.a.i) Milestones.
Technology SME	John McInally, Partner, Senior Solution Architect, Health Care Transformation Services, Philips Healthcare	Advise on EMR, EBS strategies and solutions.
WMC IT Committee	John Moustakakis, CIO, WMC	Review IT-related policies and procedures; interface with EC, members of IT committee and responsible for overall IT governance. SME for hospital based sytems and liaison to WMC IT vendors.
DSRIP IT Governance and Oversight	IT Governance Committee	Advise on current state, change management strategy, data sharing and interoperability, and data security and confidentialty planning and implementation.
Security of Health Information	John Moustakakis, Chief Security Officer, WMC	Oversee the identficiation, implementation, and monitoring of information security processes including DSRIP- specific requirements.
Strategy Development, Data Analytics and Total Population Health	Deborah Viola, Ph D., WMC PMO	Provide input related to development and deployment of WMC data platforms, MAPP tools, and data use needed to support DSRIP milestones and goals.
Analytics Platform Vendor	John McInally, Partner, Senior Solution Architect, Health Care Transformation Services, Philips Healthcare	Develop and deploy IT platform and applications to support analytics and reporting.
Technical Support	Steven Goriah, Director, IT Planning & Implementations, WMC IT	Networking, applications, desktop support, and importantly, access to vendors and suppliers.
Clinical Informatics Lead	Janet Sullivan, VP, Medical Director, PMO	Performs CMIO function on behalf of WMC PPS; overall responsibility for clinical metrics and measurement for outcomes improvement.

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IPQR Module 5.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
WMC PPS/PMO	Oversight & execution	Achievement of IT/Systems Milestones; provision of actionable clinical and process data to achieve outcomes
External Stakeholders		
HealthLinkNY	QE (RHIO)	Enabling connections to RHIO; providing Direct Messaging; providing administrative analytics including consent for RHIO use
PPS Network Partners	Program Participants; Data Sharing	Meeting program requirements, adopting approved P&Ps, participating in governance and work teams
DOH/MAPP	Data Management and Analytics	Functionality related to member management, analytics, and reporting
EMR Vendors	Data Integration Partners	Creation of interfaces to achieve data sharing & EMR integration
Consumer/Family/Caregiver	Advisement re patient engagement, consent issues	Membership on IT committee to provide input on barriers and facilitators to consenting to data sharing, cultural competencies, and public communications strategies

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Westchester Medical Center (PPS ID:21)

IPQR Module 5.7 - Progress Reporting

Instructions :

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

Success of the IT Systems and Processes workstream will be measured principally through the timely achievement of project milestones. To track progress against milestones in accordance with quarterly reporting to the DOH, we will deploy project management software to document deliverables, tasks, resources, timing, dependencies, and other critical success factors. Project management capabilities will also include proactive monitoring for early identification of possible slippage of due dates enabling the team to correct course as necessary.

IPQR Module 5.8 - IA Monitoring

Instructions :

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Delivery System Reform Incentive Payment Project

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Westchester Medical Center (PPS ID:21)

Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1. WMC PPS creates plan for the development and implementation of platforms to share administrative, milestone, and project information with network partners. These platforms will also support the establishment and tracking of data sharing agreements.	Completed	See Task.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Establish pilots/incubators for interim reports and communication modules using Pareto charts to identify key providers for quarterly reports.	Completed	See Task.	10/06/2015	12/31/2015	10/06/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Implement interim reporting tool for DSRIP milestone reporting and performance (see IT Systems and Processes, milestone #3).	Completed	See Task.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Establish a staffing plan for managing clinical and financial outcomes reporting with a designated project manager and PMO executive	Completed	See Task.	11/05/2015	12/31/2015	11/05/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
responsible for each project..									
Task Step 5. Obtain Executive Committee approval of Reporting and Communications strategy.	Completed	See Task.	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6. Provide training on MAPP: as appropriate MAPP tools become available, support staff will be trained and charged with presenting relevant MAPP reports to their committees.	In Progress	See Task.	07/06/2015	06/30/2016	07/06/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7. The Quality Steering Committee and its workgroups will review and revise project plans based on performance reports (rapid cycle evaluation) and will report and communicate "up" to PPS Executive Committee and "down" to partners through local deployment groups.	In Progress	See Task.	08/09/2016	09/30/2016	08/09/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	In Progress	Finalized performance reporting training program.	11/05/2015	06/30/2016	11/05/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1. The WMC PPS Quality Steering Committee will provide oversight and local deployment councils will provide feedback on implementation for clinical programs of each project.	In Progress	See Task.	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. The PMO will design curriculum and modalities for training PPS clinicians around each project intervention.	In Progress	See Task.	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3. Field based deployment will follow an academic detailing model including centrally based and locally deployed staff.	Not Started	See Task.	04/12/2016	06/30/2016	04/12/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4. PMO will monitor training roll-out and assess effectiveness via participant evaluation.	Not Started	Additional Information as Required by IA: Partner feedback will be routinely solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the Quality Steering Committee and/or its	05/10/2016	06/30/2016	05/10/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.							

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The WMC PPS is a partnership of diverse network participants and stakeholders. While we view this as a necessity and strength in establishing an integrated delivery system of care, we recognize that there will be variations in experience and capabilities using reports to evaluate performance in the clinical setting. Levels of data literacy will vary, and partner organizations will need assistance in understanding both how to provide information for performance reporting, as well as how to use reports supplied to them. To mitigate this risk, we will start by conducting a thorough current state assessment to understand specifically the strengths and weaknesses of our partners with respect to performance and quality reporting. Based on this information, action plans with a focus on training on performance measurement and reporting will be developed and rolled out throughout the network. Additionally, the Quality Steering Committee will provide strategic direction and leadership on engaging providers and securing buy-in among staff to adopt data-driven best practices.

IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Performance reporting is generally interdependent with all other workstreams. As a "cross-cutting" workstream, performance measurement and reporting is integral to the success of all other DSRIP workstreams because of the heavy reliance on information management. Clearly, performance monitoring entails the implementation and use of automated systems and effective reporting, covered in the IT Systems and Processes workstream. Finance, budgets, and funds flow likewise all will rely on our ability to capture, analyze and report on program and organizational data.

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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
IT Systems and Processes Lead	Helene Kopal, Sr Director, Integrated Delivery Systems, PMO	Overall responsibility for IT System & Processes Milestone Completion; Overall responsibility for IDS (2.a.i) Milestones.
Clinical Programs and Provider Engagement Lead	Janet Sullivan, VP, Medical Director, PMO	Overall responsibility for clinical program milestone completion and performance.
Total Population Health Lead	Deborah Viola, PhD, Health Services Research and Data Analytics, PMO	Overall responsibility for TPH milestone completion.
WMC IT Committee	John Moustakakis, CIO, WMC	Review IT-related policies and procedures; interface with EC, member of IT committee and responsible for overall governance. SME for hospital based sytems and liaison to WMC IT vendors.
Analytic Vendor	Philips HealthCare	Platform Development and Deployment.
Member Management & Analytics, Reporting	NYS DOH/MAPP	MAPP Portal; Quarterly Reports
WMC PPS Quality Steering Committee	Clinical leads of each Project Advisory Quality Committee (available) and identified leaders representing other stakeholdergroups	Review of all NYS defined metrics and development of project specific metrics for monitoring success of each project

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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		
WMC PPS PMO	Oversight and management	Establishing performance measurement systems and processes
External Stakeholders		
HealthLInk NY	Data Sharing and Analytics	Enabling connections to RHIO; providing Direct Messaging; providing adminstrative analytics including consent for RHIO use
EMR Vendors	Data Integration Partners	Creation of interfaces to achieve data sharing & EMR integration.
PPS Network Partners	Program Participants; Data Sharing	Meeting program requirements, adopting approved P&Ps, particpating in governance and work teams.
Quality Steering Committee	Performance Review, measure development, and intervention design.	Regular review of performance results and progress against milestones; review of all NYS defined metrics and development of project specific metrics for monitoring success of each project; development of strategies and interventions to achieve goals.
Executive Committee	Performance Review , review of proposed new metrics and interventions and Decision-Making	Regular review of performance results and progress against milestones; review of PMO and PPS committee's quarterly reports, proposed strategies and interventions against performance goals, action plans as needed.
Workforce Committee	Performance Review relative to workforce deliverables.	Regular review of performance results and progress against workforce related milestones; investigation of barriers to success; strategies for interventions.

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IPQR Module 6.7 - IT Expectations

Instructions :

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

Our reliance on the NYS DOH MAPP system greatly facilitates our approach to performance reporting and provides many benefits:

1. It will free up resources to focus on training and supporting practices to engage in measurement and reporting.
2. It provides the ability to use a standard approach across the network as defined by NYSDOH.
3. It facilitates development and sharing among PPSs best practices and lessons learned.
4. It reduces [potential] duplication in data analytic services.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

Success of the Performance Reporting workstream will be measured principally through the timely achievement of project milestones. To track progress against milestones in accordance with quarterly reporting to the DOH, we will deploy project management software to document deliverables, tasks, resources, timing, dependencies, and other critical success factors. Project management capabilities will also include proactive monitoring for early identification of possible slippage of due dates enabling the team to correct course as necessary.

IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1. Submit general plan for Clinical Governance including Quality Committee and its workgroups to Executive Committee.	Completed	Task Completed; see upload.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2. Convene the Hudson Region DSRIP Public Health Council (HRDPHC) including participation by all three Hudson Valley PPS with local departments of health, mental health and social services. HRDPHC will be a forum for ensuring LGU input into the work of DSRIP PPSs in the Hudson Valley.	Completed	Task Completed; see upload in Governance Milestone #7, Task 1.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3. Convene the WMC PPS project specific Advisory Quality Committees and workgroups.	Completed	See Task. We revised task end date because our annual quality summit is Nov 5, 2015 where all project advisory committees will meet. Because of the size of participation (over 200 network partners) we culd not get it coordinated and scheduled by 9/30/2015.	04/01/2015	11/05/2015	04/01/2015	11/05/2015	12/31/2015	DY1 Q3	
Task	Completed	See Task.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 4. PPS creates a plan for the development and implementation of platforms to share administrative, milestone and project information with network partners.									
Task Step 5. Convene a planning group for a Population Health Improvement Program (PHIP)/ PPS Clinical Quality Committee. Since our application was submitted the PHIP has been charged with convening a regional quality council. All 3 PPSs in our region agree that a region wide clinical council to coordinate PPS activities should be aligned with the PHIP.	Completed	See Task.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6. Implement interim reporting tied to DSRIP milestone reporting and performance (as indicated in the IT Systems and Processes section, Milestone #3).	In Progress	See Task.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7. Convene WMC PPS Quality Committee and local deployment councils.	In Progress	See Task.	12/31/2015	03/31/2016	12/31/2015	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.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1. Establish Webinars & Conference calls: Webinars and conference calls allow busy practitioners to incorporate PPS meetings into their schedules with less disruption to patient care. As we have done during the DSRIP planning period, the PPS will continue to use webinars with conference lines as the main forum for convening committees, workgroups and for presentations about the DSRIP program and PPS- specific projects, goals and progress.	Completed	See Task. We revised task end date because our annual quality summit is Nov 5, 2015 where all project advisory committees will meet. Because of the size of participation (over 200 network partners) we culd not get it coordinated and scheduled by 9/30/2015. Summit preparatory calls took place during the months of September and October with all quality project advisory committees.	04/01/2015	11/05/2015	04/01/2015	11/05/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 2. Training on use of MIX: As appropriate, committees and workgroups will set up group sites on the MIX. (HRDPHC tobacco cessation group already has a site.) All committee members will be offered MIX training.	Completed	See Task.	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3. Conduct face to face meetings and work sessions to train and educate providers. Quality committees and workgroups leading a PPS project will meet face-to-face at least once a year. These meetings will include presentations on the DSRIP program and PPS-specific quality improvement agenda with status updates on progress to goals. Periodically the PPS will also sponsor forums for exchange of best practices.	Completed	See Task.	11/05/2015	12/31/2015	11/05/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4. Training on use of MAPP: As appropriate MAPP tools become available, support staff will be trained and charged with presenting relevant MAPP reports to their committees.	Not Started	See Task.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5. PMO will monitor training roll-out and assess effectivess via participant evaluation.	Not Started	Additional Specificity as Required by IA: Partner feedback will be routinely solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff. The PPS has developed a template for identification of potential members for quality committee participation that identifies professional specialty, stakeholder group and geographic region represented by each potential participant. Use of the template will help ensure that committees all have broad professional and stakeholder representation.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 7.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

One risk is the current level of practitioner engagement. Practitioner engagement for DSRIP has been characterized as establishing a structure for clinical governance, involving clinicians in participation and engaging practitioners in review of reports addressing DSRIP goals. Our PPS has made significant progress on all fronts. Our PPS is not building upon an existing organization but rather creating something new. This has the disadvantage of requiring a bit more work and a bit more time to get established but the advantage of being able to create an infrastructure specific to the tasks at hand and supported by new technology. To mitigate this risk we are systematically involving clinical leaders among our partners in the development of clinical governance for our PPS. We have a proposal for a clinical governance structure which has been well received in discussions with key clinical leaders of partner organizations. During the DSRIP planning and application period our PPS held numerous small and large meetings and hosted many webinars attended by 100s of practitioners; the responses regarding participation in quality committees and workgroups indicate that interest remains high. With the other Hudson Valley PPSs we have already convened planning meetings for two cross-PPS regional committees: a Hudson Region DSRIP Public Health Council (HRDPHC) and a Hudson Region DSRIP Clinical Council (HRDCC) in coordination with the PHIP. The HRDPHC has already met to discuss tobacco cessation, and we have also coordinated joint meetings of all PPSs around BH Crisis stabilization with local governments in more than one county.

A second risk is the need to begin engaging patients around each project in DY1, Q2 before all committees have convened, before contracts are in place with all our partners and before the PPS is fully staffed. Engaged patient targets for DY1 are at risk as a result. To mitigate this risk we are developing a two stage process for collecting data on engaged patients with a short term plan that will take into account that without consent from patients and executed BAA and DEAA we cannot collect PHI.

A third risk is the same one cited in the Clinical Integration workstream: our PPS is working with unaffiliated clinical partners with businesses that are in some cases competitors. This presents an obstacle to clinical integration. Risk mitigation strategies include communicating policy imperatives that are driving change.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Practitioner Engagement is heavily dependent on IT Systems and Processes as noted in IT expectations, specifically the ability to generate reports that are meaningful to physicians. Successful population health management strategies will require effective practitioner engagement both to change practices and provide data. There is a major dependency on governance for overseeing compliance with protocols and participant

contracts and overall DSRIP operations.

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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
Clinical Programs and Provider Engagement Lead	Jessie Sullivan, MD, VP, PMO	Overall responsibility for clinical program milestone completion and performance.
Network Director	Maureen Doran, VP Integrated Care Network	Aligning integrated relationships with external physicians and group practices, hospital and health systems and insurance networks.
Quality Steering Committee	Dr. Jonathan Nasser, Crystal Run Dr. Allen Dozor, CWPW Dr. Darin Wu, Open Door Family Medical Center Dr. Rodney Williams, BSCHS Dr. Scott Hines, Crystal Run Dr. Avi Silber, Greater Hudson Valley Family Health Center Dr. Frank Ehrlich, Health Alliance Dr. Steven Fernando, WMCHealth Mr. Dominic Bizzanno, MVP Healthcare	Clinical protocols and oversight of general project plans.

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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		
Workforce Committee	Performance Review and Decision-Making	Regular review of performance results and progress against milestones; action plans as needed.
External Stakeholders		
PHIP (Population Health Improvement Program)	Regional contractor selected by NYSDOH to promote Triple Aim.	Support and advance ongoing Prevention Agenda activities.
Regional Clinical Council	Multiple providers and provider types	Overarching protocol and metrics direction on projects that are common to more than one PPS in the region.
Regional Public Health Council	Multiple providers, CBOs, Local county departments	Overarching direction on population health projects that are common to more than one PPS in the region.

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IPQR Module 7.7 - IT Expectations

Instructions :

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

Shared IT infrastructure impacts the Practitioner Engagement workstream because of the need for data and reporting in the DSRIP program. Since our Practitioner Engagement strategy is dependent on effective communication and reporting, we will rely upon existing and new IT systems. We will rely upon IT for communications purposes including webinars and conference calls, sharing of results, and the collection and management of patient data including EMR-based, Patient Activation, and other assessments.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

Success of the Practitioner Engagement workstream will be measured principally through the timely achievement of project milestones. To track progress against milestones in accordance with quarterly reporting to the DOH, we will deploy project management software to document deliverables, tasks, resources, timing, dependencies, and other critical success factors. Project management capabilities will also include proactive monitoring for early identification of possible slippage of due dates enabling the team to correct course as necessary.

IPQR Module 7.9 - IA Monitoring

Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4	NO
Task Step 1. Update CNA hotspotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.	Completed	See Task.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. The population health management roadmap mirrors the steps in the third milestone in IT Systems & Processes, "Roadmap to achieving clinical data sharing and interoperability."	In Progress	See Task and IT section.	08/08/2015	12/31/2016	08/08/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3. Obtain Executive Committee approval of Population Health Roadmap.	Not Started	See Task.	01/17/2018	03/31/2018	01/17/2018	03/31/2018	03/31/2018	DY3 Q4	
Task Step 4. The plan for achieving PCMH mirrors the	In Progress	Additional Specificity as Required by IA: An RFP was issued 5/15/2015 for a vendor to do	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
7th Milestone in the IDS Project Plan.		PCMH/APC readiness assessment of the WMC PPS network. Local deployment councils to serve as local PPS contacts for network partners engaging in PCMH/APCM will convene 11/5/2015; current state analysis of network partners to determine eligibility for PCMH/APCM, current certification status if any and EHR/MU capabilities will be completed by 3/31/2016. PMO with PCMH vendor will by 6/30/2016 create an action plan for PCMH/APCM eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services. Early adopter sites will be identified by 9/30/2016. Lessons learned from early connections will be summarized to inform a planned phase roll-out for other partners by 6/30/2017. Phase 1 of PCMH/APCM will be rolled out by 9/30/2017; Phase 2 of PCMH/APCM will be rolled out by 12/31/2017. Documentation of PCMH/APCM will be completed by 3/31/2018.							
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	NO
Task Step 1. Establish a Medical Village Project team that includes representatives from BSCH and HealthAlliance as well as a project manager from the PMO who will be responsible for monitoring and reporting on the progress of the WMC PPS Medical Village Project. Our goal is to right-size hospital capacity at two of our partner hospitals by reducing 125 staffed beds as described in our project application.	Completed	See Task.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Evaluate impact on bed reduction of the WMC PPS crisis stabilization project plan that should result from the provision of crisis services across our region that fill gaps in care (e.g. mobile crisis teams, expanded and intensive crisis services, crisis lines to centralize triage	In Progress	See Task. This task won't complete before 3/31/2020 so we adjusted Milestone end date accordingly.	08/08/2015	03/31/2020	08/08/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
services, outreach/support including increased use of peer workers) for adults with serious BH disorders.									
Task Step 3. Convene Medical Village Project team to review project plan, implementation timelines and deliverables against submitted capital Restructuring Financing Program submissions. Make adjustments to Medical Village Implementation Plan steps as required.	In Progress	Additional Information as Required by IA: Both of our Medical Village partners, HAHV and BSCH, are developing their own implementation plans with guidance from the PMO- these are being considered with respect to funding and timelines will be modified as needed to reflect level of activity to complete the Milestone.	08/08/2015	03/31/2019	08/08/2015	03/31/2019	03/31/2019	DY4 Q4	
Task Step 4. Present BSCH and HAHV medical village plans to the Executive Committee for approval.	Not Started	See Task.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Milestone Review Status

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

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IPQR Module 8.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

A primary risk is managing only to the attributed population by relying on data from NYS through MAPP. To truly impact the Medicaid population at-large, WMC PPS and its network will have to address the needs of every Medicaid patient. Attrition and "churn" in the attributed population, as well as the practical impossibility of identifying attributed members at the point of care, will require us to implement process changes regardless of attribution. However, we will not have access from NYS to data for non-attributed members in our service area. This will impede our ability to proactively identify patients with gaps in care or other service needs, as well as monitor quality performance for the population at large. To mitigate this risk, we are exploring HIPAA compliant possibilities for collecting data on the broader population served by the partner organizations in our PPS. An associated risk is that our IT roadmap assumes maximization of the DOH-supplied MAPP portal and analytics, which will not support inclusion of a broader data set. Accordingly, our IT and IDS strategies include transitioning to a powerful PPS based analytics platform.

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.)

Bed reduction is dependent upon the Medical Village Project; although not a workstream, the dependency on this project is critical and bears mentioning. Likewise, it should be noted that risks defined within that project apply here. Rebalancing health delivery to focus on primary and ambulatory care will result in staffing growth in certain job categories (e.g., outpatient, care management, community health workers) and staffing reductions in some inpatient units. Our PPS through its Workforce Strategy is committed to retaining/retraining/redeploying impacted staff to meet the skills-mix required to maintain employment or gain skills for new positions. This includes working with our labor organizations to access retraining resources for both new positions and for at-risk workers. To aid the development of an effective workforce strategy, BSCH and HealthAlliance have created a detailed timeline documenting the specifics of bed reduction and rationale.
Overall Population Health management is heavily dependent on IT Systems and Processes as noted in IT expectations. The expenses associated with IT and PCMH also have significant impact on the Finance Sustainability workstream. In addition, successful population health management strategies will require effective practitioner engagement and clinical integration both to change practices and provide data as detailed in those workstreams.

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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
IT Systems and Processes Lead	Helene Kopal, Sr Director, Integrated Delivery Systems, PMO	Overall responsibility for IT System & Processes Milestone Completion; Overall responsibility for IDS (2.a.i) Milestones.
Clinical Programs and Provider Engagement Lead	Jessie Sullivan MD, Medical Director, PMO	Overall responsibility for clinical program milestone completion and performance.
Deborah Viola, PhD, Health Services Research and Data Analytics	Deborah Viola, PhD, Health Services Research and Data Analytics	Overall responsibility for total population health milestone completion.
Health Alliance Hospital	Medical Village Particpant	Achievement of Medical Village Project Milestones.
Bon Secours Hospital	Medical Village Particpant	Achievement of Medical Village Project Milestones.
Analytics , Reporting, Data Management Strategy	WMC IT Committee	Review IT-related policies & procedures; interface with Executive Committee; responsible for overall governance. SME for hospital based sytems and liaison to WMC IT vendors.

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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		
PMO (CRHI)	Oversight and management	Establishing performance measurement systems and processes.
External Stakeholders		
HealthLink NY	Data Sharing and Analytics	Enabling connections to RHIO; providing Direct Messaging; providing adminstrative analytics including consent for RHIO use.
EMR Vendors	Data Integration Partners	Creation of interfaces to achieve data sharing & EMR integration.
PPS Network Partners	Program Participants; Data Sharing	Meeting program requirements, adopting approved policies and procedures, particpating in governance and work teams.
Quality Steering Committee	Performance Review and Decision-Making	Regular review of performance results and progress against milestones; action plans as needed.
Executive Committee	Performance Review and Decision-Making	Regular review of performance results and progress against milestones; action plans as needed.
County Health, Mental Health and Social Services deparments	Local county stakeholders who provide input and feedback on community needs	Community needs assessment.

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IPQR Module 8.7 - IT Expectations

Instructions :

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

IT will play a key role in achieving Population Health Management. Many providers in the WMC PPS network have EMRs. For those without, the procurement of a certified EMR will be evaluated. Our plan is to maximize the use of the NYSDOH MAPP portal for member management and analytics, which will be supplemented as necessary with other platforms. Data security and confidentiality plans, dashboards, and platforms for patient-generated data will also be established.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

Success of the Population Health Management workstream will be measured principally through the timely achievement of project milestones. To track progress against milestones in accordance with quarterly reporting to the DOH, we will deploy project management software to document deliverables, tasks, resources, timing, dependencies, and other critical success factors. Project management capabilities will also include proactive monitoring for early identification of possible slippage of due dates enabling the team to correct course as necessary.

IPQR Module 8.9 - IA Monitoring

Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1. Draft plan for needs assessment accounting for provider type, specialties and locations including social services and community based organizations.	Completed	See Task. End date revised to reflect NYSDOH opening up the PPS networks in October for new provider NPIs and the draft plan needs to take these new providers into consideration.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2. Meet with Health Homes to assess capacity and links to other care providers: medical, behavioral health, social services.	In Progress	See Task.	08/08/2015	06/30/2016	08/08/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3. Meet with partners to share clinical integration experiences and identify gaps and opportunities.	In Progress	See Task.	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4. Assess network to confirm specialties and provider types for HIE capability, links to care management including Health Homes and	In Progress	See Task.	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
links to social services.									
Task Step 5. Map provider network locations.	In Progress	See Task.	08/08/2015	09/30/2016	08/08/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 6. Assess IT capacities of CBOs and social service agencies to share information.	Not Started	See Task.	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7. PPS Quality Steering Committee review and approval of clinical integration needs assessment.	In Progress	See Task.	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1. Create PPS-wide data sharing roadmap.	In Progress	See Task.	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2. Identify by provider type and project role the clinical information to be shared among partners.	In Progress	See Task.	04/12/2016	09/30/2016	04/12/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3. Create roadmap for data sharing and reporting using platform to support population health analysis.	Not Started	See Task.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4. Plan training for appropriate partners and staff on care transition protocols from Hospital Transition and Health Home at risk projects.	In Progress	See Task.	12/01/2016	12/31/2016	12/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task	In Progress	See Task.	12/01/2016	12/31/2016	12/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 5. PPS Quality Steering Committee review and approval of Clinical Integration Strategy.									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

One risk is that the PPS is working with unaffiliated clinical partners with businesses that are in some cases competitors. This presents an obstacle to clinical integration. Risk mitigation strategies include adopting and communicating policy imperatives including Committee guidelines, conflicts of interest policy, data sharing policies, compliance plan and dispute resolution procedures that are driving change and involving our partners as detailed in our Governance workstream. The information sharing strategy is dependent on the IT Systems and Processes workstream; risks inherent to that stream also apply here.

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.)

Clinical Integration is dependent upon the clinical governance milestone in the Governance workstream. Clinical partners will have individualized schedules to their Master Services Agreements that describe their obligations with respect to DSRIP projects – including reporting and data sharing obligations and the funding related to performance of those obligations. Clinical Integration is heavily dependent on IT Systems and Processes as noted in IT expectations and the funding of these systems in turn is dependent on Financial Sustainability. Successful Population Health Management strategies will require effective clinical integration both to change practices and provide data.

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IPQR Module 9.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Clinical Programs and Provider Engagement Lead	Jessie Sullivan, MD, VP, Medical Director, PMO	Overall responsibility for clinical program milestone completion and performance.
IT Systems and Processes Lead	Helene Kopal, Sr Director, Integrated Delivery Systems, PMO	Overall responsibility for IT System & Processes Milestone Completion; Overall responsibility for IDS (2.a.i) Milestones.
Total Population Health Lead	Deborah Viola, Ph D, VP and Director, Health Services Research and Data Analytics	Overall responsibility for TPH milestone completion.
Network Director	Maureen Doran, VP Integrated Care Network, WMC, PMO	Aligning integrated relationships with external physicians and group practices, hospital and health systems and insurance networks.

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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		
Quality Steering Committee and workgroups	Performance Review and Decision-Making	Regular review of performance results and progress against milestones; action plans as needed.
Executive Committee	Performance Review and Decision-Making	Regular review of performance results and progress against milestones; action plans as needed.
IT Committee	Overall responsibility for IT System & Processes Milestone Completion	Review IT-related policies and procedures; interface with EC, member of IT committee and responsible for overall governance. SME for hospital based sytems and liaison to WMC IT vendors.
Finance Committee	Operational oversight of business, operations and finance protocols	Review PMO Business plan and Budget for sustained funding of IT infrastructure and support.
External Stakeholders		
HealthLink NY	Data Sharing and Analytics	Enabling connections to RHIO; providing Direct Messaging; providing adminstrative analytics including consent for RHIO use.
Medical Professional Groups	Program participants, data sharing, network for VBP	Meeting program requirements, particpating in governance and work teams including discussion of models for VBP.
Public Sector Agencies	Ensuring that perspective of public health entities included in PPS clinical integration work.	Participation in Hudson River DSRIP Public Health Council work groups on tobacco cessation and cancer screening.
Patients and Families	Clinical Integration should improve the patient experience of care	Participation in Focus groupsto gather patient and family perspective.

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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.

Shared IT infrastructure impacts Clinical Integration because of the need for data and reporting in the DSRIP program. Since our Clinical Integration strategy is dependent on effective communication and reporting, we will rely upon existing and new IT systems. We will rely upon IT for communications purposes including webinars and conference calls, sharing of results, and the collection and management of patient data including EMR-based, Patient Activation, and other assessments.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

Success of the Clinical Integration workstream will be measured principally through the timely achievement of project milestones. To track progress against milestones in accordance with quarterly reporting to the DOH, we will deploy project management software to document deliverables, tasks, resources, timing, dependencies, and other critical success factors. Project management capabilities will also include proactive monitoring for early identification of possible slippage of due dates enabling the team to correct course as necessary.

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.

From day one, our PPS's guiding principles have been to leverage the DSRIP opportunity to develop community -driven and -led, regionally-focused care transformation that is: inclusive, transparent, patient and family focused and that fosters a culture of continuous learning and improvement. To achieve that goal and realize the overarching goals of DSRIP, the WMC PPS implementation is supported by five pillars: (1) engaging & connecting, (2) analyzing & identifying (both high risk patients and gaps in care), (3) stratifying & applying evidence and standardization, (4) supporting & communicating, and (5) incentivizing & performance monitoring.

These five pillars are operationalized through ten foundational elements and capabilities:
(1) Robust Data Analytics, including ongoing hot spotting, outcome evaluation, the integration of non-clinical data that address the broader determinants of health, and actionable communication of key data to those who provide and receive care;
(2) "Supporting Excellence," wherein evidence-based protocols are disseminated throughout the network, and adherence is tracked and facilitated through the use of rapid cycle evaluation mechanisms;
(3) Quality Oversight and Strong Clinical and IT Governance, including standing committees, project-specific work groups, local deployment councils and region-wide multi-PPS collaborations/councils;
(4) Practice Transformation, including achieving National Committee for Quality Assurance (NCQA) patient centered medical home (PCMH) Level 3 certification among eligible providers in the PPS;
(5) Collaborative Care, supported through the creation of medical neighborhoods comprised of diverse networks of medical, behavioral health, Health Homes, and community-based organizations;
(6) Care Management, linking appropriate care management to delivery of care (including mental/behavioral health services and community based services);
(7) Data Sharing, leveraging health information exchange (HIE), shared care plans, and technologies that enable actionable information to providers and their patients;
(8) Development of Value-Based Payment Models and Incentives with ongoing performance monitoring;
(9) Patient Engagement, including both culturally competent patient outreach and training and equipping providers with tools to empower patients and their care givers; and
(10) Relevant and targeted Training and Workforce Development to support both skills development and cultural transformation.

These competencies will be supported through a strong, collaborative, multi-stakeholder governance model and dedicated FTE staff at the WMC Project Management Office as well as contracted services from Participants and key vendor partners (including CBOs). Participants in our PPS are contractually agreeing to adhere to a set of expectations and requirements such as information technology adoption, adherence to evidence-based protocols and care pathways or guidelines adopted by the PPS Quality Committee, participation in performance monitoring and data sharing, participating in training programs, etc. While each individual DSRIP project has unique requirements and outcomes, ultimately, our PPS network is on a journey to develop a strong integrated, patient-centered delivery system capable of advancing value-based payment and

population health management. Our Health IT Roadmap includes the development of performance dashboards and tools to promote transparency and actionable data. By systemically integrating data and measurement, applying evidence and standardization, and changing process and behavior, our health network will work together to improve patient care, decrease unnecessary utilization and demonstrate value to patients and purchasers.

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

Instructions :

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

Our PPS serves an eight county region, which increases the complexity of coordination not just across our own PPS DSRIP programs but across multiple PPSs. Under DSRIP, patients may receive care from any provider, some participating in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and State. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center and WMC, have establish a provider-led, regional clinical council to support development of a regional system of efficient and effective care, patient safety and quality improvement.

The Hudson Region DSRIP Clinical Council (HRDCC), with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, requirements and expectations will minimize providers' implementation burdens, and create consistent, high quality patient experiences. The HRDCC will identify region-wide care improvement goals and serve as a forum to share and evaluate clinical strategies and practices. The HRDCC will support the rapid and widespread adoption of agreed-upon clinical protocols, as well as evidence-based practices across the region and payers.

In addition, strong clinical and IT governance within our own PPS – and broad, committed participation from across our Participants - will be critical to our success. As such, we have developed a framework that includes multiple levels of governance, including multi-disciplinary local deployment councils, transparency, and multiple pathways for input and stakeholder feedback. We have mapped out a robust framework of supporting requirements for project implementation at both a centralized and a local level. We have identified the following cross-cutting elements that are a component of most projects: (1) Evidence-base and care protocols; (2) Data sharing agreements (including privacy protections); (3) Use of EHRs and HIE; (4) Health homes and care management; (5) Coordination of care across transitions; (6) Performance reporting; (7) Cultural competence and health literacy; and (8) Workforce training and development. These are underpinned by an effective financial incentive sharing approach. As such our approach to project implementation is one that embraces the interdependencies and implements a systemic integrated transformation program, rather than a series of siloed independent projects.

The project management office leadership team is accountable to the WMC PPS Executive Committee and the PAC and will report regularly on progress against implementation milestones, as well as risks or resource needs.

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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
WMC PPS Project Management Office (PMO)	Center for Regional Healthcare Innovation (CRHI) at WMC	The PMO is responsible for overall PPS DSRIP project management and daily operations and for delivering quarterly reports to DOH. The PMO is responsible for implementation of DSRIP projects, staffing the PPS governing Committees and driving the implementation of PPS infrastructure such as IT, workforce training, practice support services, etc. The PMO is also responsible for collaborative cross-PPS project needs and establishing the Hudson Region DSRIP Clinical and Public Health Councils.
PMO Project Specific Staff Teams	Project management for individual DSRIP projects	Responsible for day-to-Day management of progress against Project requirements and alignment with and integration of PPS-wide initiatives such as cultural competency and health literacy efforts, PCMH transformation, IT implementation, workforce training, etc.
WMC PPS Quality Committee	PPS Quality Committee	Responsible for establishing evidence-based protocols and PPS project specific care pathways, quality metrics and reporting guidelines.
WMC PPS Hubs and Local Deployment Councils	PPS Hubs and Local Deployment Councils	Interdisciplinary stakeholder teams responsible for local governance and local project implementation, working with PMO.
WMC PPS Workforce Committee	PPS Workforce Committee	Responsible for the development and implementation of the WMC PPS's workforce plan and implementation to support successful DSRIP project implementation.
Westchester Medical Center Finance Leadership	John Morgan & Mark Fersko	Working with the PMO, oversight of all financial workstreams, including funding allocation for specific project implementations and incentive payments to providers.

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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		
WMC PPS Executive Committee	PPS Governance	Governing body of the PPS, in effect the Board of the PAC. Responsible for adopting terms sheet, policies and procedures, committee charters, etc. and well as populating committees. Responsible for transparency and accountability.
WMC PPS PAC	PPS Governance	WMC PPS Participant representation body. Participation in Committees and Workgroups, participation in PAC meetings, input and feedback on draft documents, adherence to participation agreements.
WMC PPS IT Committee	PPS IT Committee	Review IT-related policies and procedures; interface with EC, member of IT committee and responsible for overall governance. SME for hospital based systems and liaison to IT vendors.
WMC PPS Finance Committee	PPS Finance Committee	Responsible for financial policies and procedures, recommendations on funds flow and provider incentives, oversight of annual provider financial health assessment (and, with the Executive Committee and CRHI, on plans to ensure service provision and continuation of DSRIP performance) and creation and adoption of Value Vision and Action Plan (through its Taskforce).
WMC PPS Communications Team	Network and community communications	Responsible for supporting transparency and the challenging task of timely, informative and actionable communication to both ensure network participants are engaged and have the information they need and community and regional constituents feel informed and that they have a voice in care transformation in their community.
WMC SVP and Deputy General Council	Lead attorney	Oversight of contracting and legal compliance.
WMC SVP Internal Audit and Compliance	Compliance	Oversight of contracting and legal compliance.
External Stakeholders		
Network providers and their teams	Care transformation	Culture and care transformation requires commitment and engagement from clinical, administrative and professional staff at PPS Partner organizations. Will be responsible for participation in

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		training programs, data sharing, adherence to PPS clinical protocols and care pathways, performance reporting and project-specific commitments (such as PCMH transformation).
Hudson Region DSRIP Clinical Committee	Regional clinical committee including Montefiore and Refuah-led PPSs	Overarching protocol and metrics direction on projects that are common to more than one PPS in the region.
Hudson Region DSRIP Public Health Council	Regional public health council including Montefiore and Refuah-led PPSs	Overarching direction and community engagement on Domain 4 projects that are common to more than one PPS in the region.
County Health, Mental Health and Social Services departments	Local county stakeholders who provide input and feedback on community needs and resource coordination	Community needs assessment, support for project implementation, with an emphasis on behavioral health transformation and public health projects.
New York Medical College, School of Health Sciences and Practice and 1199SEIU Training and Employment Funds (TEF)	Training and development vendors	Preparing workforce for service excellence and transformation as a result of DSRIP.
Workforce representatives	Organized labor unions who will support training and workforce transformation through DSRIP	Input into and feedback on Workforce strategy; communication with members to help keep them informed of DSRIP initiatives and prepared for their role in transformation.
HealthLink NY RHIO	RHIO	Connectivity to SHIN-NY; possible additional services (such as ADT feeds) to support PPS data analytics.
Contracted CBOs	Provide subject matter expertise and assistance and services for execution of select projects	Key project deliverables.
Patients, families and patient advocates	Recipients of enhanced DSRIP services	Feedback on program implementation, patient needs and patient engagement
Managed Care Organizations and other payers	Payers	Providing data to PPS and active partnership in effort to advance Value-Based Payment reforms

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IPQR Module 10.5 - IT Requirements

Instructions :

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

IT is a cross-cutting workstream that supports and impacts all of the DSRIP projects. Accordingly, our plan is to establish the IT infrastructure necessary to enable WMC PPS network partners to form an integrated delivery system through data sharing and interoperability and to support the PPS itself in achieving its population health management objectives of patient identification, data-driven change, and performance reporting. While WMC PPS has created a high-level IT strategy to achieve these two goals, the current state analysis of IT capabilities across the network, including critical gaps to be completed by the end of the first year, will inform the prioritization and planning of IT systems deployment and enhancement. The WMC IT Committee, with representatives from diverse stakeholders including medical and behavioral health providers as well as CBOs, will play a key role in developing a tactical approach to IT implementation and other critical project milestones including an IT change management strategy and data security and confidentiality plans.

WMC PPS's approach to meeting its IT requirements is summarized below:

• Establish a database to support the PPS in managing its network partners related to their program participation and reporting, as well as administrative functions such as contracting;
• Identify and communicate throughout the network opportunities identified through the current state assessment to utilize IT to improve the process and outcomes of care, with an understanding of the risks and impacts of IT-driven change on provider practices;
• Connect network providers to the local HIE (QE) SHIN-NY to ensure the availability of clinical data as well as the ability to share it as appropriate;
• Foster the adoption of interoperable health IT platforms, including EHRs that meet MU standards;
• Leverage the potential of NYS DOH's MAPP portal for management of attributed members including enrollment, gaps in care, utilization and outcomes analysis, and performance reporting;
• Identify an interim solution reporting DSRIP milestones in accordance with quarterly reporting requirements, as well as a longer term road map for establishing a platform to support health analytics; and
• Create a training strategy for clinical and non-clinical segments of the workforce to use IT effectively.

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

Proactive performance monitoring is key to the overall success of the DSRIP projects and program. Our PPS will develop and implement a framework to enable tracking of administrative, milestone, and project performance information with network partners in an effective and secure manner. The framework will include NYS DOH's MAPP portal, as well as the PPS's own customer relations management system. Our

performance monitoring plan will also include a staffing plan wherein each project has a designated project manager and a responsible executive. Our Quality Committee will have responsibility for reviewing and monitoring project plans based on quarterly outcomes. In addition, we will establish project-specific quality steering committees to review Quality Committee input and in turn work with the local deployment councils to revise projects and assure the achievement of quality objectives.

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IPQR Module 10.7 - Community Engagement

Instructions :

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

The WMC PPS commitment to community engagement began with the formation of our PPS last year. In 2014 we undertook an extensive CNA that recognized the integral role of our community stakeholders, e.g. community based organizations, consumers, and local county departments. The needs and opinions represented by these stakeholders were gathered in a systematic way that included a series of meetings with county department leadership; focus groups; and a consumer survey that garnered close to 5000 responses. We listed 34 organizations in our application who are representative of our larger CBO network. As we begin project implementation plans this April, our PPS will make use of our IT Systems to support communication and the exchange of information with our CBO partners and local county departments as noted in #5 above.

To facilitate implementation planning, we reconvened with the county health, mental health and social services leadership in addition to many of our behavioral health partners so that they could share their insights on our project strategies. We have also formed with the other two PPSs in the region (Montefiore Medical Center and Refuah Health Center) a Hudson Region DSRIP Public Health Council (HRDPHC). The HRDPHC's first initiative involves Project 4.b.i, Tobacco Cessation. We have established a group on the MIX that includes representatives from such groups as the Center for a Tobacco-Free Hudson Valley, American Lung Association of the Northeast, and Search for Change. Common messaging and strategies will be shared across PPSs through the HRDPHC; within our PPS, local deployment councils will work with other community based groups to share findings.

Local deployment councils (LDCs) are an important component of our community engagement as we implement projects across our eight counties. We will rely upon our LDCs to assure appropriate outreach and effective communication takes place between local community groups and the PPS project management teams. Although the involvement of community stakeholders will vary by project, they will be critical towards our PPS achieving success with several cross-cutting work streams, including workforce training and cultural competency. For this reason, we are conducting additional focus groups, coordinated through the LDCs during DY1 with consumers and CBOs in "hot spots" identified as part of our CNA to help determine key access factors and effective communication pathways that acknowledge cultural differences, language, and health literacy competencies from a community perspective.

We realize the challenge of reaching out to uninsured populations in addition to some of our most vulnerable, including those with behavioral health issues and those who are homeless. We will provide training for our community based partners to help us with outreach and patient activation. Community stakeholders will be critical to the success of Project 2.d.i, Implementation of Patient Activation Measures.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

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

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

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1. Establish Workforce Project Team to support Workforce Committee	Completed	See Task	08/15/2015	09/30/2015	08/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2. Identify the health care workforce characteristics and categories to track and identify sources of data to define target state.	In Progress	We began this as part of our Current State Assessment and for our Workforce Survey.	08/08/2015	09/30/2016	08/08/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3. Develop target workforce state and review with Workforce Committee for approval.	In Progress	We have begun to develop a model with our vendor that will enable this analysis.	09/30/2015	09/30/2016	09/30/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4. Annually update target workforce state.	On Hold	See Task	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Not Started	Completed workforce transition roadmap, signed off by PPS workforce governance body.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	NO
Task Step 1. Consult with stakeholders to identify transition needs for training, redeployment, recruitment, hiring, and communications. Milestone 1 will provide input to workforce transition roadmap target state.	Not Started	See Task	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2. Develop preliminary workforce transition roadmap including timeline, decision-making roles regarding resource availability, training, redeployment, and hiring.	Not Started	See Task	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task	Not Started	See Task	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3. Review final version of workforce transition roadmap with Workforce Committee.									
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	09/08/2015	03/31/2017	09/08/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1. Workforce Committee Project Team will determine health care workforce characteristics and categories to track; and will also identify sources of data to define current state. The current state assessment will serve as the baseline workforce, which will be compared to the target state (produced in Milestone 1) and will support the development of the detailed gap analysis.	In Progress	See Task	09/08/2015	09/30/2016	09/08/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2. Collect information on healthcare workforce current state, including headcounts, organizational structures, HR policies, wages/benefits, labor requirements, roles/responsibilities, competencies, experience, certifications, etc.	In Progress	See Task	09/08/2015	12/31/2016	09/08/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3. Using data from workforce transition roadmap, establish target workforce state, compare to the current state, identify gaps and propose options for gap closure.	Not Started	See Task	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4. Analyze and update the workforce budget.	Not Started	See Task	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	
Task Step 5. Review final version of workforce gap analysis with Workforce Committee and obtain approval.	Not Started	See Task	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
redeployed staff, as well as new hires, particularly focusing on full and partial placements.									
Task Step 1. Project Team assesses compensation (including salaries and benefits) in the marketplace and implications for DSRIP projects, and compensation and benefits of employees that are likely to be redeployed or retrained.	Not Started	See Task	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2. Develop recommendtions for review with Workforce Committee, unions and labor management regarding compensation and benefits.	Not Started	See Task	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 3. Develop communications strategy for compensation and benefit recommendations.	Not Started	See Task	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4. Transmit final compensation and benefit recommendations to Executive Committee for review and approval.	Not Started	See Task	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	In Progress	Finalized training strategy, signed off by PPS workforce governance body.	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1. The PPS PMO will provide oversight for the design of curriculum and modalities for training PPS clinicians around each project intervention to support Performance Reporting Milestone #2 (training on clinical quality) and will coordinate with Workforce Committee Project Team.	Not Started	See Task	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2. In collaboration with partners and vendors identified in the Workforce Training plan, including CBOs, providers, and unions, the PMO will develop or subcontract to vendors training that addresses disparities identified in our Cultural Competency and Health Literacy training	In Progress	See Task	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
plan.									
Task Step 3. The Project Team will develop a preliminary training strategy (e.g., scale, timing, scope, methodologies, content and cultural competency considerations) and budget requirements regarding compensation and benefits and overall training costs.	Not Started	See Task	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4. The Project Team will collect information of existing and planned training programs and resources, via surveys with our partners, including their capacity to expand and support PPS workforce training needs as identified in the gap analysis.	In Progress	See Task	09/08/2015	12/31/2016	09/08/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5. Review preliminary training strategy and budget requirements with Workforce Committee and stakeholders.	Not Started	See Task	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6. Develop detailed schedule and communications plan for training strategy.	Not Started	See Task	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7. Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation. Develop mechanism to measure training effectiveness in relation to goals once strategy and plan implemented.	Not Started	See Task	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	
Task Step 8. Transmit final training strategy, schedule, and budget recommendations to Workforce Committee and Executive Committee for review & approval.	Not Started	See Task	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	
Create a workforce transition roadmap for achieving defined target workforce state.	
Perform detailed gap analysis between current state assessment of workforce and projected future state.	
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Our PPS has contracted with a compensation and benefit vendor, Integrated Health Care Strategies, to administer compensation and benefit surveys to a relevant sample of our PPS provider network.
Develop training strategy.	

Milestone Review Status

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

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

1. Accurately gauging the impact of non-DSRIP factors on the health care workforce will present challenges. While the healthcare transformation enabled by WMC's DSRIP projects will significantly shape the future demands on the health care workforce in the region, other forces will have influence as well. Our analysis of the current and projected state of the workforce will include assessments of demographic changes, the aging of the population and the workforce, the anticipated effects of other payers (i.e., Medicare and commercial plans), and the impact of other PPSs in our region.
2. The development of budgets for redeployment and hiring will require assessments of sensitive, and at times confidential, information on wages, benefits, policies, and timing of anticipated workforce reductions. WMC PPS will engage a broad range of stakeholders from labor representatives, management, front line workers, HR personnel, legal counsel, public health agencies, workforce investment boards, and the NYS Department of Labor to ensure that issues are identified, discussed, and addressed in fair, legal, and transparent manner.
3. Recruitment challenges could be considerable. Our CNA identified clinical hotspots in a number of geographically isolated and underserved areas across our region. Recruiting health care providers, particularly clinical staff, to work in rural and underserved settings is a well documented challenge. The inability to recruit, hire and retain the staff needed to provide care delivery and management will pose a significant risk to our ability to meet milestones and measures. To address this risk, we will require DSRIP project budgets and plans to include costs for recruitment that are bench-marked to regional standards. We will also work with the PPSs in our region to collaborate and coordinate recruiting efforts.
4. Healthcare transformation, and the resulting changes to the delivery of care, can create uncertainty and anxiety among health care workers. WMC PPS will leverage the experience and expertise of PPS participants who have planned and implemented healthcare transformations that have impacted their workforce. We will catalogue best-practices, communication efforts, cultural competency and health literacy, team-based approaches to care, and change management strategies. To mitigate concerns and confusion, our PPS will continue to be inclusive of all stakeholders, rigorous in our collection of both input and feedback, transparent in decision-making processes, and timely and thorough in communication to PPS participants and the public.
5. Disparate HR policies across PPS participants will provide challenges to developing common training and compensation strategies. Unlike other PPSs, WMC is not an integrated delivery network of inpatient and outpatient services. As a result, the WMC PPS lacks the financial control to impose common compensation, hiring, and training practices across the PPS participants. We will leverage our collaborative process to build consensus on common approaches and best practices and utilize contracts and financial incentives to encourage and enforce compliance as appropriate. We also realize that relying on each PPS within our region to identify and develop workforce plan initiatives for regional programs may result in a fractured workforce strategy rather than a comprehensive, coordinated plan. The WMC PPS is working towards a collaboration of all PPS in the region to discuss and share workforce training strategies.
6. The DSRIP program is a highly visible culture shaping initiative that is moving care from a "medical model" to a community/recovery focus. The workforce will need major support to make a full transition to the new care models. Transformation will require fundamental change in the skills, competencies and deployment of the health care workforce. Adequate time and resourc

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

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Instructions :

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

The Workforce Strategy is foundational to the development of our care delivery model, our cultural competency and health literacy capabilities, and our implementation of all 11 DSRIP projects. The transition to a care delivery model focused on prevention, care coordination, and population health management will create demand for new positions in outpatient settings and increase availability of care navigators and managers.

Staffing costs are anticipated to be the largest component of many project budgets, and accordingly, all finance plans will require accurate and ongoing assessments of hiring and redeployment volume, timing, and costs, in addition to the costs and timing for retraining.

There is also a relationship between the workforce strategy and our cultural competency and health literacy efforts. To engage patients effectively and address the broad range of factors influencing their health, the workforce recruitment and training efforts will include elements to ensure that cultural, linguistic, and educational competencies are enhanced and maintained.

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
WMC PPS Workforce Project Lead	Barbara Hill, Director, Community Workforce Transformation (PMO)	Dedicated project manager who will lead WMC PPS's workforce strategy design, development, implementation, and monitoring.
WMC PPS Workforce Project Team	"Workforce Project Team includes: • Barbara Hill, Workforce Project Lead • June Keenan, Executive Director (PMO) • Mecca Santana, Vice President, Community and Cultural Affairs/Diversity Officer (WMC) • Deborah Viola, VP, Health Services Research & Data Analytics PMO)"	WMC PPS dedicated team that will develop Workforce Strategy plans, oversee and monitor implementation, and report progress to the PMO and the WMC PPS leaders.
Workforce Committee	"Workforce Committee Members: * Deborah Marshall, Co-Chair, Good Samaritan Regional Medical Center * Cynthia Wolff, Co-Chair, 1199SEIU * Robert Wingate, Catskill Hudson Area Health Education Center * Roger King, Civil Service Employees Association representative, Westchester Medical Center * Jonathan Nasser, Crystal Run Healthcare * Susan Cohen, Dominican Sisters Family Health Service * Heidi Rosborough, HealthAlliance of the Hudson Valley * Annie Wiseman, The Institute for Family Health * Montgomery Douglas, New York Medical College * Sam Caquias, NYSNA Representative, Westchester Medical Center * Cliff Wood, Rockland Community College * Glenn Courounis, St. Luke's Cornwall Hospital * Kathleen Lynch Cartine, Westchester Medical Center * Barbara Hill, WMC PMO * June Keenan, WMC PMO * Nadine Williamson, 1199SEIU RN Division * Deborah Viola, WMC PMO Committee Observers * Jayne Cammisa, NYSNA Representative, WMC	Committee of key stakeholders who meet regularly to inform, guide, and review the development and implementation of the WMC PPS's workforce plan and implementation.

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	* Anna Sers, NYSNA Representative, WMC * Bonnie Reyna, 1199SEIU Training and Employment Funds (TEF)"	
Workforce Consultant	KPMG	An organization that can assist in the collection, analysis, development, implementation, and monitoring of the workforce strategy.
Workforce Training Vendor	1199SEIU Training and Employment Funds (TEF)	A training vendor that provides training modules and/or certification training to support workforce re-training needs.

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IPQR Module 11.7 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Leaders of PPS participant organizations	• Provide input, guidance. • Provide estimated hiring, retraining, and redeployment • Participate in strategy development, implementation, and communication	Input, feedback, and participation in PPS Committees and Workgroups
HR representatives of PPS participants	• Provide HR policies, salary and benefit information as appropriate.	HR policies, salary and benefit information as appropriate
Frontline staff	"• Provide input, guidance • Participate in strategy development, implementation, and communication	Input, feedback, and participation in PPS Committees and Workgroups
External Stakeholders		
Labor unions (including 1199SEIU, CSEA, NYS Nurses Association)	Provide input on workforce hiring, retraining, and redeployment impacts resulting from DSRIP projects	Input, feedback, and participation in PPS Committees and Workgroups
1199SEIU Training and Employment Funds (TEF)	A training vendor that provides training modules and/or certification training to support workforce re-training needs.	Training modules and/or certification training
Area Health Education Centers (AHECs)	Providing a pipeline for prospective medical students and clinical trainees who are willing to work in the diverse rural and underserved areas in our PPS. These AHECs also provide cultural competency training to existing healthcare workers.	Workforce pipeline and cultural competency training
NYS Department of Labor	Provision of career fairs and on-the-job training programs	Workforce data, training programs, and placement support.

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IPQR Module 11.8 - IT Expectations

Instructions :

Please describe how the development of shared IT infrastructure across the PPS will support your plans for workforce transformation.

WMC PPS will maintain a centralized IT management platform to track all project implementation work streams. The Workforce Strategy Training module will track the staff that have been trained, the type of training, the method of training, the training vendor, and duration. The Workforce Strategy Hiring and Redeployment module will track staff changes across the PPS. As required by the DSRIP Domain 1 milestones, the system will produce quarterly reports on the number of and budgets for hired, redeployed and trained personnel and will be used to identify trends, challenges, and potential risks.

Recognizing that many small to mid-sized providers lack the HR resources to support training on their own, the PMO will provide a centralized workforce capability that includes: the collection of available positions; staff to facilitate rapid placement of candidates into training programs; maintenance of an electronically available inventory of position descriptions, recruitment materials, and position postings; and communication and marketing services.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

We will maintain a centralized IT management platform to track all project implementation work streams. The Workforce Strategy Training module will track staff that have been trained by type of training, method/approach, vendor, and duration. The Workforce Strategy Hiring and Redeployment module will track staff changes across the PPS. As required by the DSRIP Domain 1 milestones, the system will produce quarterly reports on the number of and budgets for hired, redeployed and trained personnel and will be used to identify trends, challenges, and potential risks.

Based on contractual arrangements with our PPS participants, WMC PPS will establish a process for reporting workforce information on a timely and reoccurring basis. Data collection will be overseen and monitored by PMO staff for compliance.

For their respective projects, DSRIP project teams will provide information on recruitment, hiring, redeployment, retraining, and communication efforts.

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IPQR Module 11.10 - Staff Impact

Instructions :

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

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

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

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

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

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IPQR Module 11.11 - IA Monitoring:

Instructions :

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

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

Instructions :

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

As the primary mechanism of Medicaid service payments, MCOs must be engaged to achieve a value-based payment (VBP) structure. MCOs also have relationships with providers in our network and with the Medicaid patients that must be leveraged to meet DSRIP goals. Accordingly, we have begun preliminary discussions with a major Medicaid regional MCO and plan to expand our discussions to other MCOs. MCO engagement requires a concerted effort to communicate to MCOs the mutual benefit to be derived from working with our PPS: since we all share the DSRIP goals and objectives of cost-effective and high-quality care, WMC (and other PPSs) can assist the MCOs in establishing the infrastructure that providers will inevitably need to operate in a VBP model. Where possible, we will align our DSRIP workstreams with MCOs' efforts: outreach to members, quality reporting, directories of CBOs, and Health Home expansion can provide opportunities for streamlining, efficiency, and coordination. We will incorporate an ongoing function of monitoring of state policies and practices related to Medicaid Managed Care, and other regulatory and operational drivers of payment reform. Engagement and contacts with MCOs will be tracked using our CRM, Salesforce, which enables the documentation, tracking, and updates not only of MCO locations, but also key contacts, and the ability to record and display (internally) calls, emails, meeting attendance, project participation and governance roles – information which will facilitate a coherent and informed relationship over the course of the DSRIP program. A second risk is the current lack of EMRs among all eligible providers. An in-depth current state assessment is a milestone in our IT/Systems Plan, but preliminary data obtained from the RHIO and our CNA show that some practices are without EMRs. Without an EMR, practices will not be able to obtain PCMH certification, impacting achievement of IDS milestone #7, and greatly impeding the achievement of other milestones related to connecting to the RHIO, interoperability, and data sharing. To mitigate this risk, we plan a multifaceted process. First, our current state assessment results will show the magnitude of the EMR gap across the PPS. Second, we will participate with the NYSDOH CIO council and the RHIO and the other PPSs in our region, and coordinate our strategy with the region, the state, and overall best practices. Third, we will develop a strategy to close the gap, including a cost analysis and the comparison of various solutions. We will evaluate whether to procure an EMR solution, endorse one or more certified-EMRs, and other options. EMR adoption and use will also be tracked. Current state assessment results will be stored in Salesforce, enabling ready analysis of many variables including EMR product and version, MU, certification, deployment stage, hosting model, technical support, features, and other important factors. Likewise, RHIO connections, PCMH status, and other information relevant to EMR-driven data sharing will also be tracked. A third risk is the transition to ICD 10 in October 2015. Because coding and billing are mission-critical to health care providers, ICD 10 adoption will compete with DSRIP initiatives. At the same time, ICD 10 represents a modernizing of the infrastructure that is in concert with DSRIP goals and objectives which the PPS will support. We will explore our role in referring providers to resources supplied by CMS, the AMA, and other stakeholders aimed at facilitating the transition, and will work through our PCMH vendors, local deployment councils, and other technical assistance partners to assess and mitigate risks to DSRIP project work.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 1. WMC PPS customizes Salesforce to support IDS network; establish provider type, geographic, and other categories.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Execute Master Services Agreement with PPS network Participants and/or services contract between the PPS PMO and CBOs as appropriate.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3.WMC PPS to identify gaps in provider types, geographic coverage or other factors by crosswalking existing network to needs identified in CNA.	Project		In Progress	08/08/2015	12/31/2016	08/08/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. WMC PPS practitioner engagement and IDS teams reach out to potential new partners.	Project		In Progress	08/08/2015	12/31/2016	08/08/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. WMC PPS practioner engagement and communication teams develop and deploy "onboarding" materials and processes to integrate new partners in network and programs.	Project		In Progress	10/03/2015	03/31/2016	10/03/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS identifes Health Homes and assesses capabilities to underpin IDS including sharing systems and best practices.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. WMC PPS identifies ACOs and assesses capabilities to underpin IDS including sharing systems and best practices.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Unlike other PPSs who have experience as a result of developing ACOs and/or HHs, WMC PPS will meet with ACOs & HHs within and external to our network to identify successful models which can be replicated in our own IDS strategy.	Project		In Progress	08/08/2015	12/31/2016	08/08/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
followed.									
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS plans clinical governance structure to include participation of medical, behavioral health, post acute and long term care and public health partners.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. As part of the practitioner engagement workstream, WMC PPS wll establish local deployment councils to include local CBOs which will be encouraged to participate; CBOs will also be invited to participate in the Quality Committee.	Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Assess network to confirm specialties and provider types for HIE capability, links to care management including Health Homes and links to social services.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. WMC PPS creates protocols for care coordination and process flow as part of Hospital Transitions and Health Home at Risk projects.	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. As part of Practicioner Engagement workstream PPS will plan training for appropriate partners and staff on care transitions protocols for Hosptial Transitions and Health Home at Risk projects.	Project		In Progress	11/05/2015	09/30/2016	11/05/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.	Project		In Progress	08/08/2015	06/30/2016	08/08/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. PPS reviews and finalizes action plan.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Identify pilot partner/early adopter sites for QE connection.	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.	Project		In Progress	08/18/2015	12/31/2016	08/18/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Evaluate lessons learned from initial connections.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7. Plan phased implementation for network rollout.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Implement Phase 1 of network rollout.	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Implement Phase 2 of network rollout.	Project		Not Started	03/31/2017	03/31/2018	03/31/2017	03/31/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners to activate functionality.	Project		Not Started	06/30/2016	03/31/2018	06/30/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	08/08/2015	03/31/2018	08/08/2015	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	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. WMC PPS, based on findings of MS #1 (current state assessment) finalizes plan for procuring and rolling out certified EHRs to safety net primary care providers.	Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 2. Define functional reporting requirements for clinical projects.									
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Begin IT based population health reporting.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Project	N/A	In Progress	05/15/2015	03/31/2018	05/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		In Progress	11/15/2015	03/31/2018	11/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	11/15/2015	03/31/2018	11/15/2015	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	11/15/2015	03/31/2018	11/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment.	Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .	Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. WMC PPS working with PCMH vendor creates action plan for PCMH eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in	Project		Not Started	05/18/2016	12/31/2017	05/18/2016	12/31/2017	12/31/2017	DY3 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
processes and services.									
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS identifies and meets with MCOs doing business in our service area.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Conduct current state assessment of value based payment arrangements across all WMC PPS participants.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Identify lessons learned from PPS partner experiences with value based payment arrangements.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Per Financial Sustainability milestones contract with medicaid managed care organizations and other payors.	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		Not Started	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. WMC PPS and MCOs plan for sharing reports including establishing data sharing agreements.	Project		Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Create PPS/MCO agenda series aimed at developing	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
business case for MCO engagement; incorporate principles of DOH Value-Based Payment roadmap including the alignment of incentives, regulatory amendments and other requirements of payment reform.									
Task Step 4. WMC PPS and MCOs establish a regular meeting schedule to review performance and develop action plans as appropriate.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Project	N/A	In Progress	09/15/2015	03/31/2018	09/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		In Progress	10/23/2015	03/31/2018	10/23/2015	03/31/2018	03/31/2018	DY3 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		Not Started	06/30/2016	03/31/2018	06/30/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Review final State value-based payment roadmap with Finance and Executive Committees.	Project		Completed	10/23/2015	12/31/2015	10/23/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. WMC aligns PPS payments for patient engagement for DSRIP projects.	Project		In Progress	11/15/2015	03/31/2018	11/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 3. Establish Value-Based Payment Task Force (note, previously referred to as Financial Sustainability Taskforce in DSRIP Application; further guidance on financial sustainability workstream expectations from DOH led to modification).	Project		In Progress	09/15/2015	03/31/2016	09/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Conduct current state assessment of value-based payment across all WMC PPS Participants.	Project		In Progress	09/15/2015	03/31/2016	09/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Review baseline assessment of Participants' value-based payment arrangements (and capabilities).	Project		In Progress	12/15/2015	12/31/2016	12/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Conduct gap assessment to achieving stated goal of 90% within five years.	Project		In Progress	12/15/2015	12/31/2016	12/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 7. PPS Draft VBP Plan, including MCO strategy, distributed	Project		In Progress	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
for stakeholder feedback.									
Task Step 8. WMC PPS establishes guidelines for calculating incentive payments.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 9. Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee.	Project		In Progress	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 10. WMC PPS working with performance reporting, network partners, and the MAPP development team, creates and deploys dashboards to support VBP.	Project		Not Started	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
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	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 1. Establish a Community Engagement Quality Advisory Committee.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2. Identify cultural competency and health literacy champions within the local deployment groups established as part of Clinical Governance who are responsible for patient and provider engagement. These Champions will communicate cultural competency strategy and plans to our provider network and report back to the WMC Quality Committee and Workforce Committee.	Project		In Progress	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Conduct Focus groups with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	Project		In Progress	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Working with the Cultural Competency/Health Literacy	Project		In Progress	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3

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workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee									
Task Step 5. WMC PPS creates staffing plan to support patient engagement including documented human resource/workforce needs & reporting relationships.	Project		In Progress	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Complete identification of appropriate and meaningful measures to monitor ongoing impact of the WMC PPS Cultural Competency Strategy. Work with IT Committee to develop a platform for required quarterly reports and for sharing annual results with community stakeholders via portals that allow for web-based feedback.	Project		In Progress	11/15/2015	12/31/2016	11/15/2015	12/31/2016	12/31/2016	DY2 Q3

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task Step 1. WMC PPS customizes Salesforce to support IDS network; establish provider type, geographic, and other categories.										
Task Step 2. Execute Master Services Agreement with PPS network Participants and/or services contract between the PPS PMO and CBOs as appropriate.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 3.WMC PPS to identify gaps in provider types, geographic coverage or other factors by crosswalking existing network to needs identified in CNA.										
Task Step 4. WMC PPS practitioner engagement and IDS teams reach out to potential new partners.										
Task Step 5. WMC PPS practioner engagement and communication teams develop and deploy "onboarding" materials and processes to integrate new partners in network and programs.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task Step 1. WMC PPS identifes Health Homes and assesses capabilities to underpin IDS including sharing systems and best practices.										
Task Step 2. WMC PPS identifies ACOs and assesses capabilities to underpin IDS including sharing systems and best practices.										
Task Step 3. Unlike other PPSs who have experience as a result of developing ACOs and/or HHs, WMC PPS will meet with ACOs & HHs within and external to our network to identify successful models which can be replicated in our own IDS strategy.										
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										

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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
identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task Step 1. WMC PPS plans clinical governance structure to include participation of medical, behavioral health, post acute and long term care and public health partners.										
Task Step 2. Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.										
Task Step 3. As part of the practitioner engagement workstream, WMC PPS wll establish local deployment councils to include local CBOs which will be encouraged to participate; CBOs will also be invited to participate in the Quality Committee.										
Task Step 4. Assess network to confirm specialties and provider types for HIE capability, links to care management including Health Homes and links to social services.										
Task Step 5. WMC PPS creates protocols for care coordination and process flow as part of Hospital Transitions and Health Home at Risk projects.										
Task Step 6. As part of Practicioner Engagement workstream PPS will plan training for appropriate partners and staff on care transitions protocols for Hosptial Transitions and Health Home at Risk projects.										
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	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
requirements.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Identify pilot partner/early adopter sites for QE connection.										
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.										
Task Step 6. Evaluate lessons learned from initial connections.										
Task Step 7. Plan phased implementation for network rollout.										
Task Step 8. Implement Phase 1 of network rollout.										
Task Step 9. Implement Phase 2 of network rollout.										
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners to activate functionality.										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
and/or APCM 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 Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.										
Task Step 3. WMC PPS, based on findings of MS #1 (current state assessment) finalizes plan for procuring and rolling out certified EHRs to safety net primary care providers.										
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. Define functional reporting requirements for clinical projects.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.										
Task Step 4. Begin IT based population health reporting.										
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										

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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
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 Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment.										
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .										
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.										
Task Step 4. WMC PPS working with PCMH vendor creates action plan for PCMH eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task Step 1. WMC PPS identifies and meets with MCOs doing business in our service area.										
Task Step 2. WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.										
Task Step 3. Conduct current state assessment of value based										

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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
payment arrangements across all WMC PPS participants.										
Task Step 4. Identify lessons learned from PPS partner experiences with value based payment arrangements.										
Task Step 5. Per Financial Sustainability milestones contract with medicaid managed care organizations and other payors.										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task Step 1. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.										
Task Step 2. WMC PPS and MCOs plan for sharing reports including establishing data sharing agreements.										
Task Step 3. Create PPS/MCO agenda series aimed at developing business case for MCO engagement; incorporate principles of DOH Value-Based Payment roadmap including the alignment of incentives, regulatory amendments and other requirements of payment reform.										
Task Step 4. WMC PPS and MCOs establish a regular meeting schedule to review performance and develop action plans as appropriate.										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task Step 1. Review final State value-based payment roadmap with Finance and Executive Committees.										
Task Step 2. WMC aligns PPS payments for patient engagement for										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
DSRIP projects.										
Task Step 3. Establish Value-Based Payment Task Force (note, previously referred to as Financial Sustainability Taskforce in DSRIP Application; further guidance on financial sustainability workstream expectations from DOH led to modification).										
Task Step 4. Conduct current state assessment of value-based payment across all WMC PPS Participants.										
Task Step 5. Review baseline assessment of Participants' value-based payment arrangements (and capabilities).										
Task Step 6. Conduct gap assessment to achieving stated goal of 90% within five years.										
Task Step 7. PPS Draft VBP Plan, including MCO strategy, distributed for stakeholder feedback.										
Task Step 8. WMC PPS establishes guidelines for calculating incentive payments.										
Task Step 9. Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee.										
Task Step 10. WMC PPS working with performance reporting, network partners, and the MAPP development team, creates and deploys dashboards to support VBP.										
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
Task Step 1. Establish a Community Engagement Quality Advisory Committee.										
Task Step 2. Identify cultural competency and health literacy champions within the local deployment groups established as part of Clinical Governance who are responsible for patient and										

Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
provider engagement. These Champions will communicate cultural competency strategy and plans to our provider network and report back to the WMC Quality Committee and Workforce Committee.										
Task Step 3. Conduct Focus groups with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.										
Task Step 4. Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee										
Task Step 5. WMC PPS creates staffing plan to support patient engagement including documented human resource/workforce needs & reporting relationships.										
Task Step 6. Complete identification of appropriate and meaningful measures to monitor ongoing impact of the WMC PPS Cultural Competency Strategy. Work with IT Committee to develop a platform for required quarterly reports and for sharing annual results with community stakeholders via portals that allow for web-based feedback.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 1. WMC PPS customizes Salesforce to support IDS network; establish provider type, geographic, and other categories.										
Task Step 2. Execute Master Services Agreement with PPS network Participants and/or services contract between the PPS PMO and CBOs as appropriate.										
Task Step 3.WMC PPS to identify gaps in provider types, geographic coverage or other factors by crosswalking existing network to needs identified in CNA.										
Task Step 4. WMC PPS practitioner engagement and IDS teams reach out to potential new partners.										
Task Step 5. WMC PPS practioner engagement and communication teams develop and deploy "onboarding" materials and processes to integrate new partners in network and programs.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task Step 1. WMC PPS identifes Health Homes and assesses capabilities to underpin IDS including sharing systems and best practices.										
Task Step 2. WMC PPS identifies ACOs and assesses capabilities to underpin IDS including sharing systems and best practices.										
Task Step 3. Unlike other PPSs who have experience as a result of developing ACOs and/or HHs, WMC PPS will meet with ACOs & HHs within and external to our network to identify successful models which can be replicated in our own IDS strategy.										

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.										
Task Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task Step 1. WMC PPS plans clinical governance structure to include participation of medical, behavioral health, post acute and long term care and public health partners.										
Task Step 2. Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.										
Task Step 3. As part of the practitioner engagement workstream, WMC PPS wll establish local deployment councils to include local CBOs which will be encouraged to participate; CBOs will also be invited to participate in the Quality Committee.										
Task Step 4. Assess network to confirm specialties and provider types for HIE capability, links to care management including Health Homes and links to social services.										
Task Step 5. WMC PPS creates protocols for care coordination and process flow as part of Hospital Transitions and Health Home at Risk projects.										
Task Step 6. As part of Practicioner Engagement workstream PPS will plan training for appropriate partners and staff on care transitions protocols for Hosptial Transitions and Health Home at Risk projects.										

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #4 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	272	272	272	272	272	272	272	272	272
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	409	409	409	409	409	409	409	409	409
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	15	15	15	15	15	15	15	15	15
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	110	110	110	110	110	110	110	110	110
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	40	40	40	40	40	40	40	40	40
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Identify pilot partner/early adopter sites for QE connection.										
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.										
Task Step 6. Evaluate lessons learned from initial connections.										
Task Step 7. Plan phased implementation for network rollout.										
Task Step 8. Implement Phase 1 of network rollout.										

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 9. Implement Phase 2 of network rollout.										
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners to activate functionality.										
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	272	272	272	272	272	272	272	272	272
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.										
Task Step 3. WMC PPS, based on findings of MS #1 (current state assessment) finalizes plan for procuring and rolling out certified EHRs to safety net primary care providers.										
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. Define functional reporting requirements for clinical projects.										
Task Step 3. WMC PPS creates roadmap for data sharing 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
reporting to support population health analytics.										
Task Step 4. Begin IT based population health reporting.										
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	609	609	609	609	609	609	609	609	609
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment.										
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .										
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.										
Task Step 4. WMC PPS working with PCMH vendor creates action plan for PCMH eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.										
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.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 1. WMC PPS identifies and meets with MCOs doing business in our service area.										
Task Step 2. WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.										
Task Step 3. Conduct current state assessment of value based payment arrangements across all WMC PPS participants.										
Task Step 4. Identify lessons learned from PPS partner experiences with value based payment arrangements.										
Task Step 5. Per Financial Sustainability milestones contract with medicaid managed care organizations and other payors.										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task Step 1. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.										
Task Step 2. WMC PPS and MCOs plan for sharing reports including establishing data sharing agreements.										
Task Step 3. Create PPS/MCO agenda series aimed at developing business case for MCO engagement; incorporate principles of DOH Value-Based Payment roadmap including the alignment of incentives, regulatory amendments and other requirements of payment reform.										
Task Step 4. WMC PPS and MCOs establish a regular meeting schedule to review performance and develop action plans as appropriate.										
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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Westchester Medical Center (PPS ID:21)

Project 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 Step 1. Review final State value-based payment roadmap with Finance and Executive Committees.										
Task Step 2. WMC aligns PPS payments for patient engagement for DSRIP projects.										
Task Step 3. Establish Value-Based Payment Task Force (note, previously referred to as Financial Sustainability Taskforce in DSRIP Application; further guidance on financial sustainability workstream expectations from DOH led to modification).										
Task Step 4. Conduct current state assessment of value-based payment across all WMC PPS Participants.										
Task Step 5. Review baseline assessment of Participants' value-based payment arrangements (and capabilities).										
Task Step 6. Conduct gap assessment to achieving stated goal of 90% within five years.										
Task Step 7. PPS Draft VBP Plan, including MCO strategy, distributed for stakeholder feedback.										
Task Step 8. WMC PPS establishes guidelines for calculating incentive payments.										
Task Step 9. Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee.										
Task Step 10. WMC PPS working with performance reporting, network partners, and the MAPP development team, creates and deploys dashboards to support VBP.										
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.										

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 1. Establish a Community Engagement Quality Advisory Committee.										
Task Step 2. Identify cultural competency and health literacy champions within the local deployment groups established as part of Clinical Governance who are responsible for patient and provider engagement. These Champions will communicate cultural competency strategy and plans to our provider network and report back to the WMC Quality Committee and Workforce Committee.										
Task Step 3. Conduct Focus groups with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.										
Task Step 4. Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee										
Task Step 5. WMC PPS creates staffing plan to support patient engagement including documented human resource/workforce needs & reporting relationships.										
Task Step 6. Complete identification of appropriate and meaningful measures to monitor ongoing impact of the WMC PPS Cultural Competency Strategy. Work with IT Committee to develop a platform for required quarterly reports and for sharing annual results with community stakeholders via portals that allow for web-based feedback.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
appropriate.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.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- Dec. 2014 commitments were based on our then current understanding of definitions and specifications. Subsequent or future changes, e.g. for an activated patient, may substantially affect our ability to meet targets. We will mitigate this risk by respectfully raising concerns and issues relevant to our performance.

#2- To satisfy PPS speed and scale commitments providers must meet project requirements by a certain date. However, the appropriate role of any participant may vary by specialty, setting and provider type and we risk having based our commitments on a view of provider roles not fully aligned with the view of the IA. To mitigate this risk we describe our assumptions: Providers will assume leading, secondary or supporting roles as appropriate. Leading participants will satisfy all project requirements while participants in secondary or supporting roles will satisfy a role specific subset of requirements. A related risk relates to our view that hospitals are important participants for the success of this project but were an omitted type in the application, we therefore included hospitals in our count for "all other."

#3- This project requires PCMH/APCM recognition for PCPs. The number required was based on NYS criteria which included some not eligible for PCMH/APCM, e.g. Hospitalists. To mitigate the risk of falling short, we will encourage other PCPs to join our PPS and will work with NYS on requirements for those not eligible for PCMH/APCM.

#4- This project requires the patient care team use Health Information Exchange (HIE) to share information and make referrals. We plan to satisfy this requirement by connecting providers with the SHIN_NY through Qualified Entity (QE) enabled HIE. There is significant risk the QE may not be able to support this requirement, and/or that some providers may not be able to meet the aggressive time frame of this project. To mitigate the risk we continue to work closely with our local QE, PCPs and Health Homes.

#5- For all projects there is a risk of poor alignment of the population of patients attributed to the PPS through the NYS algorithm based on past experience and the population of current Medicaid patients treated by PPS partners. To mitigate this risk our PPS will advocate for modifications to the attribution algorithm that will, overtime, lead to a closer fit between the set of patients attributed to a PPS and the set of patients treated by PPS partners.

#6- This project shares risks with other projects and work streams: A risk that practices will be overwhelmed by the volume of guidelines, policies and training related to DSRIP which will be mitigated by support from PMO staff and by setting reasonable and staged due dates for milestones. Project speed and scale commitments were made before contracts with partners were executed and before any integrated PPS infrastructure was in place. To mitigate the risk of falling short, we are developing a two stage process for collecting data on engaged patients taking into account prohibitions on collecting PHI prior to meeting requirements for IT security, patient consent and contractual agreements. A risk that relying solely

on data from NYS through MAPP the PPS will not have information needed to meet the needs of every Medicaid patient served by PPS providers, including those not "attributed" to the PPS. To mitigate this risk, we are exploring HIPAA compliant possibilities for collecting data on the broader population served by the partner organizations in our PPS. An associated risk is that our IT roadmap assumes maximization of the DOH-supplied MAPP portal and analytics, which will not support inclusion of a broader data set. Accordingly, our IT and IDS strategies include transitioning to PPS based project management, analytics, and care management platforms.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	20,000

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
2,008	2,008	40.16%	2,992	10.04%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (5,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL2215_1_3_20160202161059_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3.	02/02/2016 04:11 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Project	N/A	In Progress	06/30/2015	03/31/2017	06/30/2015	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	06/30/2015	03/31/2017	06/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. In consultation with partner organizations (including health homes and case management agencies) and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), explore models for implementing a health home at risk intervention program. attributed to our PPS. DY1, Q2	Project		Completed	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Convene HHPAQC to review and discuss the candidate care management plan tools and components and the roles and responsibilities of both health homes and primary care providers in the health home at risk project.	Project		In Progress	06/30/2015	03/31/2016	06/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. In consultation with PMO and HHPAQC develop staffing, training and implementation plan including roles of PCMH PCPs and HHs.	Project		Not Started	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training	Project		Not Started	08/10/2016	03/31/2017	08/10/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.									
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	05/15/2015	03/31/2018	05/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	11/15/2015	03/31/2018	11/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.	Project		Completed	05/15/2015	07/01/2015	05/15/2015	07/01/2015	09/30/2015	DY1 Q2
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH.	Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics primary care provider type, as well as current PCMH or APC certification if any and EHR and MU capabilities.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	Project		Not Started	05/18/2016	12/31/2017	05/18/2016	12/31/2017	12/31/2017	DY3 Q3
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	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	Provider	Safety Net Practitioner - Primary Care Provider	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements.		(PCP)							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Case Management / Health Home	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.	Project		In Progress	08/08/2015	06/30/2016	08/08/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. PPS reviews and finalizes action plan.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Plan phased implementation for network rollout.	Project		Not Started	03/31/2016	06/30/2017	03/31/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 5. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.	Project		Not Started	06/30/2016	03/31/2018	06/30/2016	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	08/10/2015	03/31/2018	08/10/2015	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	08/10/2015	03/31/2018	08/10/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/10/2015	03/31/2018	08/10/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as	Project		In Progress	08/10/2015	03/31/2016	08/10/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
current PCMH/APC certification if any and EHR and MU capabilities.									
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.	Project		Not Started	08/17/2016	03/31/2018	08/17/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 3. As detailed in Milestone 2, Step 4 of this project (2.a.iii), the WMC PPS working with the PCMH/APC practice transformation vendor creates an action plan for PCMH eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services. This includes technical assistance from the vendor to assist practices in achieving MU stage 2 CMS requirements and NCQA Level 3 PCMH standards.	Project		Not Started	08/17/2016	03/31/2018	08/17/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services delivered during DY1.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Define functional reporting requirements for Health home at Risk project.	Project		Not Started	05/18/2016	06/30/2016	05/18/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.	Project		Not Started	08/10/2016	09/30/2016	08/10/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. Report and track actively engaged patients.	Project		Not Started	11/16/2016	03/31/2018	11/16/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Procedures to engage at-risk patients with care management plan instituted.									
Task Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify evidence based literature and best practices for candidate care management plans, tools, components.	Project		Completed	09/10/2015	12/31/2015	09/10/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Convene Health Home at Risk Project Advisory Quality Committee (HHPAQC) to review and discuss the candidate care management plan tools and components.	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. In consultation with PMO and HHPAQC develop staffing, trianing and implementation plan including roles of PCMH PCPs and HHs.	Project		Not Started	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. In consultation with partner organizations and PMO the HHPAQC will identify or develop metrics to assess success of project implementation.	Project		Not Started	08/10/2016	06/30/2017	08/10/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 5. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	Project		Not Started	11/30/2017	03/31/2018	11/30/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Project	N/A	In Progress	09/15/2015	03/31/2017	09/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/15/2015	03/31/2017	09/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Case Management / Health Home	In Progress	09/15/2015	03/31/2017	09/15/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate Health Home partners to provide care management services.	Project		Completed	09/15/2015	12/31/2015	09/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Convene Health Home at Risk Project Advisory Committee to review and discuss the roles and responsibilities of both health homes and primary care providers in the health home at risk project.	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Explore successful models for information sharing between PCPs and Health Homes.	Project		Not Started	05/10/2016	03/31/2017	05/10/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	Project	N/A	In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	11/05/2015	03/31/2017	11/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Case Management / Health Home	In Progress	11/05/2015	03/31/2017	11/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	Project		Not Started	11/30/2016	03/31/2017	11/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Meet with Health Homes to assess capacity and links to other care providers: medical, behavioral health, social services.	Project		In Progress	08/08/2015	06/30/2016	08/08/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Meet with partners to share experiences and identify gaps and opportunities.	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Assess network to confirm specialties and provider types for ability to exchange information, links to care management including Health Homes and links to social services.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	02/10/2016	06/30/2016	02/10/2016	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 4. Identify by provider type and project role the clinical information to be shared among providers									
Task Step 5. Create roadmap for data sharing and reporting	Project		Not Started	02/10/2016	06/30/2016	02/10/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Plan training for appropiate partners and staff	Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Project	N/A	In Progress	11/05/2015	03/31/2017	11/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	Project		In Progress	11/05/2015	12/31/2016	11/05/2015	12/31/2016	12/31/2016	DY2 Q3
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Project		Not Started	02/17/2016	06/30/2016	02/17/2016	06/30/2016	06/30/2016	DY2 Q1
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.	Project		In Progress	11/05/2015	12/31/2016	11/05/2015	12/31/2016	12/31/2016	DY2 Q3
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Project		Not Started	08/17/2016	03/31/2017	08/17/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing risk factor reduction, care engagement, and chronic disease management.	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Convene the HHPAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The HHPAQC includes clinical leaders from partner organizations and other stakeholder including social service agencies representing a range of credentials and experience relevant to the project.	Project		Not Started	02/17/2016	06/30/2016	02/17/2016	06/30/2016	06/30/2016	DY2 Q1

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Task Step 3. The Cultural Competency/Health Literacy workgroup, a subset of the Workforce Committee, is charged with identification of evidence-based clinical training and educational materials that takes into consideration disease risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup will suggest approaches for patient self management of disease risk factors that are culturally appropriate and will review these with WMC PPS quality steering committee and its workgroups	Project		In Progress	11/05/2015	11/30/2016	11/05/2015	11/30/2016	12/31/2016	DY2 Q3
Task Step 4. Plan phased roll out of culturally competent materials adapted to local considerations.	Project		Not Started	11/30/2016	03/31/2017	11/30/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task Step 1. In consultation with partner organizations (including health homes and case management agencies) and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), explore models for implementing a health home at risk intervention program. attributed to our PPS. DY1, Q2										
Task Step 2. Convene HHPAQC to review and discuss the candidate care management plan tools and components and the roles and responsibilities of both health homes and primary care providers in the health home at risk project.										
Task Step 3. In consultation with PMO and HHPAQC develop staffing, training and implementation plan including roles of PCMH PCPs and HHs.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 4. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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 Step 1. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.										
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH.										
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics primary care provider type, as well as current PCMH or APC certification if any and EHR and MU capabilities.										
Task Step 4. WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.										
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	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
requirements.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Plan phased implementation for network rollout.										
Task Step 5. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as current PCMH/APC certification if any and EHR and MU capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.										
Task Step 3. As detailed in Milestone 2, Step 4 of this project (2.a.iii), the WMC PPS working with the PCMH/APC practice transformation vendor creates an action plan for PCMH eligible										

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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
organizations as approprirate based on their particular gaps so as to enable them to close gaps in processes and services. This includes technical assistance from the vendor to assist practices in achieving MU stage 2 CMS requirements and NCQA Level 3 PCMH standards.										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services delivered during DY1.										
Task Step 2. Define functional reporting requirements for Health home at Risk project.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										
Task Step 4. Report and track actively engaged patients.										
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 Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify evidence based literature and best practices for candidate care management plans, tools, components.										
Task Step 2. Convene Health Home at Risk Project Advisory Quality Committee (HHPAQC) to review and discuss the candidate care management plan tools and components.										
Task Step 3. In consultation with PMO and HHPAQC develop staffing, trianing and implementation plan including roles of PCMH PCPs										

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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 HHs.										
Task Step 4. In consultation with partner organizations and PMO the HHPAQC will identify or develop metrics to assess success of project implementation.										
Task Step 5. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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	0	0	0	0	0
Task Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate Health Home partners to provide care management services.										
Task Step 2. Convene Health Home at Risk Project Advisory Committee to review and discuss the roles and responsibilities of both health homes and primary care providers in the health home at risk project.										
Task Step 3. Explore successful models for information sharing between PCPs and Health Homes.										
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

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DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS has established 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 Step 1. Meet with Health Homes to assess capacity and links to other care providers: medical, behavioral health, social services.										
Task Step 2. Meet with partners to share experiences and identify gaps and opportunities.										
Task Step 3. Assess network to confirm specialties and provider types for ability to exchange information, links to care management including Health Homes and links to social services.										
Task Step 4. Identify by provider type and project role the clinical information to be shared among providers										
Task Step 5. Create roadmap for data sharing and reporting										
Task Step 6. Plan training for appropiate partners and staff										
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 Step 1. In consultation with partner organizations and the Health										

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing risk factor reduction, care engagement, and chronic disease management.										
Task Step 2. Convene the HHPAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The HHPAQC includes clinical leaders from partner organizations and other stakeholder including social service agencies representing a range of credentials and experience relevant to the project.										
Task Step 3. The Cultural Competency/Health Literacy workgroup, a subset of the Workforce Committee, is charged with identification of evidence-based clinical training and educational materials that takes into consideration disease risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup will suggest approaches for patient self management of disease risk factors that are culturally appropriate and will review these with WMC PPS quality steering committee and its workgroups										
Task Step 4. Plan phased roll out of culturally competent materials adapted to local considerations.										

Project 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 Step 1. In consultation with partner organizations (including health homes and case management agencies) and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), explore models for implementing a health home at risk intervention program. attributed to our PPS. DY1, Q2										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 2. Convene HHPAQC to review and discuss the candidate care management plan tools and components and the roles and responsibilities of both health homes and primary care providers in the health home at risk project.										
Task Step 3. In consultation with PMO and HHPAQC develop staffing, training and implementation plan including roles of PCMH PCPs and HHs.										
Task Step 4. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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	524	524	524	524	524	524	524	524	524
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.										
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH.										
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics primary care provider type, as well as current PCMH or APC certification if any and EHR and MU capabilities.										
Task Step 4. WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.										
Milestone #3 Ensure that all participating safety net providers are actively										

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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
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	203	203	203	203	203	203	203	203	203
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	300	300	300	300	300	300	300	300	300
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	17	17	17	17	17	17	17	17	17
Task PPS uses alerts and secure messaging functionality.										
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Plan phased implementation for network rollout.										
Task Step 5. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	203	203	203	203	203	203	203	203	203
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
current PCMH/APC certification if any and EHR and MU capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.										
Task Step 3. As detailed in Milestone 2, Step 4 of this project (2.a.iii), the WMC PPS working with the PCMH/APC practice transformation vendor creates an action plan for PCMH eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services. This includes technical assistance from the vendor to assist practices in achieving MU stage 2 CMS requirements and NCQA Level 3 PCMH standards.										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services delivered during DY1.										
Task Step 2. Define functional reporting requirements for Health home at Risk project.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										
Task Step 4. Report and track actively engaged patients.										
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 Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
evidence based literature and best practices for candidate care management plans, tools, components.										
Task Step 2. Convene Health Home at Risk Project Advisory Quality Committee (HHPAQC) to review and discuss the candidate care management plan tools and components.										
Task Step 3. In consultation with PMO and HHPAQC develop staffing, trianing and implementation plan including roles of PCMH PCPs and HHs.										
Task Step 4. In consultation with partner organizations and PMO the HHPAQC will identify or develop metrics to assess success of project implementation.										
Task Step 5. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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	524	524	524	524	524	524	524	524	524
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	27	27	27	27	27	27	27	27	27
Task Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate Health Home partners to provide care management services.										
Task Step 2. Convene Health Home at Risk Project Advisory Committee to review and discuss the roles and responsibilities of both health homes and primary care providers in the health home at risk project.										
Task Step 3. Explore successful models for information sharing between PCPs and Health Homes.										

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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	524	524	524	524	524	524	524	524	524
Task PPS has established partnerships to medical, behavioral health, and social services.	0	27	27	27	27	27	27	27	27	27
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Step 1. Meet with Health Homes to assess capacity and links to other care providers: medical, behavioral health, social services.										
Task Step 2. Meet with partners to share experiences and identify gaps and opportunities.										
Task Step 3. Assess network to confirm specialties and provider types for ability to exchange information, links to care management including Health Homes and links to social services.										
Task Step 4. Identify by provider type and project role the clinical information to be shared among providers										
Task Step 5. Create roadmap for data sharing and reporting										
Task Step 6. Plan training for appropiate partners and staff										
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.										

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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 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 Step 1. In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing risk factor reduction, care engagement, and chronic disease management.										
Task Step 2. Convene the HHPAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The HHPAQC includes clinical leaders from partner organizations and other stakeholder including social service agencies representing a range of credentials and experience relevant to the project.										
Task Step 3. The Cultural Competency/Health Literacy workgroup, a subset of the Workforce Committee, is charged with identification of evidence-based clinical training and educational materials that takes into consideration disease risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup will suggest approaches for patient self management of disease risk factors that are culturally appropriate and will review these with WMC PPS quality steering committee and its workgroups										
Task Step 4. Plan phased roll out of culturally competent materials adapted to local considerations.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	
Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.a.iv – Create a medical village using existing hospital infrastructure

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

Instructions :

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

Both BSCH and HealthAlliance face conversion costs and funding challenges, potential disruptions in care delivery during the transition period, and workforce training and redeployment considerations. Specifically, the date for which capital projects are approved and receipt for total monies requested pose significant risks.
To contain costs, BSCH will utilize internal and community resources to further develop urgent care in the ED, outpatient psychiatric services, and rehabilitation, laboratory, radiology and surgical services for outpatients. BSCH will provide community education space to minimize costs and maximize usage for services such as smoking cessation and diabetes education, and nutrition and fitness programs.
To fund infrastructure development, BSCH and HealthAlliance did apply for the Capital Restructuring Financing Program, new market tax credits, foundation funding for capital and VAP funding for operating losses. Both Medical Villages will also attempt to offset losses through expansion and/or consolidation of outpatient services—including laboratory, behavioral health, diagnostic radiology, and ambulatory surgery.
Medical Village development requires facility changes, closures, and creation of new services that shift patterns of care. Patients, out of habit, may arrive at the wrong location. To mitigate potential disruptions in care delivery, BSCH and HealthAlliance are conducting comprehensive community engagement and planning to identify needs, assets, health behavior and utilization patterns and perceptions. BSCH and HealthAlliance will continue efforts to increase awareness of and promote access to the new services. Dedicated outreach programs will focus on identified health needs of the community and include comprehensive marketing and communication efforts.
Rebalancing health delivery to focus on primary and ambulatory care will result in staffing growth in certain job categories (e.g., outpatient, care management, community health workers) and staffing reductions in some inpatient units and support services. Our PPS is committed to retaining/retraining/redeploying impacted staff to meet the skill-mix required to maintain employment or gain skills for new positions. This includes working with our labor organizations and local educational institutions to access retraining resources for both new positions and for at-risk workers.
To aid the development of an effective workforce strategy, BSCH and HealthAlliance will create a detailed timeline documenting the specifics of bed reduction and rationale.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	12,000

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
1,709	1,709	85.45%	291	14.24%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (2,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL2315_1_3_20160202162433_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3.	02/02/2016 04:28 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task A strategic plan is in place which includes, at a minimum: - Definition of services to be provided in medical village and justification based on CNA - Plan for transition of inpatient capacity - Description of process to engage community stakeholders - Description of any required capital improvements and physical location of the medical village - Plan for marketing and promotion of the medical village and consumer education regarding access to medical village services	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Establish a Medical Village Project Quality Advisory Committee that includes representatives from BSCH and HealthAlliance as well as project management from the PMO who will be responsible for monitoring and reporting on the progress of the WMC PPS Medical Village Project.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 2. Review community health assessments undertaken in Ulster and Orange county as well as CNA conducted by the PPS to determine service needs.	Project		Completed	04/01/2015	11/05/2015	04/01/2015	11/05/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3. Convene Medical Village Project team to review project plan, implementation timelines and deliverables against submitted capital Restructuring Financing Program submissions.	Project		Not Started	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 4. Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required.	Project		Not Started	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 5. Once CRFP is approved, a plan for marketing and promotion of the medical village and consumer education regarding access to medical village services will be developed.	Project		Not Started	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 6. Plan community presentations as town hall type review that will be open to neighbors and stakeholders.	Project		Not Started	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #2 Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required and review timeline as it relates to staffed bed reduction.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Complete and submit Certificate of Need (CON) for bed reduction.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Once CON approved, maintain baseline bed capacity and periodic progress reports documenting bed reduction.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	Project	N/A	In Progress	05/15/2015	03/31/2018	05/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment.									
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .	Project		In Progress	11/05/2015	06/30/2016	11/05/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. WMC PPS working with PCMH vendor creates action plan for PCMH eligible organiztions as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #4 Ensure that all safety net providers participating in Medical Villages 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	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.5	Project		In Progress	08/08/2015	06/30/2016	08/08/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4

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DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.									
Task Step 3. PPS reviews and finalizes action plan.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Identify pilot partner/early adopter sites for QE connection.	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.	Project		In Progress	08/18/2015	12/31/2016	08/18/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Evaluate lessons learned from initial connections.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7. Plan phased implementation for network rollout.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Implement Phase 1 of network rollout.	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Implement Phase 2 of network rollout.	Project		Not Started	03/31/2017	03/31/2018	03/31/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.	Project		Not Started	06/30/2016	03/31/2018	06/30/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of EHRs.	Project		Not Started	05/10/2016	09/30/2016	05/10/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task	Project		Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 4. Begin IT based population health reporting.									
Milestone #6 Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2	Project	N/A	In Progress	08/08/2015	03/31/2018	08/08/2015	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	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR capabilities.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. WMC PPS, based on findings of current state assessment finalizes plan for procuring and rolling out certified EHRs.	Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.).	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Review Community Needs Assessment to determine migration plan.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Develop guidelines and protocols to ensure appropriate migration.	Project		In Progress	11/05/2015	03/31/2017	11/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Policies and procedures are developed to determine the frequency of updates to guidelines and protocols.	Project		Not Started	02/10/2017	03/31/2017	02/10/2017	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.										
Task A strategic plan is in place which includes, at a minimum: - Definition of services to be provided in medical village and justification based on CNA - Plan for transition of inpatient capacity - Description of process to engage community stakeholders - Description of any required capital improvements and physical location of the medical village - Plan for marketing and promotion of the medical village and consumer education regarding access to medical village services										
Task Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.										
Task Step 1. Establish a Medical Village Project Quality Advisory Committee that includes representatives from BSCH and HealthAlliance as well as project management from the PMO who will be responsible for monitoring and reporting on the progress of the WMC PPS Medical Village Project.										
Task Step 2. Review community health assessments undertaken in Ulster and Orange county as well as CNA conducted by the PPS to determine service needs.										
Task Step 3. Convene Medical Village Project team to review project plan, implementation timelines and deliverables against submitted capital Restructuring Financing Program submissions.										
Task Step 4. Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required.										
Task Step 5. Once CRFP is approved, a plan for marketing and promotion of the medical village and consumer education regarding access to medical village services will be developed.										
Task Step 6. Plan community presentations as town hall type review that will be open to neighbors and stakeholders.										
Milestone #2 Provide a detailed timeline documenting the specifics of bed										

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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
reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.										
Task PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.										
Task Step 1. Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required and review timeline as it relates to staffed bed reduction.										
Task Step 2. Complete and submit Certificate of Need (CON) for bed reduction.										
Task Step 3. Once CON approved, maintain baseline bed capacity and periodic progress reports documenting bed reduction.										
Milestone #3 Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	0	0	0
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment.										
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .										
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.										
Task Step 4. WMC PPS working with PCMH vendor creates action plan for PCMH eligible organiztions as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.										
Milestone #4 Ensure that all safety net providers participating in Medical Villages 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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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.5										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Identify pilot partner/early adopter sites for QE connection.										
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.										
Task Step 6. Evaluate lessons learned from initial connections.										
Task Step 7. Plan phased implementation for network rollout.										
Task Step 8. Implement Phase 1 of network rollout.										
Task Step 9. Implement Phase 2 of network rollout.										
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.										
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.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of EHRs.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.										
Task Step 4. Begin IT based population health reporting.										
Milestone #6 Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.										
Task Step 3. WMC PPS, based on findings of current state assessment finalizes plan for procuring and rolling out certified EHRs.										
Milestone #7 Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.										
Task Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.).										
Task Step 1. Review Community Needs Assessment to determine migration plan.										
Task Step 2. Develop guidelines and protocols to ensure appropriate migration.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 3. Policies and procedures are developed to determine the frequency of updates to guidelines and protocols.										

Project 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 Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.										
Task A strategic plan is in place which includes, at a minimum: - Definition of services to be provided in medical village and justification based on CNA - Plan for transition of inpatient capacity - Description of process to engage community stakeholders - Description of any required capital improvements and physical location of the medical village - Plan for marketing and promotion of the medical village and consumer education regarding access to medical village services										
Task Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.										
Task Step 1. Establish a Medical Village Project Quality Advisory Committee that includes representatives from BSCH and HealthAlliance as well as project management from the PMO who will be responsible for monitoring and reporting on the progress of the WMC PPS Medical Village Project.										
Task Step 2. Review community health assessments undertaken in Ulster and Orange county as well as CNA conducted by the PPS to determine service needs.										
Task Step 3. Convene Medical Village Project team to review project plan, implementation timelines and deliverables against submitted capital Restructuring Financing Program submissions.										
Task Step 4. Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required.										
Task Step 5. Once CRFP is approved, a plan for marketing 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
promotion of the medical village and consumer education regarding access to medical village services will be developed.										
Task Step 6. Plan community presentations as town hall type review that will be open to neighbors and stakeholders.										
Milestone #2 Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.										
Task PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.										
Task Step 1. Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required and review timeline as it relates to staffed bed reduction.										
Task Step 2. Complete and submit Certificate of Need (CON) for bed reduction.										
Task Step 3. Once CON approved, maintain baseline bed capacity and periodic progress reports documenting bed reduction.										
Milestone #3 Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	112	112	112	112	112
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment.										
Task Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .										
Task Step 3. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.										
Task Step 4. WMC PPS working with PCMH vendor creates action plan for PCMH eligible organiztions as appropriate based on their particular gaps so as to enable them to close gaps in processes										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
and services.										
Milestone #4 Ensure that all safety net providers participating in Medical Villages 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	112	112	112	112	112
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	192	192	192	192	192
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	6	6	6	6	6
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	5	5	5	5	5
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.5										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Identify pilot partner/early adopter sites for QE connection.										
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.										
Task Step 6. Evaluate lessons learned from initial connections.										
Task Step 7. Plan phased implementation for network rollout.										
Task Step 8. Implement Phase 1 of network rollout.										
Task Step 9. Implement Phase 2 of network rollout.										
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
support and training to network partners activate functionality.										
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 Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of EHRs.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.										
Task Step 4. Begin IT based population health reporting.										
Milestone #6 Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.										
Task Step 3. WMC PPS, based on findings of current state assessment finalizes plan for procuring and rolling out certified EHRs.										
Milestone #7 Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.										
Task Strategy developed for migration of any services to different										

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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
setting or location (clinic, hospitals, etc.).										
Task Step 1. Review Community Needs Assessment to determine migration plan.										
Task Step 2. Develop guidelines and protocols to ensure appropriate migration.										
Task Step 3. Policies and procedures are developed to determine the frequency of updates to guidelines and protocols.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.	
Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.	
Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	
Ensure that all safety net providers participating in Medical Villages 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.	
Use EHRs and other technical platforms to track all patients engaged in the project.	
Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

#1- Hospitals may be reluctant for care managers not credentialed by the hospital to see patients prior to discharge and HH care managers without nursing/medical backgrounds may not be qualified to evaluate deteriorating medical conditions post-discharge. To mitigate these risks we will explore a hospital or PCP affiliated RN care manager working in tandem with HH colleagues.

#2- This project requires the PPS to coordinate care, share records, determine HH eligibility and notify care managers and PCPs about upcoming discharges. If the admitted patient is not an attributed beneficiary the PPS will not have the benefit of the MAPP tools to meet these requirements. To mitigate this risk we will advocate for PPS notification of hospital admissions without regard to PPS "attribution" and access to PCP and HH assignment for admitted patients not attributed to the PPS.

#3- Dec. 2014 commitments were based on our understanding of definitions and specifications. Subsequent or future changes, e.g. for an activated patient, may substantially affect our ability to meet targets. We will mitigate this risk by respectfully raising concerns and issues.

#4- To satisfy PPS speed and scale commitments providers must meet requirements by a certain date. We are at risk for interpreting that the appropriate role of a participant varies by specialty, setting and provider type and basing our commitments on those roles. To mitigate this risk we describe our assumptions: Providers will assume leading, secondary or supporting roles as appropriate; leading participants will satisfy all project requirements while those in secondary or supporting roles will satisfy only role-applicable milestones.

#5-To meet the requirement for Health Information Exchange (HIE) we plan to connect providers to the SHIN_NY through our Qualified Entity (QE). There is significant risk the QE may not be able to support this requirement or providers may not be able to meet the aggressive time frame. To mitigate risk we will work closely with our QE and partners.

#6- This project shares risks with others: Practices may be overwhelmed by the volume of guidelines, policies and training related to DSRIP, a risk to be mitigated by support from PMO staff and by setting reasonable and staged dates for milestones. Project speed and scale commitments made before executed contracts with partners and PPS infrastructure was in place may be at risk. To mitigate we are developing a two stage process for collecting data on engaged patients taking into account requirements for IT security, patient consent and contractual agreements. Relying solely on data from NYS through MAPP the PPS would not have information needed to meet the needs of Medicaid patients served by PPS providers but not "attributed" to the PPS. To mitigate this risk, we are exploring HIPAA compliant possibilities for collecting data on the broader population served by our partner organizations. An associated risk is that our IT roadmap assumes maximization of the DOH-supplied MAPP portal and analytics, which will not support inclusion of a broader data set. Accordingly, our IT and IDS strategies include transitioning to PPS based project management, analytics, and care management platforms.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	5,600

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
240	240	24.00%	760	4.29%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (1,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL2815_1_3_20160202163209_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3	02/02/2016 04:32 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Project	N/A	In Progress	10/14/2015	03/31/2017	10/14/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Project		In Progress	10/14/2015	03/31/2017	10/14/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. In consultation with partner organizations and the Care Transitions Project Advisory Quality Committee (CTPAQC,a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing care transitions.	Project		In Progress	10/14/2015	03/31/2017	10/14/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Convene the CTPAQC review and discuss the candidate best best practices/protocols/ guidelines/standards. The Care Transitions Project Advisory Quality Committee includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Compare status of current practice among participating partners to identified best practices, including current ability of partner hospitals to identify Health Home enrolled or Health Home eligible patients, to notify of planned discharge, to provide a care manager visit with transition services prior to discharge, and to create and share a timely care transition record.	Project		In Progress	02/10/2016	06/30/2016	02/10/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Plan phased roll out of best practices/protocols/	Project		In Progress	08/17/2016	03/31/2017	08/17/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
guidelines/standards adapted to local considerations. Protocols will include: notification of early discharge, transmission of a transition care record, facilitation of visit by transition care manager, assessment of Health Home enrollment and or eligiblity, notification of MCO and, if applicable, Health Home and will include a 30 day transition period.									
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		Not Started	08/17/2016	03/31/2018	08/17/2016	03/31/2018	03/31/2018	DY3 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Project		Not Started	05/18/2016	03/31/2018	05/18/2016	03/31/2018	03/31/2018	DY3 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		In Progress	08/15/2015	03/31/2018	08/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS cunducts analysis of current practice among participating hospital partners regarding current ability to identify Health Home enrolled or Health Home eligible patients.	Project		In Progress	08/15/2015	03/31/2016	08/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for implementing identification of Health Home enrolled or eligible patients and to link the patient to Health Home services.	Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. WMC PPS identifies Medicaid Managed Care Organizations (MCOs) and Health Homes (HHs) doing business in our service area whose members and clients are at risk of admission to partner hospitals.	Project		Completed	08/10/2015	09/30/2015	08/10/2015	09/30/2015	09/30/2015	DY1 Q2
Task	Project		Not Started	08/17/2016	03/31/2017	08/17/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 4. WMC PPS conducts learning sessions for area HH and MCO care managers on the new care transition protocols. See role out of protocols 2biv M1: 8/17/2016-3/31/2017.									
Task Step 5. MCOs and HHs are invited to participate in committees, work groups and local deployment councils working on care coordination. WMC PPS seeks to identify a contact person at each MCO who will work with PPS partners to ensure coordination of care management.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 6. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for reimbursement for transition services.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure required social services participate in the project.	Project	N/A	Not Started	05/20/2016	03/31/2018	05/20/2016	03/31/2018	03/31/2018	DY3 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		Not Started	05/20/2016	03/31/2018	05/20/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. In collaboration with PPS partners working on community engagement and patient activation, identify local social services, including medically tailored home food services, within the service area of each participating hospital.	Project		Not Started	05/20/2016	09/30/2016	05/20/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. In consultation with CBOs, social service agencies, network partners and the CTPQAC, create resource tools including lists of available social services and protocols for making referals for use by care managers, hospitals, primary care and other network providers.	Project		Not Started	11/18/2016	06/30/2017	11/18/2016	06/30/2017	06/30/2017	DY3 Q1
Task Step 3. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the CTPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	Project		Not Started	08/16/2017	03/31/2018	08/16/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #4	Project	N/A	Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Provider	Practitioner - Primary Care Provider (PCP)	Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Non-Primary Care Provider (PCP)	Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospital	Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Project		Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to notify of planned discharges and provide care manager visit prior to discharge to provide transition services.	Project		Not Started	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for implementing early notification of planned discharges and care manager visits prior to discharge to provide transition services.	Project		Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.	Project		Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS completes current state analysis of current	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
EHR based connections to RHIO.									
Task Step 2. WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to create and share a timely care transition record.	Project		Not Started	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for closing gaps to enable the sharing of a care transition plan with primary care practices caring for discharged patients.	Project		Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	Not Started	08/17/2016	03/31/2017	08/17/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		Not Started	08/17/2016	03/31/2017	08/17/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Phased roll out of best practices/protocols/ guidelines/standards will include a 30 day transition period.	Project		Not Started	08/17/2016	03/31/2017	08/17/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking tacking into account all project compliant services for DY1.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Define functional reporting requirements for care transition project.	Project		In Progress	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Begin reporting to track all activated patients.	Project		In Progress	11/15/2015	09/30/2016	11/15/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 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 Step 1. In consultation with partner organizations and the Care Transitions Project Advisory Quality Committee (CTPAQC,a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing care transitions.										
Task Step 2. Convene the CTPAQC review and discuss the candidate best best practices/protocols/ guidelines/standards. The Care Transitions Project Advisory Quality Committee includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3. Compare status of current practice among participating partners to identified best practices, including current ability of partner hospitals to identify Health Home enrolled or Health Home eligible patients, to notify of planned discharge, to provide a care manager visit with transition services prior to discharge, and to create and share a timely care transition record.										
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations. Protocols will include: notification of early discharge, transmission of a transition care record, facilitation of visit by transition care manager, assessment of Health Home enrollment and or eligiblity, notification of MCO and, if applicable, Health Home and will include a 30 day transition period.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1. WMC PPS cunducts analysis of current practice among participating hospital partners regarding current ability to identify Health Home enrolled or Health Home eligible patients.										
Task Step 2. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for implementing identification of Health Home enrolled or eligible patients and to link the patient to Health Home services.										
Task Step 3. WMC PPS identifies Medicaid Managed Care Organizations (MCOs) and Health Homes (HHs) doing business in our service area whose members and clients are at risk of admission to partner hospitals.										
Task Step 4. WMC PPS conducts learning sessions for area HH and MCO care managers on the new care transition protocols. See role out of protocols 2biv M1: 8/17/2016-3/31/2017.										
Task Step 5. MCOs and HHs are invited to participate in committees, work groups and local deployment councils working on care coordination. WMC PPS seeks to identify a contact person at each MCO who will work with PPS partners to ensure coordination of care management.										
Task Step 6. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for reimbursement for transition services.										
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 Step 1. In collaboration with PPS partners working on community engagement and patient activation, identify local social services, including medically tailored home food services, within the service area of each participating hospital.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 2. In consultation with CBOs, social service agencies, network partners and the CTPQAC, create resource tools including lists of available social services and protocols for making referals for use by care managers, hospitals, primary care and other network providers.										
Task Step 3. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the CTPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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 Step 1. WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to notify of planned discharges and provide care manager visit prior to discharge to provide transition services.										
Task Step 2. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for implementing early notification of planned discharges and care manager visits prior to discharge to provide transition services.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly 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
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 Step 1. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 2. WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to create and share a timely care transition record.										
Task Step 3. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for closing gaps to enable the sharing of a care transition plan with primary care practices caring for discharged patients.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task Step 1. Phased roll out of best practices/protocols/ guidelines/standards will include a 30 day transition period.										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking tacking into account all project compliant services for DY1.										
Task Step 2. Define functional reporting requirements for care transition project.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 4. Begin reporting to track all activated patients.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 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 Step 1. In consultation with partner organizations and the Care Transitions Project Advisory Quality Committee (CTPAQC,a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing care transitions.										
Task Step 2. Convene the CTPAQC review and discuss the candidate best best practices/protocols/ guidelines/standards. The Care Transitions Project Advisory Quality Committee includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3. Compare status of current practice among participating partners to identified best practices, including current ability of partner hospitals to identify Health Home enrolled or Health Home eligible patients, to notify of planned discharge, to provide a care manager visit with transition services prior to discharge, and to create and share a timely care transition record.										
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations. Protocols will include: notification of early discharge, transmission of a transition care record, facilitation of visit by transition care manager, assessment of Health Home enrollment and or eligiblity, notification of MCO and, if applicable, Health Home and will include a 30 day transition period.										
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.										

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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 A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1. WMC PPS cunducts analysis of current practice among participating hospital partners regarding current ability to identify Health Home enrolled or Health Home eligible patients.										
Task Step 2. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for implementing identification of Health Home enrolled or eligible patients and to link the patient to Health Home services.										
Task Step 3. WMC PPS identifies Medicaid Managed Care Organizations (MCOs) and Health Homes (HHs) doing business in our service area whose members and clients are at risk of admission to partner hospitals.										
Task Step 4. WMC PPS conducts learning sessions for area HH and MCO care managers on the new care transition protocols. See role out of protocols 2biv M1: 8/17/2016-3/31/2017.										
Task Step 5. MCOs and HHs are invited to participate in committees, work groups and local deployment councils working on care coordination. WMC PPS seeks to identify a contact person at each MCO who will work with PPS partners to ensure coordination of care management.										
Task Step 6. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for reimbursement for transition services.										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored										

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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
home food services, are provided in care transitions.										
Task Step 1. In collaboration with PPS partners working on community engagement and patient activation, identify local social services, including medically tailored home food services, within the service area of each participating hospital.										
Task Step 2. In consultation with CBOs, social service agencies, network partners and the CTPQAC, create resource tools including lists of available social services and protocols for making referals for use by care managers, hospitals, primary care and other network providers.										
Task Step 3. Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the CTPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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	524	524	524	524	524	524	524	524	524
Task Policies and procedures are in place for early notification of planned discharges.	0	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Task Policies and procedures are in place for early notification of planned discharges.	0	14	14	14	14	14	14	14	14	14
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task Step 1. WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to notify of planned discharges and provide care manager visit prior to discharge to provide transition services.										
Task Step 2. In consultation with partner organizations and the										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
CTPAQC the PMO will work with each participating hospital to develop a plan for implementing early notification of planned discharges and care manager visits prior to discharge to provide transition services.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Step 1. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 2. WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to create and share a timely care transition record.										
Task Step 3. In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for closing gaps to enable the sharing of a care transition plan with primary care practices caring for discharged patients.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task Step 1. Phased roll out of best practices/protocols/ guidelines/standards will include a 30 day transition period.										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking tacking into account all project compliant services for DY1.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 2. Define functional reporting requirements for care transition project.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										
Task Step 4. Begin reporting to track all activated patients.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.d.i – Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

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

Instructions :

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

We anticipate challenges and risks in locating patients for this project. During our CNA process we identified hot spots that were most frequently represented within disease categories. This experience provided us with a sense of how difficult it may be to survey and engage individuals as part of Project 2.d.i. Although we were successful in getting into these communities and developing relationships with local providers and CBOs, we realize that the target population's size and geographic distribution will represent logistical challenges to achieving project milestones. To minimize this risk we will work through our local deployment councils (LDCs) which will communicate with the FQHCs, MCOs and CBOs who are part of our project effort.

Another challenge will be directing the UI/NU/LU to care and improving patient activation scores and utilization of primary and prevention services. In our region, these populations currently engage the health system at multiple points, including FQHCs, EDs, Medicaid MCOs, and organizations that facilitate insurance enrollment. Our strategy includes working with partner organizations like MISN and our MCOs to facilitate enrollment into the NYS Exchange or guide the uninsured to our partner FQHCs. We will also work with the MCOs to obtain lists of their low and non-utilizing Medicaid beneficiaries to help connect these patients to their primary care provider. To increase the likelihood of patients' completion of activation measures, we will offer a free mobile app that links patients to local clinical and social services.

This project shares similar risks identified in our IT Systems and Population Health work streams, briefly summarized here. We have committed to engaging patients for this project before all committees have convened, before contracts are in place with all our partners and before the PPS is fully staffed. To mitigate this risk we are developing a two stage process for collecting data on engaged patients with a short term plan that will take into account that without consent from patients, and executed BAA and DEAA, we cannot collect PHI information. We are also at risk of only being able to manage our attributed population by relying on data from NYS through MAPP. To truly impact the Medicaid population at-large, the WMC PPS and its network will have to address the needs of every Medicaid patient. Not having access to data for non-attributed members in our service area will impede our ability to proactively identify patients with gaps in care or other service needs, as well as monitor quality performance for the population at large. To mitigate this risk, we are exploring HIPAA compliant possibilities for collecting data on the broader population served by the partner organizations in our PPS. An associated risk is that our IT roadmap assumes maximization of the DOH-supplied MAPP portal and analytics, which will not support inclusion of a broader data set. Accordingly, our IT and IDS strategies include transitioning to a powerful PPS based analytics platform.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	81,500

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
176	176	1.47%	11,824	0.22%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (12,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL3615_1_3_20160202163449_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3	02/02/2016 04:35 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4.

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Module Review Status

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

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.	Project		In Progress	11/06/2015	03/31/2019	11/06/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Establish a Community Engagement Quality Advisory Committee.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2. PPS will establish relationships with CBOs by connecting to local/ regional coalitions and quality advisory groups.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Execute MSA with some PPS Participants and/or service contracts between PMO and CBOs as appropriate.	Project		In Progress	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. The Community Engagement Quality Advisory Committee will evaluate and provide oversight and ensure the engagement is sufficient and appropriate	Project		In Progress	11/15/2015	03/31/2019	11/15/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Project	N/A	In Progress	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Patient Activation Measure(R) (PAM(R)) training team established.	Project		In Progress	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 1. Conduct trainings with Core PAM Team.	Project		Completed	06/01/2015	08/11/2015	06/01/2015	08/11/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2. Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation. Develop mechanism to measure training effectiveness in relation to goals once strategy and plan implemented.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Utilize CNA's baseline data as a starting point to ascertain "hot spot" areas where the UI, NU, and LU are most likely to go to for health care or social support services; emergency departments, community health centers, public hospitals, charitable clinics, teaching and community hospitals, and the Departments of Social Services, in the Hudson Valley region.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Collaborate with CBOs through the (Community Engagement Quality Advisory) Committee as per Milestone 1	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	In Progress	10/08/2015	03/31/2017	10/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community engagement forums and other information-gathering mechanisms established and performed.	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Conduct Focus groups / community engagement session with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	Project		Completed	10/27/2015	12/31/2015	10/27/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Participate in monthly community / regional network meetings that will allow us to identify the CBO in our hot spots	Project		In Progress	10/08/2015	03/31/2017	10/08/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and engage community members throughout the Hudson Valley.									
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Project	N/A	In Progress	08/10/2015	03/31/2019	08/10/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	Project		In Progress	08/10/2015	03/31/2019	08/10/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee	Project		Completed	10/06/2015	12/31/2015	10/06/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Finalize appropriate role-based training strategy for non-clinical and clinical segments of workforce based on the previous step, incorporating on-site and on-line based input from providers and CBOs.	Project		Not Started	03/31/2016	03/31/2019	03/31/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 3. Identify cultural competancy and health literacy champions within the local deployment groupos established as part of Clinical governance who are responsible for patient and provider emgagement.	Project		Completed	10/06/2015	12/31/2015	10/06/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources,	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.									
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. WMC PPS and MCOs plan for sharing reports to help reconnect benificiaries to designated PCPs including establishing data sharing agreements.	Project		Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Review with respective MCOs and PCPs outreach materials.	Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Project	N/A	In Progress	08/05/2015	09/30/2019	08/05/2015	09/30/2019	09/30/2019	DY5 Q2
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	Project		In Progress	08/05/2015	03/31/2019	08/05/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. LU/NU Medicaid beneficiaries and the UI in the Hudson Valley region will be engaged and activated through the administration of PAM.	Project		In Progress	08/05/2015	03/31/2019	08/05/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 2. Identify by User IDs, baseline PAM activation level and score will be captured and tracked at the individual level. These PAM respondents will be followed-up at set intervals defined by the State by their providers.	Project		Not Started	08/31/2016	03/31/2019	08/31/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 3. Through data analysis, cohorts of LU/NU and UI, as well	Project		Not Started	08/31/2016	09/30/2019	08/31/2016	09/30/2019	09/30/2019	DY5 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
as subgroups based on PAM activation level and score will be assessed at each follow-up to determine progress and improvement trend, and to establish subsequent achievement goals.									
Milestone #8 Include beneficiaries in development team to promote preventive care.	Project	N/A	Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. The Community Engagement Quality Advisory Committee through the local deployment council will provide oversight to include beneficiaries in the development process.	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Conduct Community engagement sessions with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better	Project	N/A	In Progress	09/01/2015	03/31/2019	09/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.									
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement	Project		In Progress	11/15/2015	03/31/2019	11/15/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. WMC PPS creates a plan for the development of platforms to share administrative, milestone, and project information with network partners with includes patients using PAM and their scores	Project		In Progress	11/15/2015	03/31/2019	11/15/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 2. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS (see Milestone #6)	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of clinicians trained in	Project		Not Started	01/01/2017	03/31/2017	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PAM									
Task Step 4. As noted in IT Milestone 3 Step 8, "Create roadmap for data sharing and reporting using platform to support population health analytics including assessment of patient engagement."	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. Generate reports and submit to Department of Health	Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Volume of non-emergent visits for UI, NU, and LU populations increased.	Project		Not Started	08/15/2016	03/31/2019	08/15/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Through PAM administration and its coaching functionality and capability, many providers in our network (FQHCs, MCOs) will be able to assess our beneficiaries' access to care information for non-emergent care.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 2. WMC-PPS project teams will collaborate with these providers to create a referral network for our beneficiaries to access these primary care services.	Project		In Progress	08/15/2015	03/31/2019	08/15/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Project	N/A	In Progress	09/30/2015	03/31/2019	09/30/2015	03/31/2019	03/31/2019	DY4 Q4
Task Community navigators identified and contracted.	Provider	PAM(R) Providers	In Progress	11/16/2015	03/31/2019	11/16/2015	03/31/2019	03/31/2019	DY4 Q4
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	Provider	PAM(R) Providers	In Progress	09/30/2015	03/31/2019	09/30/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Contract with CBOs as described in Milestone 1	Project		In Progress	09/30/2015	03/31/2019	09/30/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 2. Develop preliminary training strategy (e.g., scale, timing, scope, methodologies, content and cultural competency considerations) as defined in Milestone 5 of the Workforce	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Strategy.									
Task Step 3. 3) Similar to Milestone 10, through PAM administration and its coaching functionality, this group of trained community navigators will be able to coach and connect patients to relevant preventive care services and educational resources.	Project		Not Started	08/15/2016	03/31/2019	08/15/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Project	N/A	In Progress	08/05/2015	03/31/2017	08/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures for customer service complaints and appeals developed.	Project		In Progress	08/05/2015	03/31/2017	08/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS will follow WMC policy on Patient Complaints and Grievances, policy # RI-11A.	Project		In Progress	08/05/2015	03/31/2017	08/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Along with WMC's 24/7 toll free help line which is available to patients and staff, WMC is well positioned to receive and respond to all recipients and project participants.	Project		In Progress	08/05/2015	03/31/2017	08/05/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Project	N/A	In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task List of community navigators formally trained in the PAM(R).	Provider	PAM(R) Providers	In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Core team will train community navigators who will be responsible for performing PAM.	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of community navigators	Project		In Progress	11/15/2015	03/31/2017	11/15/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	Provider	PAM(R) Providers	In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Identify hot spots as indicated in Milestone 3	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 2. Train navigators as indicated in Milestone 5, 11 and 13	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 3. Community navigators will utilize resources that will allow them to connect, track and follow up on engaged UI/LU/NU to ensure appropriate health services and insurance options were provided and/or discussed.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project	N/A	In Progress	11/15/2015	03/31/2019	11/15/2015	03/31/2019	03/31/2019	DY4 Q4
Task Navigators educated about insurance options and healthcare resources available to populations in this project.	Project		In Progress	11/15/2015	03/31/2019	11/15/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Train navigators as indicated in Milestones 5, 11, 13 and 14	Project		In Progress	11/15/2015	03/31/2019	11/15/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Project	N/A	In Progress	10/14/2015	03/31/2019	10/14/2015	03/31/2019	03/31/2019	DY4 Q4
Task Timely access for navigator when connecting members to services.	Project		Not Started	10/31/2016	03/31/2019	10/31/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Plan training for navigators on care transition protocols	Project		In Progress	10/14/2015	03/31/2019	10/14/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 2. Follow care transition strategy as outlined in 2biv Milestone #2	Project		Not Started	05/18/2016	03/31/2018	05/18/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
able to track actively engaged patients for project milestone reporting.									
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of EHRs.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Begin IT based population health reporting.	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task Step 1. Establish a Community Engagement Quality Advisory Committee.										
Task Step 2. PPS will establish relationships with CBOs by connecting to local/ regional coalitions and quality advisory groups.										
Task Step 3. Execute MSA with some PPS Participants and/or service contracts between PMO and CBOs as appropriate.										
Task Step 4. The Community Engagement Quality Advisory Committee will evaluate and provide oversight and ensure the engagement is sufficient and appropriate										
Milestone #2 Establish a PPS-wide training team, comprised of members with										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task Step 1. Conduct trainings with Core PAM Team.										
Task Step 2. Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation. Develop mechanism to measure training effectiveness in relation to goals once strategy and plan implemented.										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task Step 1. Utilize CNA's baseline data as a starting point to ascertain "hot spot" areas where the UI, NU, and LU are most likely to go to for health care or social support services; emergency departments, community health centers, public hospitals, charitable clinics, teaching and community hospitals, and the Departments of Social Services, in the Hudson Valley region.										
Task Step 2. Collaborate with CBOs through the (Community Engagement Quality Advisory) Committee as per Milestone 1										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task Step 1. Conduct Focus groups / community engagement session with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.										
Task Step 2. Participate in monthly community / regional network										

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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
meetings that will allow us to identify the CBO in our hot spots and engage community members throughout the Hudson Valley.										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task Step 1. Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee										
Task Step 2. Finalize appropriate role-based training strategy for non-clinical and clinical segments of workforce based on the previous step, incorporating on-site and on-line based input from providers and CBOs.										
Task Step 3. Identify cultural competancy and health literacy champions within the local deployment groupos established as part of Clinical governance who are responsible for patient and provider emgagement.										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 1. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.										
Task Step 2. WMC PPS and MCOs plan for sharing reports to help reconnect benificiaries to designated PCPs including establishing data sharing agreements.										
Task Step 3. Review with respective MCOs and PCPs outreach materials.										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task Step 1. LU/NU Medicaid beneficiaries and the UI in the Hudson Valley region will be engaged and activated through the administration of PAM.										
Task Step 2. Identify by User IDs, baseline PAM activation level and score will be captured and tracked at the individual level. These PAM respondents will be followed-up at set intervals defined by the State by their providers.										
Task Step 3. Through data analysis, cohorts of LU/NU and UI, as well as subgroups based on PAM activation level and score will be assessed at each follow-up to determine progress and improvement trend, and to establish subsequent achievement goals.										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										

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Task Step 1. The Community Engagement Quality Advisory Committee through the local deployment council will provide oversight to include beneficiaries in the development process.										
Task Step 2. Conduct Community engagement sessions with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established										

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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
- Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 1. WMC PPS creates a plan for the development of platforms to share administrative, milestone, and project information with network partners with includes patients using PAM and their scores										
Task Step 2. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS (see Milestone #6)										
Task Step 3. As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of clinicians trained in PAM										
Task Step 4. As noted in IT Milestone 3 Step 8, "Create roadmap for data sharing and reporting using platform to support population health analytics including assessment of patient engagement."										
Task Step 5. Generate reports and submit to Department of Health										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task Step 1. Through PAM administration and its coaching functionality and capability, many providers in our network (FQHCs, MCOs) will be able to assess our beneficiaries' access to care information for non-emergent care.										
Task Step 2. WMC-PPS project teams will collaborate with these providers to create a referral network for our beneficiaries to access these primary care services.										
Milestone #11 Contract or partner with CBOs to develop a group of community										

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navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	0	3	20	80	120	160	200	275	275	275
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	0	3	20	80	120	160	200	275	275	275
Task Step 1. Contract with CBOs as described in Milestone 1										
Task Step 2. Develop preliminary training strategy (e.g., scale, timing, scope, methodologies, content and cultural competency considerations) as defined in Milestone 5 of the Workforce Strategy.										
Task Step 3. 3) Similar to Milestone 10, through PAM administration and its coaching functionality, this group of trained community navigators will be able to coach and connect patients to relevant preventive care services and educational resources.										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task Step 1. WMC PPS will follow WMC policy on Patient Complaints and Grievances, policy # RI-11A.										
Task Step 2. Along with WMC's 24/7 toll free help line which is available to patients and staff, WMC is well positioned to receive and respond to all recipients and project participants.										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	0	3	20	80	120	160	200	275	275	275
Task Step 1. Core team will train community navigators who will be responsible for performing PAM.										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Step 2. As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of community navigators										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	0	3	20	80	120	160	200	275	275	275
Task Step 1. Identify hot spots as indicated in Milestone 3										
Task Step 2. Train navigators as indicated in Milestone 5, 11 and 13										
Task Step 3. Community navigators will utilize resources that will allow them to connect, track and follow up on engaged UI/LU/NU to ensure appropriate health services and insurance options were provided and/or discussed.										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task Step 1. Train navigators as indicated in Milestones 5, 11, 13 and 14										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task Step 1. Plan training for navigators on care transition protocols										
Task Step 2. Follow care transition strategy as outlined in 2biv Milestone #2										
Milestone #17										

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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
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of EHRs.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.										
Task Step 4. Begin IT based population health reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task Step 1. Establish a Community Engagement Quality Advisory Committee.										
Task Step 2. PPS will establish relationships with CBOs by connecting to local/ regional coalitions and quality advisory groups.										
Task Step 3. Execute MSA with some PPS Participants and/or service contracts between PMO and CBOs as appropriate.										
Task Step 4. The Community Engagement Quality Advisory Committee will evaluate and provide oversight and ensure the engagement is sufficient and appropriate										

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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 #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task Step 1. Conduct trainings with Core PAM Team.										
Task Step 2. Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation. Develop mechanism to measure training effectiveness in relation to goals once strategy and plan implemented.										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task Step 1. Utilize CNA's baseline data as a starting point to ascertain "hot spot" areas where the UI, NU, and LU are most likely to go to for health care or social support services; emergency departments, community health centers, public hospitals, charitable clinics, teaching and community hospitals, and the Departments of Social Services, in the Hudson Valley region.										
Task Step 2. Collaborate with CBOs through the (Community Engagement Quality Advisory) Committee as per Milestone 1										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task Step 1. Conduct Focus groups / community engagement session with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 2. Participate in monthly community / regional network meetings that will allow us to identify the CBO in our hot spots and engage community members throughout the Hudson Valley.										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task Step 1. Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee										
Task Step 2. Finalize appropriate role-based training strategy for non-clinical and clinical segments of workforce based on the previous step, incorporating on-site and on-line based input from providers and CBOs.										
Task Step 3. Identify cultural competancy and health literacy champions within the local deployment groupos established as part of Clinical governance who are responsible for patient and provider emgagement.										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 1. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.										
Task Step 2. WMC PPS and MCOs plan for sharing reports to help reconnect benificiaries to designated PCPs including establishing data sharing agreements.										
Task Step 3. Review with respective MCOs and PCPs outreach materials.										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task Step 1. LU/NU Medicaid beneficiaries and the UI in the Hudson Valley region will be engaged and activated through the administration of PAM.										
Task Step 2. Identify by User IDs, baseline PAM activation level and score will be captured and tracked at the individual level. These PAM respondents will be followed-up at set intervals defined by the State by their providers.										
Task Step 3. Through data analysis, cohorts of LU/NU and UI, as well as subgroups based on PAM activation level and score will be assessed at each follow-up to determine progress and improvement trend, and to establish subsequent achievement goals.										
Milestone #8 Include beneficiaries in development team to promote preventive care.										

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Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task Step 1. The Community Engagement Quality Advisory Committee through the local deployment council will provide oversight to include beneficiaries in the development process.										
Task Step 2. Conduct Community engagement sessions with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to:										

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- Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 1. WMC PPS creates a plan for the development of platforms to share administrative, milestone, and project information with network partners with includes patients using PAM and their scores										
Task Step 2. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS (see Milestone #6)										
Task Step 3. As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of clinicians trained in PAM										
Task Step 4. As noted in IT Milestone 3 Step 8, "Create roadmap for data sharing and reporting using platform to support population health analytics including assessment of patient engagement."										
Task Step 5. Generate reports and submit to Department of Health										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task Step 1. Through PAM administration and its coaching functionality and capability, many providers in our network (FQHCs, MCOs) will be able to assess our beneficiaries' access to care information for non-emergent care.										
Task Step 2. WMC-PPS project teams will collaborate with these providers to create a referral network for our beneficiaries 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
access these primary care services.										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	275	275	275	275	275	275	275	275	275	275
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	275	275	275	275	275	275	275	275	275	275
Task Step 1. Contract with CBOs as described in Milestone 1										
Task Step 2. Develop preliminary training strategy (e.g., scale, timing, scope, methodologies, content and cultural competency considerations) as defined in Milestone 5 of the Workforce Strategy.										
Task Step 3. 3) Similar to Milestone 10, through PAM administration and its coaching functionality, this group of trained community navigators will be able to coach and connect patients to relevant preventive care services and educational resources.										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task Step 1. WMC PPS will follow WMC policy on Patient Complaints and Grievances, policy # RI-11A.										
Task Step 2. Along with WMC's 24/7 toll free help line which is available to patients and staff, WMC is well positioned to receive and respond to all recipients and project participants.										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	275	275	275	275	275	275	275	275	275	275

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Task Step 1. Core team will train community navigators who will be responsible for performing PAM.										
Task Step 2. As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of community navigators										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	275	275	275	275	275	275	275	275	275	275
Task Step 1. Identify hot spots as indicated in Milestone 3										
Task Step 2. Train navigators as indicated in Milestone 5, 11 and 13										
Task Step 3. Community navigators will utilize resources that will allow them to connect, track and follow up on engaged UI/LU/NU to ensure appropriate health services and insurance options were provided and/or discussed.										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task Step 1. Train navigators as indicated in Milestones 5, 11, 13 and 14										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task Step 1. Plan training for navigators on care transition protocols										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 2. Follow care transition strategy as outlined in 2biv Milestone #2										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of EHRs.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics.										
Task Step 4. Begin IT based population health reporting.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	
Survey the targeted population about healthcare needs in the PPS' region.	
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	
Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	
Include beneficiaries in development team to promote preventive care.	
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
• Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

#1- Dec. 2014 commitments were based on our then current understanding of definitions and specifications. Subsequent or future changes, e.g. for an activated patient, may substantially affect our ability to meet targets. We will mitigate this risk by respectfully raising concerns and issues relevant to our performance.

#2- To satisfy PPS speed and scale commitments providers must meet project requirements by a certain date. However, the appropriate role of any participant may vary by specialty, setting and provider type and we risk having based our commitments on a view of provider roles not fully aligned with the view of the IA. To mitigate this risk we describe our assumptions: Providers will assume leading, secondary or supporting roles as appropriate. Leading participants will satisfy all project requirements while participants in secondary or supporting roles will satisfy a role specific subset of requirements.

#3-This project includes tasks which could require modifications to EHRs by vendors who may be unable/unwilling to make changes, or the requested modifications could be prohibitively costly putting practices/clinics with a primary role in this project are at risk of failing timely milestone completion. To mitigate we will explore alternative solutions to linking documentation of screening and transfer to BH with the point of care electronic health record.

#4- Integration of medical and Behavioral Health records within an individual patient record could be interpreted to violate privacy standards posing a risk for the PPS/partners who must comply with regulations. To mitigate this risk we will collaborate with DOH/other PPS to demonstrate integration of records in a manner compliant with regulatory and other requirements.

#5- Primary care participants in this project include small independent practices wanting to co-locate BH services for their patients. Because current regulation limits licensed BH agencies in providing services in off-site location, and current contract arrangements with managed care plans may not support providing BH in a medical practice, co-location may not be financially viable. We will mitigate the risk by exploring regulatory waivers to allow licensed BH agencies to collaborate with private PC practices, and modification of managed care contracts to support BH-PC co-location. A related risk is the shortage of licensed BH professionals to be addressed under the workforce work stream.

#6- This project shares risks with other projects and work streams: A risk that practices will be overwhelmed by the volume of guidelines, policies and training related to DSRIP which will be mitigated by support from PMO staff and by setting reasonable and staged due dates for milestones. Project speed and scale commitments were made before contracts with partners were executed and before any integrated PPS infrastructure was in place. To mitigate the risk of falling short, we are developing a two stage process for collecting data on engaged patients taking into account prohibitions on collecting PHI prior to meeting requirements for IT security, patient consent and contractual agreements. A risk that relying solely on data from NYS through MAPP the PPS will not have information needed to meet the needs of every Medicaid patient served by PPS providers,

including those not "attributed" to the PPS. To mitigate this risk, we are exploring HIPAA compliant possibilities for collecting data on the broader population served by the partner organizations in our PPS. An associated risk is that our IT roadmap assumes maximization of the DOH-supplied MAPP portal and analytics, which will not support inclusion of a broader data set. Accordingly, our IT and IDS strategies include transitioning to PPS based project management, analytics, and care management platforms.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	31,000

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
11,522	11,522	230.44%	-6,522	37.17%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL3715_1_3_20160202163655_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3	02/02/2016 04:37 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	05/15/2015	03/31/2018	05/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	11/15/2015	03/31/2018	11/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	05/15/2015	03/31/2018	05/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.		Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Conduct current state analysis of BH services, if any, at PPS participating primary care sites & identifies co-location staffing needs.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH or APC model.		Project		In Progress	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics, as well as current PCMH or APC certification if any and EHR and MU capabilities.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task		Project		Not Started	05/18/2016	12/31/2017	05/18/2016	12/31/2017	12/31/2017	DY3 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 5. WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	05/18/2015	03/31/2017	05/18/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	05/18/2015	03/31/2017	05/18/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	05/18/2015	03/31/2017	05/18/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. In consultation with partner organizations and the Behavioral Health Project Quality Committee (BHPQC), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care.		Project		In Progress	09/16/2015	06/30/2016	09/16/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Convene the BHPQC to review and discuss the candidate best practices/protocols/guidelines/standards. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.		Project		In Progress	11/05/2015	09/30/2016	11/05/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3.Compare status of current practice among participating partners to identified best practices		Project		Not Started	02/10/2016	12/31/2016	02/10/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.		Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Gather lessons learned and feedback from Partners and local deployment workgroups; BHPQC,		Project		Not Started	11/30/2016	03/31/2017	11/30/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and/or Quality Steering Committee (QSC) and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 1	Project	N/A	In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		In Progress	05/01/2015	03/31/2018	05/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. Assess current practice among partners at participating primary care sites re BH screening, follow-up treatment (warm transfer) and documentation in the EHR.		Project		In Progress	05/15/2015	12/31/2016	05/15/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 2. Assess barriers to screening, to completing "warm transfer" for patients screening positive and to recording screening and transfer in EHR.		Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Convene the BHPQC to address the appropriate frequency of each recommended screening and appropriate inclusion criteria for patients to be screened. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range		Project		In Progress	10/13/2015	03/31/2017	10/13/2015	03/31/2017	03/31/2017	DY2 Q4

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DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
of credentials and experience relevant to the project.										
Task Step 4. The BHPCQ and/or the QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to appropriate care documented in EHR. Measures of success may be revised as appropriate.		Project		Not Started	05/18/2017	03/31/2018	05/18/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 6. Sites where BH care has been integrated will develop a plan for workflow, policies and proceedures to support screening, "warm transfer" to BH care, documentation of all in the EHR and regular calculation of performance rates to facilitate improvement.		Project		Not Started	05/18/2016	03/31/2018	05/18/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 7. Summarize lessons learned from early adoption sites, through discussions among partners in local deployment workgroups.		Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. Based on lessons learned and feedback from Partners and local deployment workgroups, The BHPQC and/or QSC or its workgroup will review lessons learned, feedback from partners and, in consultation with PMO staff, will adjust plan for on-going monitoring of screening and connection of patients to care.		Project		Not Started	11/30/2016	03/31/2018	11/30/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. Agree to collaborate with other PPSs toshare best practices, educationalmaterials, training strategies and strategies to overcome project implementation barriers.		Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	11/08/2015	03/31/2017	11/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Westchester Medical Center (PPS ID:21)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1. Implement interim reporting tool for DSRIP milestone reporting and performance taking into account all project compliant services for DY1.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers.		Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Create roadmap for data sharing and reporting using platform to support population health analytics.		Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4. At sites where BH care has been integrated, develop workflow to support electronic reporting of BH screenings and tracking of patients for milestone reporting; to support documentation within an individual patient record of connection with BH provider after a positive screening and transfer for appropriate BH services.		Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordinated evidence-based care protocols are in place,		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
including a medication management and care engagement process.										
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	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	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards,	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.		Project		On Hold	04/01/2015	03/31/2020	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	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	0	0	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 Step 1. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.										
Task Step 2. Conduct current state analysis of BH services, if any, at PPS participating primary care sites & identifies co-location staffing needs.										
Task Step 3. WMC PPS establishes local deployment councils to										

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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
serve as local PPS contacts for network partners engaging in PCMH or APC model.										
Task Step 4. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics, as well as current PCMH or APC certification if any and EHR and MU capabilities.										
Task Step 5. WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and 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 Step 1. In consultation with partner organizations and the Behavioral Health Project Quality Committee (BHPQC), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care.										
Task Step 2. Convene the BHPQC to review and discuss the candidate best practices/protocols/guidelines/standards. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3.Compare status of current practice among participating partners to identified best practices										
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.										
Task Step 5. Gather lessons learned and feedback from Partners and local deployment workgroups; BHPQC, and/or Quality Steering Committee (QSC) and/or its workgroups will review and adjust										

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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
training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
Task Step 1. Assess current practice among partners at participating primary care sites re BH screening, follow-up treatment (warm transfer) and documentation in the EHR.										
Task Step 2. Assess barriers to screening, to completing "warm transfer" for patients screening positive and to recording screening and transfer in EHR.										
Task Step 3. Convene the BHPQC to address the appropriate frequency of each recommended screening and appropriate inclusion criteria for patients to be screened. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 4. The BHPCQ and/or the QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to appropriate care documented in EHR. Measures of success may be revised as appropriate.										
Task Step 6. Sites where BH care has been integrated will develop a plan for workflow, policies and proceedures to support screening, "warm transfer" to BH care, documentation of all in the EHR 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
regular calculation of performance rates to facilitate improvement.										
Task Step 7. Summarize lessons learned from early adoption sites, through discussions among partners in local deployment workgroups.										
Task Step 8. Based on lessons learned and feedback from Partners and local deployment workgroups, The BHPQC and/or QSC or its workgroup will review lessons learned, feedback from partners and, in consultation with PMO staff, will adjust plan for on-going monitoring of screening and connection of patients to care.										
Task Step 5. Agree to collaborate with other PPSs toshare best practices, educationalmaterials, training strategies and strategies to overcome project implementation barriers.										
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 Step 1. Implement interim reporting tool for DSRIP milestone reporting and performance taking into account all project compliant services for DY1.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers.										
Task Step 3. Create roadmap for data sharing and reporting using platform to support population health analytics.										
Task Step 4. At sites where BH care has been integrated, develop workflow to support electronic reporting of BH screenings and tracking of patients for milestone reporting; to support documentation within an individual patient record of connection with BH provider after a positive screening and transfer for appropriate BH services.										
Milestone #5 Co-locate primary care services at behavioral health sites.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS has 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
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.										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
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.										

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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.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	100	100	100	100	100	100	100	100	100
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	115	115	115	115	115	115	115	115	115
Task Step 1. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.										
Task Step 2. Conduct current state analysis of BH services, if any, at PPS participating primary care sites & identifies co-location staffing needs.										
Task Step 3. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH or APC model.										
Task Step 4. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics, as well as current										

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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
PCMH or APC certification if any and EHR and MU capabilities.										
Task Step 5. WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and 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 Step 1. In consultation with partner organizations and the Behavioral Health Project Quality Committee (BHPQC), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care.										
Task Step 2. Convene the BHPQC to review and discuss the candidate best practices/protocols/guidelines/standards. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3.Compare status of current practice among participating partners to identified best practices										
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.										
Task Step 5. Gather lessons learned and feedback from Partners and local deployment workgroups; BHPQC, and/or Quality Steering Committee (QSC) and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT)										

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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 Step 1. Assess current practice among partners at participating primary care sites re BH screening, follow-up treatment (warm transfer) and documentation in the EHR.										
Task Step 2. Assess barriers to screening, to completing "warm transfer" for patients screening positive and to recording screening and transfer in EHR.										
Task Step 3. Convene the BHPQC to address the appropriate frequency of each recommended screening and appropriate inclusion criteria for patients to be screened. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 4. The BHPCQ and/or the QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to appropriate care documented in EHR. Measures of success may be revised as appropriate.										
Task Step 6. Sites where BH care has been integrated will develop a plan for workflow, policies and proceedures to support screening, "warm transfer" to BH care, documentation of all in the EHR and regular calculation of performance rates to facilitate improvement.										
Task Step 7. Summarize lessons learned from early adoption sites,										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
through discussions among partners in local deployment workgroups.										
Task Step 8. Based on lessons learned and feedback from Partners and local deployment workgroups, The BHPQC and/or QSC or its workgroup will review lessons learned, feedback from partners and, in consultation with PMO staff, will adjust plan for on-going monitoring of screening and connection of patients to care.										
Task Step 5. Agree to collaborate with other PPSs toshare best practices, educationalmaterials, training strategies and strategies to overcome project implementation barriers.										
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 Step 1. Implement interim reporting tool for DSRIP milestone reporting and performance taking into account all project compliant services for DY1.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers.										
Task Step 3. Create roadmap for data sharing and reporting using platform to support population health analytics.										
Task Step 4. At sites where BH care has been integrated, develop workflow to support electronic reporting of BH screenings and tracking of patients for milestone reporting; to support documentation within an individual patient record of connection with BH provider after a positive screening and transfer for appropriate BH services.										
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

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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
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.										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
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.										

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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 #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.a.ii – Behavioral health community crisis stabilization services

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

Instructions :

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

1. Crisis stabilization services are expensive and reimbursement will be challenging. Without funding, our PPS will be unable to meet Milestones 1, 3, 5, 6 and 7. A potential mitigation plan is to explore options for financial sustainability through HARPs and/or HCBS. Our PPS will work with Medicaid MCOs to establish agreements that cover these services and ensure their viability. Additionally, current NYS DOH requirements do not allow Article 28 hospitals to operate and be reimbursed by Medicaid for BH health observation beds. WMC may request waivers to address this issue.

2. Coordination with other PPSs in our region will be critical to ensure patients in need of BH crisis services have a seamless experience and can access services regardless of their location or provider. This project will enable all three PPSs in our region to achieve efficiencies through the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group.

3. Of the Hudson Valley counties, many have only one Article 28 hospital with an OMH licensed inpatient psychiatric unit. In some of the counties, the hospital is owned by and affiliated with another PPS and did not sign an attestation form with WMC. This will make meeting the metrics difficult since our project implementation speed is at the county level.

4. In one case, government funding of the only countywide mobile crisis team is not affiliated with a WMC hospital, not allowing WMC to apply this publically funded service to its network. This is not the intent of government funding for a county service.

5. Capturing and tracking patients and their services allow WMC PPS to accurately report the required project metrics will be challenging as most BH crisis providers are not reimbursed through Medicaid and many BH and community PPS Participants do not have EHRs. We will work with the other PPSs to develop a region-wide encounter system to capture patient services attributed to this project. The PPS will work with participating providers to ensure they are actively using EHRs and are connected to the RHIO to support secure messaging/notifications by DY 3.

6. Changing behavior is both a challenge and a key to success. Our PPS will implement outreach to encourage people with BH disorders, community service providers and family members to seek project services to prevent potential crises, resulting in ER or hospitalization versus community based services.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	3,150

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
269	269	53.80%	231	8.54%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (500)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL3815_1_3_20160202163814_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3	02/02/2016 04:38 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Review partners and county crisis intervention programs to establish a baseline of existing services--including hot spots.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. Establish the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group with Montefiore Hudson Valley Collaborative and Refuah Community Health Collaborative to collaborate on development of coordinated crisis intervention services and programming in the Hudson Valley Region.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 3. Convene HRD Behavioral Health Crisis Leadership Group	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Work with counties to determine if gaps exist.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Analyze the existing services funding to determine opportunities for leverage and development of new models.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Plan for implementation of services.	Project		Not Started	04/01/2017	03/31/2019	04/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 7. Monitor completeness of implementation plan.	Project		Not Started	01/01/2019	03/31/2019	01/01/2019	03/31/2019	03/31/2019	DY4 Q4
Task Step 4a: Once gaps are identified, continue work with the counties and providers to identify opportunities and strategies for filling service gaps. From there, the PPS, counties, and	Project		Not Started	04/01/2016	03/31/2019	04/01/2016	03/31/2019	03/31/2019	DY4 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
providers will develop a road map for implementation. Road map will identify potential funding sources (from all payers including government grants) to initiate service expansions and sustainability in collaboration with the other PPSs.									
Task Step 6a: Apply road map to improve services implementation.	Project		Not Started	04/01/2018	03/31/2019	04/01/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 7a: Monitor road map/ implementation plan by county to determine if gaps in services and geographic areas are being addressed.	Project		Not Started	01/01/2019	03/31/2019	01/01/2019	03/31/2019	03/31/2019	DY4 Q4
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	Project	N/A	In Progress	11/05/2015	03/31/2019	11/05/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).	Project		In Progress	11/05/2015	03/31/2019	11/05/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. In consultation with partner organizations and the Behavioral Health Crisis Project Advisory Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate best practices addressing diversion management processes.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2. Convene the Project Advisory Committee to review and discuss best practices for diversion management processes.	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3.PPS works with counties, health homes, and hospitals to review best practices for diversion management processes.	Project		Not Started	04/01/2017	12/31/2017	04/01/2017	12/31/2017	12/31/2017	DY3 Q3
Task Step 4. Compare status of current diversion practice among participating partners to identified best practices.	Project		Not Started	01/01/2018	06/30/2018	01/01/2018	06/30/2018	06/30/2018	DY4 Q1
Task Step 5: Plan phased rollout of diversion management processes.	Project		Not Started	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 6. Provide training resources for key personnel and finalize protocols.	Project		Not Started	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 7. Document diversion management protocols.	Project		Not Started	01/01/2019	03/31/2019	01/01/2019	03/31/2019	03/31/2019	DY4 Q4
Task Step 8. Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	Project		Not Started	01/01/2019	03/31/2019	01/01/2019	03/31/2019	03/31/2019	DY4 Q4
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.	Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. WMC PPS identifies and meets with MCOs doing business in our service area and at other times as needed to consider which services may be covered	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 2. WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. Begin dialogue with MCO regarding value-based payment models as indicated in 2ai Milestone 8.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Review options for coverage through the HARPs and HCBS for Medicaid recipients.	Project		Not Started	04/01/2017	03/31/2019	04/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated treatment care protocols are in place.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. In consultation with partner organizations and the	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Behavioral Health Crisis Project Advisory Quality Committee (a workgroup of WMC PPS), identify appropriate evidence based literature and best practices addressing coordinated treatment protocols.									
Task Step 2. Convene BHCAQC to review and discuss the best practice options for implementation.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Compare the status of current practices among participating partners to identify the best practices	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Plan phased rollout of best practices adapted to local considerations.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5. Provide training resources for key personnel and finalize protocols.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. Document treatment practices.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Hospital	Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Use results from the CNA and a mapping of providers to evaluate access to specialty services and crisis oriented services	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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and identify gaps in service coverage									
Task Step 2. PPS will work to identify a hospital with the capacity and ability to expand access to specialty psychiatric and crisis-oriented services.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. PPS will draft an action plan that may be used to improve access to psychiatric crisis and crisis-oriented services.	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.	Project		Not Started	01/01/2019	03/31/2019	01/01/2019	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Hospital	Not Started	10/01/2016	03/31/2019	10/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Clinic	Not Started	10/01/2016	03/31/2019	10/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Mental Health	Not Started	10/01/2016	03/31/2019	10/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. With the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group, use results from CNA to evaluate access and identify gaps in service coverage.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Use results from CNA and a mapping of providers to evaluate access and identify gaps in service coverage.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 3. PPS will work to identify a hospital outpatient or off	Project		Not Started	04/01/2018	03/31/2019	04/01/2018	03/31/2019	03/31/2019	DY4 Q4

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campus crisis residence that could provide an opportunity to provide access.									
Task Step 4. WMC PPS will consult with the Hudson Region DSRIP (HRD) Leadership Group and draft an action plan that may be used to improve access to services.	Project		Not Started	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	Project	N/A	In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.	Project		In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.	Project		Not Started	10/01/2018	03/31/2019	10/01/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. In consultation with the Behavioral Health Crisis & Primary Care Integration Project Quality Advisory Committee (a workgroup of the WMC PPS Quality Committee), review appropriate evidence-based literature and best practices (including current crisis teams) for mobile crisis.	Project		In Progress	07/01/2015	12/31/2018	07/01/2015	12/31/2018	12/31/2018	DY4 Q3
Task Step 2. Convene the BHCAQC to review and discuss best practices and procedures including current team practices and procedures.	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. Work with counties, the Hudson Region DSRIP (HRD) Leadership Group and providers to review practices and procedures.	Project		In Progress	09/01/2015	09/30/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 4: Plan phased roll out of best practices and procedures adapted to local considerations.	Project		Not Started	10/02/2017	03/31/2018	10/02/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. Provide training resources for key personnel and finalize best practices and procedures.	Project		Not Started	04/02/2018	09/28/2018	04/02/2018	09/28/2018	09/30/2018	DY4 Q2
Task Step 6. Document evidence based protocols.	Project		Not Started	04/02/2018	06/30/2018	04/02/2018	06/30/2018	06/30/2018	DY4 Q1
Task	Project		Not Started	07/02/2018	03/31/2019	07/02/2018	03/31/2019	03/31/2019	DY4 Q4

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Step 7. Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.									
Milestone #8 Ensure that all PPS safety net providers have actively connected 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 Demonstration Year (DY) 3.	Project	N/A	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.	Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.	Project		In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.	Project		In Progress	08/08/2015	06/30/2016	08/08/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. PPS reviews and finalizes action plan.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Identify pilot partner/early adopter sites for QE	Project		Completed	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3

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connection.									
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.	Project		In Progress	08/18/2015	12/31/2016	08/18/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Evaluate lessons learned from initial connections.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7. Plan phased implementation for network rollout.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Implement Phase 1 of network rollout.	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Implement Phase 2 of network rollout.	Project		Not Started	03/31/2017	03/31/2018	03/31/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.	Project		Not Started	06/30/2016	03/31/2018	06/30/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.	Project		Not Started	01/01/2019	03/31/2019	01/01/2019	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. Work with communities to identify existing triage services within their jurisdiction.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2. Identify gaps in existing triage services.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Identify opportunities and partnerships to expand or better coordinate triage services.	Project		Not Started	01/01/2017	12/31/2017	01/01/2017	12/31/2017	12/31/2017	DY3 Q3
Task Step 4. Work with partners to establish agreements for triage services.	Project		Not Started	01/01/2018	03/31/2019	01/01/2018	03/31/2019	03/31/2019	DY4 Q4
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has created an active quality subcommittee that reports to	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.									
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Establish Behavioral Health (Crisis) and Primary Care (Integration) Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), to identify appropriate evidence based measures addressing the quality of relevant crisis intervention approaches.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Convene the Project Advisory Committee to review and discuss quality of service interventions. The committee includes clinical leaders and representatives from county mental health departments, hospitals and behavioral health partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Create roadmap for data sharing and reporting of best practices and protocols specific to the milestones above.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Task Step 4. Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	Project		In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. WMC PPS creates roadmap for data sharing and reporting.	Project		In Progress	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.										
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.										
Task Step 1. Review partners and county crisis intervention programs to establish a baseline of existing services--including hot spots.										
Task Step 2. Establish the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group with Montefiore Hudson Valley Collaborative and Refuah Community Health Collaborative to collaborate on development of coordinated crisis intervention services and programming in the Hudson Valley Region.										
Task Step 3. Convene HRD Behavioral Health Crisis Leadership Group										
Task Step 4. Work with counties to determine if gaps exist.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 5. Analyze the existing services funding to determine opportunities for leverage and development of new models.										
Task Step 6. Plan for implementation of services.										
Task Step 7. Monitor completeness of implementation plan.										
Task Step 4a: Once gaps are identified, continue work with the counties and providers to identify opportunities and strategies for filling service gaps. From there, the PPS, counties, and providers will develop a road map for implementation. Road map will identify potential funding sources (from all payers including government grants) to initiate service expansions and sustainability in collaboration with the other PPSs.										
Task Step 6a: Apply road map to improve services implementation.										
Task Step 7a: Monitor road map/ implementation plan by county to determine if gaps in services and geographic areas are being addressed.										
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.										
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).										
Task Step 1. In consultation with partner organizations and the Behavioral Health Crisis Project Advisory Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate best practices addressing diversion management processes.										
Task Step 2. Convene the Project Advisory Committee to review and discuss best practices for diversion management processes.										
Task Step 3.PPS works with counties, health homes, and hospitals to review best practices for diversion management processes.										
Task Step 4. Compare status of current diversion practice among participating partners to identified best practices.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 5: Plan phased rollout of diversion management processes.										
Task Step 6. Provide training resources for key personnel and finalize protocols.										
Task Step 7. Document diversion management protocols.										
Task Step 8. Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.										
Task Step 1. WMC PPS identifies and meets with MCOs doing business in our service area and at other times as needed to consider which services may be covered										
Task Step 2. WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.										
Task Step 3. Begin dialogue with MCO regarding value-based payment models as indicated in 2ai Milestone 8.										
Task Step 4. Review options for coverage through the HARPs and HCBS for Medicaid recipients.										
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.										
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.										
Task Coordinated treatment care protocols are in place.										
Task Step 1. In consultation with partner organizations and 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
Behavioral Health Crisis Project Advisory Quality Committee (a workgroup of WMC PPS), identify appropriate evidence based literature and best practices addressing coordinated treatment protocols.										
Task Step 2. Convene BHCAQC to review and discuss the best practice options for implementation.										
Task Step 3. Compare the status of current practices among participating partners to identify the best practices										
Task Step 4: Plan phased rollout of best practices adapted to local considerations.										
Task Step 5. Provide training resources for key personnel and finalize protocols.										
Task Step 6. Document treatment practices.										
Task Step 7. Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.										
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network										
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	0	0	0	0	0
Task Step 1. Use results from the CNA and a mapping of providers to evaluate access to specialty services and crisis oriented services and identify gaps in service coverage										
Task Step 2. PPS will work to identify a hospital with the capacity and ability to expand access to specialty psychiatric and crisis-oriented services.										

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Task Step 3. PPS will draft an action plan that may be used to improve access to psychiatric crisis and crisis-oriented services.										
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).										
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.										
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	0	0	0	0	0
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	0	0	0	0	0
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	0	0	0	0	0	0
Task Step 1. With the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group, use results from CNA to evaluate access and identify gaps in service coverage.										
Task Step 2. Use results from CNA and a mapping of providers to evaluate access and identify gaps in service coverage.										
Task Step 3. PPS will work to identify a hospital outpatient or off campus crisis residence that could provide an opportunity to provide access.										
Task Step 4. WMC PPS will consult with the Hudson Region DSRIP (HRD) Leadership Group and draft an action plan that may be used to improve access to services.										
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.										

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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 includes mobile crisis teams to help meet crisis stabilization needs of the community.										
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.										
Task Step 1. In consultation with the Behavioral Health Crisis & Primary Care Integration Project Quality Advisory Committee (a workgroup of the WMC PPS Quality Committee), review appropriate evidence-based literature and best practices (including current crisis teams) for mobile crisis.										
Task Step 2. Convene the BHCAQC to review and discuss best practices and procedures including current team practices and procedures.										
Task Step 3. Work with counties, the Hudson Region DSRIP (HRD) Leadership Group and providers to review practices and procedures.										
Task Step 4: Plan phased roll out of best practices and procedures adapted to local considerations.										
Task Step 5. Provide training resources for key personnel and finalize best practices and procedures.										
Task Step 6. Document evidence based protocols.										
Task Step 7. Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.										
Milestone #8 Ensure that all PPS safety net providers have actively connected 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 Demonstration Year (DY) 3.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	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
requirements.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Identify pilot partner/early adopter sites for QE connection.										
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.										
Task Step 6. Evaluate lessons learned from initial connections.										
Task Step 7. Plan phased implementation for network rollout.										
Task Step 8. Implement Phase 1 of network rollout.										
Task Step 9. Implement Phase 2 of network rollout.										
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.										
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.										
Task Step 1. Work with communities to identify existing triage services within their jurisdiction.										
Task Step 2. Identify gaps in existing triage services.										
Task Step 3. Identify opportunities and partnerships to expand or better coordinate triage services.										
Task Step 4. Work with partners to establish agreements for triage services.										
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.										
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.										
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.										
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.										
Task Step 1. Establish Behavioral Health (Crisis) and Primary Care (Integration) Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), to identify appropriate										

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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
evidence based measures addressing the quality of relevant crisis intervention approaches.										
Task Step 2. Convene the Project Advisory Committee to review and discuss quality of service interventions. The committee includes clinical leaders and representatives from county mental health departments, hospitals and behavioral health partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3. Create roadmap for data sharing and reporting of best practices and protocols specific to the milestones above.										
Task Step 4. Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.										
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. WMC PPS creates roadmap for data sharing and reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.										
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.										
Task Step 1. Review partners and county crisis intervention programs to establish a baseline of existing services--including hot spots.										
Task Step 2. Establish the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group with Montefiore Hudson Valley										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Collaborative and Refuah Community Health Collaborative to collaborate on development of coordinated crisis intervention services and programming in the Hudson Valley Region.										
Task Step 3. Convene HRD Behavioral Health Crisis Leadership Group										
Task Step 4. Work with counties to determine if gaps exist.										
Task Step 5. Analyze the existing services funding to determine opportunities for leverage and development of new models.										
Task Step 6. Plan for implementation of services.										
Task Step 7. Monitor completeness of implementation plan.										
Task Step 4a: Once gaps are identified, continue work with the counties and providers to identify opportunities and strategies for filling service gaps. From there, the PPS, counties, and providers will develop a road map for implementation. Road map will identify potential funding sources (from all payers including government grants) to initiate service expansions and sustainability in collaboration with the other PPSs.										
Task Step 6a: Apply road map to improve services implementation.										
Task Step 7a: Monitor road map/ implementation plan by county to determine if gaps in services and geographic areas are being addressed.										
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.										
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).										
Task Step 1. In consultation with partner organizations and the Behavioral Health Crisis Project Advisory Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate best practices addressing diversion management processes.										
Task Step 2. Convene the Project Advisory Committee to review 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
discuss best practices for diversion management processes.										
Task Step 3.PPS works with counties, health homes, and hospitals to review best practices for diversion management processes.										
Task Step 4. Compare status of current diversion practice among participating partners to identified best practices.										
Task Step 5: Plan phased rollout of diversion management processes.										
Task Step 6. Provide training resources for key personnel and finalize protocols.										
Task Step 7. Document diversion management protocols.										
Task Step 8. Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.										
Task Step 1. WMC PPS identifies and meets with MCOs doing business in our service area and at other times as needed to consider which services may be covered										
Task Step 2. WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.										
Task Step 3. Begin dialogue with MCO regarding value-based payment models as indicated in 2ai Milestone 8.										
Task Step 4. Review options for coverage through the HARPs and HCBS for Medicaid recipients.										
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.										
Task Coordinated treatment care protocols are in place.										
Task Step 1. In consultation with partner organizations and the Behavioral Health Crisis Project Advisory Quality Committee (a workgroup of WMC PPS), identify appropriate evidence based literature and best practices addressing coordinated treatment protocols.										
Task Step 2. Convene BHCAQC to review and discuss the best practice options for implementation.										
Task Step 3. Compare the status of current practices among participating partners to identify the best practices										
Task Step 4: Plan phased rollout of best practices adapted to local considerations.										
Task Step 5. Provide training resources for key personnel and finalize protocols.										
Task Step 6. Document treatment practices.										
Task Step 7. Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.										
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network										
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	13	13	13	13	13	13	13	13	13
Task Step 1. Use results from the CNA and a mapping of providers 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
evaluate access to specialty services and crisis oriented services and identify gaps in service coverage										
Task Step 2. PPS will work to identify a hospital with the capacity and ability to expand access to specialty psychiatric and crisis-oriented services.										
Task Step 3. PPS will draft an action plan that may be used to improve access to psychiatric crisis and crisis-oriented services.										
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).										
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.										
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	13	13	13	13	13	13	13	13	13
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	40	40	40	40	40	40	40	40	40
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	60	60	60	60	60	60	60	60	60
Task Step 1. With the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group, use results from CNA to evaluate access and identify gaps in service coverage.										
Task Step 2. Use results from CNA and a mapping of providers to evaluate access and identify gaps in service coverage.										
Task Step 3. PPS will work to identify a hospital outpatient or off campus crisis residence that could provide an opportunity to provide access.										
Task Step 4. WMC PPS will consult with the Hudson Region DSRIP (HRD) Leadership Group and draft an action plan that may be										

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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
used to improve access to services.										
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.										
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.										
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.										
Task Step 1. In consultation with the Behavioral Health Crisis & Primary Care Integration Project Quality Advisory Committee (a workgroup of the WMC PPS Quality Committee), review appropriate evidence-based literature and best practices (including current crisis teams) for mobile crisis.										
Task Step 2. Convene the BHCAQC to review and discuss best practices and procedures including current team practices and procedures.										
Task Step 3. Work with counties, the Hudson Region DSRIP (HRD) Leadership Group and providers to review practices and procedures.										
Task Step 4: Plan phased roll out of best practices and procedures adapted to local considerations.										
Task Step 5. Provide training resources for key personnel and finalize best practices and procedures.										
Task Step 6. Document evidence based protocols.										
Task Step 7. Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.										
Milestone #8 Ensure that all PPS safety net providers have actively connected 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 Demonstration										

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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
Year (DY) 3.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	272	272	272	272	272	272	272	272	272
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	100	100	100	100	100	100	100	100	100
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	13	13	13	13	13	13	13	13	13
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	60	60	60	60	60	60	60	60	60
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.										
Task Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.										
Task Step 3. PPS reviews and finalizes action plan.										
Task Step 4. Identify pilot partner/early adopter sites for QE connection.										
Task Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.										
Task Step 6. Evaluate lessons learned from initial connections.										
Task Step 7. Plan phased implementation for network rollout.										
Task Step 8. Implement Phase 1 of network rollout.										
Task Step 9. Implement Phase 2 of network rollout.										
Task Step 10. As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
support and training to network partners activate functionality.										
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.										
Task Step 1. Work with communities to identify existing triage services within their jurisdiction.										
Task Step 2. Identify gaps in existing triage services.										
Task Step 3. Identify opportunities and partnerships to expand or better coordinate triage services.										
Task Step 4. Work with partners to establish agreements for triage services.										
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.										
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.										
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.										
Task Step 1. Establish Behavioral Health (Crisis) and Primary Care (Integration) Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), to identify appropriate evidence based measures addressing the quality of relevant crisis intervention approaches.										
Task Step 2. Convene the Project Advisory Committee to review and discuss quality of service interventions. The committee includes clinical leaders and representatives from county mental health departments, hospitals and behavioral health partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3. Create roadmap for data sharing and reporting of best practices and protocols specific to the milestones above.										
Task Step 4. Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.										
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.										
Task Step 2. WMC PPS creates roadmap for data sharing and reporting.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	
Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	
Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	
Develop written treatment protocols with consensus from participating providers and facilities.	
Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	
Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	
Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	
Ensure that all PPS safety net providers have actively connected 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 Demonstration Year (DY) 3.	
Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

#1- Dec. 2014 commitments were based on our understanding of definitions and specifications. Subsequent or future changes, e.g. for an activated patient, may substantially affect our ability to meet targets. We will mitigate this risk by respectfully raising concerns and issues. Other projects define an activated patient with services received in the current year and we continue to assume the same will apply for 3ci.

#2- To satisfy PPS speed and scale commitments providers must meet requirements by a certain date. We are at risk for interpreting that the appropriate role of a participant varies by specialty, setting and provider type and basing our commitments on those roles. To mitigate this risk we describe our assumptions: Providers will assume leading, secondary or supporting roles as appropriate; leading participants will satisfy all project requirements while those in secondary or supporting roles will satisfy only role-applicable milestones. This project requires PCMH/APCM recognition for PCPs whose number was based on NYS criteria which included some not eligible for PCMH/APCM, e.g. Hospitalists. To mitigate the risk of falling short, we will encourage other PCPs to join and will work with NYS on requirements for those not eligible for PCMH.

#3-To meet the requirement for Health Information Exchange (HIE) we plan to connect providers to the SHIN_NY through our Qualified Entity (QE). There is significant risk the QE may not be able to support this requirement or providers may not be able to meet the aggressive time frame. To mitigate risk we will work closely with our QE, and give providers who play a primary role on this project high priority for HIE.

#4-This project requires agreements with MCO's related to coordination of services. Because MCOs already have contracts with NYS, providers and their members, MCO's may have no reason for an agreement with the PPS. To mitigate this risk, our PPS will work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussions with NY MCOs around DSRIP related issues including common ground for improving diabetes care coordination.

#5-THE WMC PPS primary care Network includes pediatricians. Although increasing, the prevalence of diabetes among children is lower than among adults and treatment guidelines are different. We risk insufficient PCP involvement if Pediatric practices see the requirements as geared toward adults. To mitigate this risk the PPS will monitor the issue and if needed modify the program appropriately.

#6- This project shares risks with others: Practices may be overwhelmed by the volume of guidelines, policies and training related to DSRIP, a risk to be mitigated by support from PMO staff and by setting reasonable and staged dates for milestones. Project speed and scale commitments made before executed contracts with partners and PPS infrastructure was in place may be at risk. To mitigate we are developing a two stage process for collecting data on engaged patients taking into account requirements for IT security, patient consent and contractual agreements. Relying solely on data from NYS through MAPP the PPS would not have information needed to meet the needs of Medicaid patients served by PPS providers but not "attributed" to the PPS. To mitigate this risk, we are exploring HIPAA compliant possibilities for collecting data on the broader population served by our partner organizations. An associated risk is that our IT roadmap assumes maximization of the DOH-supplied

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MAPP portal and analytics, which will not support inclusion of a broader data set. Accordingly, our IT and IDS strategies include transitioning to PPS based project management, analytics, and care management platforms.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	8,039

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
7,151	7,151	572.08%	-5,901	88.95%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL4415_1_3_20160202164000_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3	02/02/2016 04:40 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Project	N/A	In Progress	09/09/2015	03/31/2017	09/09/2015	03/31/2017	03/31/2017	DY2 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	09/09/2015	03/31/2017	09/09/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. In consultation with partner organizations and the Diabetes Project Advisory Quality Committee (DPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing management of diabetes in community and ambulatory settings.	Project		In Progress	09/09/2015	02/18/2016	09/09/2015	02/18/2016	03/31/2016	DY1 Q4
Task Step 2. Convene the DPAQC to review and discuss the candidate best ractices/protocols/guidelines/standards. The DPAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3. Compare status of current practice among partners to identified best practices.	Project		Not Started	02/10/2016	06/30/2016	02/10/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.	Project		Not Started	05/10/2016	09/30/2016	05/10/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Gathering lessons learned and feedback from Partners	Project		Not Started	11/10/2016	03/31/2017	11/10/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and local deployment workgroups, DPAQC and/or Quality Steering Committee and/or its workgroups will review and adjust best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.									
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	Not Started	02/10/2016	03/31/2017	02/10/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	Not Started	02/10/2016	03/31/2017	02/10/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Compare status of current practice among partners to identified best practices.	Project		Not Started	02/10/2016	06/30/2016	02/10/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations	Project		Not Started	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. Monitor number of primary care providers participating or not participating, by specialty of PCP.	Project		Not Started	11/15/2016	03/31/2017	11/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. If necessary, modify the program to be able to engage Pediatric practices.	Project		Not Started	11/16/2016	03/31/2017	11/16/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Project	N/A	In Progress	11/18/2015	03/31/2017	11/18/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		Not Started	05/10/2016	03/31/2017	05/10/2016	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	11/18/2015	03/31/2017	11/18/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are established and implemented.	Project		Not Started	05/10/2016	03/31/2017	05/10/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. Identify by provider type and project role the clinical	Project		Not Started	05/10/2016	09/30/2016	05/10/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
information to be shared among providers.									
Task Step 2. Create roadmap for data sharing and reporting using platform to support population health analytics.	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Gathering lessons learned and feedback from Partners and local deployment workgroups; DPAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	Project		Not Started	11/16/2016	03/31/2017	11/16/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners, as well as pharmacists, dieticians or diabetes educators and community health workers in the community.	Project		In Progress	11/18/2015	03/31/2016	11/18/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Convene DPAQC with network partners and stakeholders broadly to discuss the roles and responsibilities of all care team members and protocols for referring patients to ensure care coordination.	Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6. In consultation with PMO and DPAQC develop staffing, training and implementation plan including roles of PCPs and other team members for care coordination.	Project		Not Started	11/16/2016	03/31/2017	11/16/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	Project	N/A	In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	10/12/2015	03/31/2017	10/12/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	11/05/2015	03/31/2017	11/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1. Identify participating partners providing the Stanford Model Diabetes Self-Management Program.	Project		In Progress	10/12/2015	03/31/2016	10/12/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3. In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners.	Project		In Progress	11/18/2015	03/31/2016	11/18/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. Convene DPAQC with network partners and stakeholders to discuss the roles and responsibilities of PCP and HH and protocols for referring patients to ensure coordination.	Project		Not Started	05/18/2016	12/31/2016	05/18/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5. Meet with Stanford Disease Self Management programs to identify ways to support, promote and expand model in the Hudson Valley.	Project		Not Started	05/18/2016	12/31/2016	05/18/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6. Prioritize locations to conduct diabetes self-management programs based on diabetes hot spotting evidence from step 2 above.	Project		Not Started	08/17/2016	12/31/2016	08/17/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 7. Develop education materials for PCPs and Health Home providers regarding local standard disease self-management programs available for their clients.	Project		Not Started	06/17/2016	09/30/2016	06/17/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Provide ongoing support to partners implementing or referring patients to the Stanford Diabetes Self-Management programs.	Project		Not Started	08/17/2016	03/31/2017	08/17/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Project	N/A	In Progress	07/15/2015	03/31/2017	07/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation	Project		Not Started	01/10/2017	03/31/2017	01/10/2017	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.									
Task Step 1. WMC PPS identifies Medicaid Managed Care Organizations (MCOs) doing business in our service area whose members may be patients of Partner providers.	Project		Completed	08/10/2015	09/30/2015	08/10/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.	Project		Completed	08/10/2015	09/30/2015	08/10/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for coordination of services.	Project		In Progress	07/15/2015	03/31/2017	07/15/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.	Project		Not Started	11/06/2016	03/31/2017	11/06/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Define functional reporting requirements for diabetes projects.	Project		In Progress	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Report and track actively engaged patients.	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #7	Project	N/A	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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).	Project		In Progress	11/15/2015	03/31/2018	11/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	08/08/2015	03/31/2018	08/08/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as current PCMH/APC certification if any and EHR and MU capabilities.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4

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

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 1. In consultation with partner organizations and the Diabetes Project Advisory Quality Committee (DPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing management of diabetes in community and ambulatory settings.										
Task Step 2. Convene the DPAQC to review and discuss the candidate best ractices/protocols/guidelines/standards. The DPAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3. Compare status of current practice among partners to identified best practices.										
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.										
Task Step 5. Gathering lessons learned and feedback from Partners and local deployment workgroups, DPAQC and/or Quality Steering Committee and/or its workgroups will review and adjust best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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	524	524	524
Task Step 1. Compare status of current practice among partners to identified best practices.										
Task Step 2. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations										
Task Step 3. Monitor number of primary care providers participating or not participating, by specialty of PCP.										
Task Step 4. If necessary, modify the program to be able to engage Pediatric practices.										
Milestone #3 Develop care coordination teams (including diabetes educators,										

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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
nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are established and implemented.										
Task Step 1. Identify by provider type and project role the clinical information to be shared among providers.										
Task Step 2. Create roadmap for data sharing and reporting using platform to support population health analytics.										
Task Step 3. Gathering lessons learned and feedback from Partners and local deployment workgroups; DPAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Task Step 4. In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners, as well as pharmacists, dieticians or diabetes educators and community health workers in the community.										
Task Step 5. Convene DPAQC with network partners and stakeholders broadly to discuss the roles and responsibilities of all care team members and protocols for referring patients to ensure care coordination.										
Task Step 6. In consultation with PMO and DPAQC develop staffing, training and implementation plan including roles of PCPs and other team members for care coordination.										
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										

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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
reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Step 1. Identify participating partners providing the Stanford Model Diabetes Self-Management Program.										
Task Step 2. Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.										
Task Step 3. In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners.										
Task Step 4. Convene DPAQC with network partners and stakeholders to discuss the roles and responsibilities of PCP and HH and protocols for referring patients to ensure coordination.										
Task Step 5. Meet with Stanford Disease Self Management programs to identify ways to support, promote and expand model in the Hudson Valley.										
Task Step 6. Prioritize locations to conduct diabetes self-management programs based on diabetes hot spotting evidence from step 2 above.										
Task Step 7. Develop education materials for PCPs and Health Home providers regarding local standard disease self-management programs available for their clients.										
Task Step 8. Provide ongoing support to partners implementing or referring patients to the Stanford Diabetes Self-Management programs.										
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1. WMC PPS identifies Medicaid Managed Care Organizations (MCOs) doing business in our service area whose members may be patients of Partner providers.										
Task Step 2. MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.										
Task Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for coordination of services.										
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.										
Task Step 2. Define functional reporting requirements for diabetes projects.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										
Task Step 4. Report and track actively engaged patients.										
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.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	524	524	524
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	203	203	203
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	225	225	225
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	53	53	53
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as current PCMH/APC certification if any and EHR and MU capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.										
Task Step 1. In consultation with partner organizations and the Diabetes Project Advisory Quality Committee (DPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing management of diabetes in community and ambulatory settings.										
Task Step 2. Convene the DPAQC to review and discuss the candidate best ractices/protocols/guidelines/standards. The										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
DPAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.										
Task Step 3. Compare status of current practice among partners to identified best practices.										
Task Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.										
Task Step 5. Gathering lessons learned and feedback from Partners and local deployment workgroups, DPAQC and/or Quality Steering Committee and/or its workgroups will review and adjust best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
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.	524	524	524	524	524	524	524	524	524	524
Task Step 1. Compare status of current practice among partners to identified best practices.										
Task Step 2. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations										
Task Step 3. Monitor number of primary care providers participating or not participating, by specialty of PCP.										
Task Step 4. If necessary, modify the program to be able to engage Pediatric practices.										
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										

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Home care managers where applicable.										
Task Care coordination processes are established and implemented.										
Task Step 1. Identify by provider type and project role the clinical information to be shared among providers.										
Task Step 2. Create roadmap for data sharing and reporting using platform to support population health analytics.										
Task Step 3. Gathering lessons learned and feedback from Partners and local deployment workgroups; DPAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Task Step 4. In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners, as well as pharmacists, dieticians or diabetes educators and community health workers in the community.										
Task Step 5. Convene DPAQC with network partners and stakeholders broadly to discuss the roles and responsibilities of all care team members and protocols for referring patients to ensure care coordination.										
Task Step 6. In consultation with PMO and DPAQC develop staffing, training and implementation plan including roles of PCPs and other team members for care coordination.										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 1. Identify participating partners providing the Stanford Model Diabetes Self-Management Program.										
Task Step 2. Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.										
Task Step 3. In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners.										
Task Step 4. Convene DPAQC with network partners and stakeholders to discuss the roles and responsibilities of PCP and HH and protocols for referring patients to ensure coordination.										
Task Step 5. Meet with Stanford Disease Self Management programs to identify ways to support, promote and expand model in the Hudson Valley.										
Task Step 6. Prioritize locations to conduct diabetes self-management programs based on diabetes hot spotting evidence from step 2 above.										
Task Step 7. Develop education materials for PCPs and Health Home providers regarding local standard disease self-management programs available for their clients.										
Task Step 8. Provide ongoing support to partners implementing or referring patients to the Stanford Diabetes Self-Management programs.										
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1. WMC PPS identifies Medicaid Managed Care Organizations (MCOs) doing business in our service area whose members may be patients of Partner providers.										

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Task Step 2. MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.										
Task Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for coordination of services.										
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.										
Task Step 2. Define functional reporting requirements for diabetes projects.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										
Task Step 4. Report and track actively engaged patients.										
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.	524	524	524	524	524	524	524	524	524	524
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	203	203	203	203	203	203	203	203	203	203

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Task EHR meets connectivity to RHIO/SHIN-NY requirements.	225	225	225	225	225	225	225	225	225	225
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	53	53	53	53	53	53	53	53	53	53
Task Step 1. WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as current PCMH/APC certification if any and EHR and MU capabilities.										
Task Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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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.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

#1- Dec. 2014 commitments were based on our understanding of definitions and specifications. Subsequent or future changes, e.g. for an activated patient, may substantially affect our ability to meet targets. We will mitigate this risk by respectfully raising concerns and issues.

#2- To satisfy PPS speed/scale commitments providers must meet requirements by a certain date. We are at risk for interpreting that the appropriate role of a participant varies by specialty, setting and provider type and for basing our commitments on those roles. To mitigate this risk we describe our assumptions: Providers will assume leading, secondary or supporting roles as appropriate; leading participants will satisfy all project requirements while those in secondary or supporting roles will satisfy only role-applicable milestones. The provider types selected by NYS for 3diii did not include hospitals and emergency rooms, yet better coordination with these entities is essential to better asthma management. To mitigate this risk we included these sites in the "all other" category.

#3- This project requires physicians share information through the QE. There is a risk the QE may not be able to support this requirement in the allotted timeframe. To mitigate this risk, we will work to ensure providers who play a primary role on this project are given high priority for QE connection.

#4- This project requires the implementation of telemedicine to improve asthma care for remotely located patients. There is risk the required study may find telemedicine is cost prohibitive or not suitable to circumstances. To mitigate the risk we will involve NYS DOH to discuss alternatives.

#5- One way to improve asthma care is to improve asthma education to patients. A shortage of certified asthma educators (AE-C's) and difficulty in receiving payment for asthma education present a risk for success. To mitigate this risk we will include the status of AE-C's in our workforce assessments and include addressing any identified shortages in our workforce plan.

#6- This project requires the PPS have written agreements with MCOs addressing asthma coverage. Because the Medicaid managed care benefit already covers asthma treatment in its entirety, MCOs may see no reason for such an agreement with the PPS. Furthermore, a PPS-MCO agreement about coverage could interfere with the MCO's existing contracts with NYS, its enrollees or its network providers. To mitigate this risk, our PPS will work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussions with NY MCOs around DSRIP related issues including asthma care.

#7- This project shares risks with others: Practices may be overwhelmed by the volume of guidelines, policies and training related to DSRIP, a risk to be mitigated by support from PMO staff and by setting reasonable and staged dates for milestones. Project speed and scale commitments made before executed contracts with partners and PPS infrastructure was in place may be at risk. To mitigate we are developing a two stage process for collecting data on engaged patients taking into account requirements for IT security, patient consent and contractual agreements.

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Relying solely on data from NYS through MAPP the PPS would not have information needed to meet the needs of Medicaid patients served by PPS providers but not "attributed" to the PPS. To mitigate this risk, we are exploring HIPAA compliant possibilities for collecting data on the broader population served by our partner organizations. An associated risk is that our IT roadmap assumes maximization of the DOH-supplied MAPP portal and analytics, which will not support inclusion of a broader data set. Accordingly, our IT and IDS strategies include transitioning to PPS based project management, analytics, and care management platforms.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	6,800

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
567	567	47.25%	633	8.34%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (1,200)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
violad	Other	21_PMDL4815_1_3_20160202164157_WMC_PPS_DSRIP_PHI_data_submission_template_-_Oct-Dec_2015.xlsx	Workbook reflecting reporting requirements for patient engagement for Q3	02/02/2016 04:42 PM

Narrative Text :

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

Our PPS is piloting our new reporting system for patient engagement as required per NYSDOH reporting guidelines that went into effect for reporting period Q3. This change required network partners to transmit DSRIP health data to the PPS within a secure, HIPAA-compliant environment and for the PPSs to assure that patients reported to us are not duplicated in other PPSs. This process was time consuming and not all providers were able to report in a timely manner. To assure that we are treating all providers fairly, we chose not to report this quarter until we are fully up and running with our new reporting system. We are pleased we began this process early and will be ready to report for Q4.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.	Project		In Progress	09/09/2015	03/31/2017	09/09/2015	03/31/2017	03/31/2017	DY2 Q4
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. In consultation with partner organizations and the Asthma Project Advisory Quality Committee (APAQC; a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care, practice standards and chronic disease management.	Project		In Progress	11/05/2015	02/14/2016	11/05/2015	02/14/2016	03/31/2016	DY1 Q4
Task Step 2. Convene the APAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The APAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project, particularly the Hudson Valley	Project		In Progress	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Asthma Coalition.									
Task Step 3. Compare status of current practice among participating partners to identified best practices.	Project		Not Started	02/10/2016	06/30/2016	02/10/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.	Project		Not Started	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5. Identify by provider type and project role the clinical information to be shared among providers.	Project		Not Started	05/18/2016	09/30/2016	05/18/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6. Create roadmap for data sharing and reporting using platform to support population health analytics.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 7. Gather lessons learned and feedback from Partners and local deployment workgroups; APAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	Project		Not Started	11/30/2016	03/31/2017	11/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8. At participating sites, identify barriers and develop plans to implement workflow to support electronic reporting and sharing of asthma action plans.	Project		Not Started	11/15/2016	03/31/2017	11/15/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Project	N/A	In Progress	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Agreements with asthma specialists and asthma educators are established.	Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	Not Started	02/10/2016	03/31/2017	02/10/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	Not Started	02/10/2016	03/31/2017	02/10/2016	03/31/2017	03/31/2017	DY2 Q4
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to:	Project		Not Started	02/10/2016	03/31/2017	02/10/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
- analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability									
Task Step 1. Identify AE-C's and Asthma specialists WMC PPS network.	Project		Not Started	02/10/2016	03/31/2016	02/10/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Establish agreements with asthma specialists and educators to adhere to national guidelines for asthma management	Project		Not Started	05/18/2016	03/31/2017	05/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. Research the potential impact of telemedicine on Asthma care in underserved areas.	Project		Not Started	05/18/2016	12/30/2016	05/18/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 4. WMC PPS completes Current state analysis of current EHR based connections to RHIO.	Project		In Progress	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. WMC PPS in coordination with QE, establishes plan to connect network partners to RHIO.	Project		In Progress	08/08/2015	06/30/2016	08/08/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Asthma project participants to be included among early adopters/pilot for QE connections	Project		Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7. Identify gaps in care that might be addressed by telemedicine based geographyl on availability of specialists or other factors.	Project		Not Started	05/18/2016	12/31/2016	05/18/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 8. Establish whether telemedicine may be the best alternative to provide these services to these geographic areas.	Project		Not Started	05/18/2016	12/31/2016	05/18/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 9. Make plan to implement a pilot program using telemedicine if it is found to be a likely successful endeavor	Project		Not Started	02/15/2017	03/31/2017	02/15/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #3	Project	N/A	Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Deliver educational activities addressing asthma management to participating primary care providers.									
Task Participating providers receive training in evidence-based asthma management.	Project		Not Started	08/12/2016	03/31/2017	08/12/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS provides oversight for the design of curriculum and modalities for training PPS clinicians on best practices of evidence-based management of Asthma, identified in Milestone 1.	Project		Not Started	08/12/2016	12/30/2016	08/12/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 2. Identify a subgroup of key personnel within provider network who can be initially trained.	Project		Not Started	08/12/2016	12/30/2016	08/12/2016	12/30/2016	12/31/2016	DY2 Q3
Task Step 3. Collect feedback from key personnel and if necessary revise education protocol and guidelines.	Project		Not Started	11/16/2016	03/31/2017	11/16/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	Project	N/A	In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 1. WMC PPS identifies MCOs and Health Homes serving Medicaid beneficiaries in our service area.	Project		Completed	08/08/2015	09/30/2015	08/08/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.	Project		Completed	08/08/2015	09/30/2015	08/08/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including asthma health issues.	Project		In Progress	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #5 Use EHRs or other technical platforms to track all patients	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
engaged in this project.									
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of asthma including asthma educatiors, community health workers, asthma educators, pharmacists, to build patient self-efficacy and confidence in self manamagment.	Project		Not Started	05/18/2016	06/30/2016	05/18/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.	Project		Not Started	08/10/2016	12/31/2016	08/10/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4. Report and track actively engaged patients.	Project		Not Started	11/06/2016	03/31/2017	11/06/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.										
Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.										
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	0	0	0	0	0	0	524	524	524
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	0	0	0	0	0	0	800	800	800

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 1. In consultation with partner organizations and the Asthma Project Advisory Quality Committee (APAQC; a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care, practice standards and chronic disease management.										
Task Step 2. Convene the APAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The APAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project, particularly the Hudson Valley Asthma Coalition.										
Task Step 3. Compare status of current practice among participating partners to identified best practices.										
Task Step 4: Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.										
Task Step 5. Identify by provider type and project role the clinical information to be shared among providers.										
Task Step 6. Create roadmap for data sharing and reporting using platform to support population health analytics.										
Task Step 7. Gather lessons learned and feedback from Partners and local deployment workgroups; APAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Task Step 8. At participating sites, identify barriers and develop plans to implement workflow to support electronic reporting and sharing of asthma action plans.										
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.										
Task Agreements with asthma specialists and asthma educators are established.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	0	0	0	0	0	0	0	203	203	203

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
requirements.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	235	235	235
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task Step 1. Identify AE-C's and Asthma specialists WMC PPS network.										
Task Step 2. Establish agreements with asthma specialists and educators to adhere to national guidelines for asthma management										
Task Step 3. Research the potential impact of telemedicine on Asthma care in underserved areas.										
Task Step 4. WMC PPS completes Current state analysis of current EHR based connections to RHIO.										
Task Step 5. WMC PPS in coordination with QE, establishes plan to connect network partners to RHIO.										
Task Step 6. Asthma project participants to be included among early adopters/pilot for QE connections										
Task Step 7. Identify gaps in care that might be addressed by telemedicine based geographyl on availability of specialists or other factors.										
Task Step 8. Establish whether telemedicine may be the best alternative to provide these services to these geographic areas.										
Task Step 9. Make plan to implement a pilot program using										

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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
telemedicine if it is found to be a likely successful endeavor										
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.										
Task Participating providers receive training in evidence-based asthma management.										
Task Step 1. WMC PPS provides oversight for the design of curriculum and modalities for training PPS clinicians on best practices of evidence-based management of Asthma, identified in Milestone 1.										
Task Step 2. Identify a subgroup of key personnel within provider network who can be initially trained.										
Task Step 3. Collect feedback from key personnel and if necessary revise education protocol and guidelines.										
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.										
Task Step 1. WMC PPS identifies MCOs and Health Homes serving Medicaid beneficiaries in our service area.										
Task Step 2. MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.										
Task Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including asthma health issues.										
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of asthma including asthma educatiors, community health workers, asthma educators, pharmacists, to build patient self-efficacy and confidence in self manamagment.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										
Task Step 4. Report and track actively engaged patients.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.										
Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.										
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	524	524	524	524	524	524	524	524	524	524
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	800	800	800	800	800	800	800	800	800	800
Task Step 1. In consultation with partner organizations and the Asthma Project Advisory Quality Committee (APAQC; a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care, practice standards and chronic disease management.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 2. Convene the APAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The APAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project, particularly the Hudson Valley Asthma Coalition.										
Task Step 3. Compare status of current practice among participating partners to identified best practices.										
Task Step 4: Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.										
Task Step 5. Identify by provider type and project role the clinical information to be shared among providers.										
Task Step 6. Create roadmap for data sharing and reporting using platform to support population health analytics.										
Task Step 7. Gather lessons learned and feedback from Partners and local deployment workgroups; APAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.										
Task Step 8. At participating sites, identify barriers and develop plans to implement workflow to support electronic reporting and sharing of asthma action plans.										
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.										
Task Agreements with asthma specialists and asthma educators are established.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	203	203	203	203	203	203	203	203	203	203
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	235	235	235	235	235	235	235	235	235	235
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited 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
- analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task Step 1. Identify AE-C's and Asthma specialists WMC PPS network.										
Task Step 2. Establish agreements with asthma specialists and educators to adhere to national guidelines for asthma management										
Task Step 3. Research the potential impact of telemedicine on Asthma care in underserved areas.										
Task Step 4. WMC PPS completes Current state analysis of current EHR based connections to RHIO.										
Task Step 5. WMC PPS in coordination with QE, establishes plan to connect network partners to RHIO.										
Task Step 6. Asthma project participants to be included among early adopters/pilot for QE connections										
Task Step 7. Identify gaps in care that might be addressed by telemedicine based geographyl on availability of specialists or other factors.										
Task Step 8. Establish whether telemedicine may be the best alternative to provide these services to these geographic areas.										
Task Step 9. Make plan to implement a pilot program using telemedicine if it is found to be a likely successful endeavor										
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.										
Task Participating providers receive training in evidence-based asthma management.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 1. WMC PPS provides oversight for the design of curriculum and modalities for training PPS clinicians on best practices of evidence-based management of Asthma, identified in Milestone 1.										
Task Step 2. Identify a subgroup of key personnel within provider network who can be initially trained.										
Task Step 3. Collect feedback from key personnel and if necessary revise education protocol and guidelines.										
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.										
Task Step 1. WMC PPS identifies MCOs and Health Homes serving Medicaid beneficiaries in our service area.										
Task Step 2. MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.										
Task Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including asthma health issues.										
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.										
Task Step 2. Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation										

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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
all the provider types essential to management of asthma including asthma educatiors, community health workers, asthma educators, pharmacists, to build patient self-efficacy and confidence in self manamagment.										
Task Step 3. WMC PPS creates roadmap for data sharing and reporting.										
Task Step 4. Report and track actively engaged patients.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	
Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	
Deliver educational activities addressing asthma management to participating primary care providers.	
Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 4.b.i – Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

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

Instructions :

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

1-Because this is one of many projects to be implemented by the PPS and its affiliated primary care and other providers there is a risk that committees will be overwhelmed by the volume of guidelines to review, practices will be overwhelmed by the number of policies to be drafted and implemented and both PPS and partners will be overwhelmed by the volume of training to be accomplished. To mitigate risks, the PPS will initially concentrate on the public health aspect of tobacco cessation by developing outreach campaigns and other programs with the HRDPHC and in later years work with partners to implement evidence based guidelines and best practice policies in their organizations. Additionally, the PPS will dedicate resources to staffing committees, drafting model policies and to training to enhance the skills of the health care workforce. A final strategy will be to stage the development and production of materials—materials for some targeted audiences will be developed first and distributed, then materials for another population will be developed.
2- A related risk is that the practices will be busy creating the building blocks of an integrated delivery system in the initial years of the DSRIP program, such as building the IT infrastructure with connections the QEs, meeting Meaningful Use requirements and developing patient tracking tools, and will be unable to meet the many technology related milestones without the infrastructure built prior to implementation. To mitigate those risks we will stage implementation of EHR alerts for tobacco cessation, for example, to follow implementation of the needed technology.
3- This project will be dependent on EHR vendors to implement alerts. Vendors may be unwilling or unable to modify their systems or the modifications may be cost prohibitive. To mitigate the risk of not being able to implement alerts in the EHR our PPS will explore other options for alerting physicians to gaps in care at the point of care and facilitating referrals to the NYS Quitline.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Initially survey PPS Participants about their outdoor policies, share best practices, and re-survey participants to assess progress in implementing tobacco-free outdoor policies	In Progress	Initially survey PPS Participants about their outdoor policies, share best practices, and re-survey Participants DY2 to assess progress in implementing tobacco-free outdoor policies	08/15/2015	03/31/2020	08/15/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1. Develop contented of survey in consultation with HRD_PHC and the provider groups represented in tobacco and asthma committees	In Progress	See Task	08/15/2015	03/31/2016	08/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2. Incorporate survey in detailed assessment by PCMH vendor.	Completed	See Task	08/15/2015	10/08/2015	08/15/2015	10/08/2015	12/31/2015	DY1 Q3
Task Step 3. In consultation with partner organizations and the tobacco cesssation workgroup, identify appropriate evidence based literature and best practices addressing tobacco cessation and tobacco-free outdoor policies.	In Progress	See Task	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Use PPS meetings and other forums to desseminate best practices on tobacco free outdoor policies to PPS partners.	In Progress	See Task	12/31/2015	09/30/2017	12/31/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 5. Resurvey those who responded in round 1 re Outdoor smoking policies	Not Started	See Task	05/15/2018	09/30/2019	05/15/2018	09/30/2019	09/30/2019	DY5 Q2
Task Step 6. Develop plan to facilitate those who have succeeded with outdoor policies assist	Not Started	See Task	10/15/2019	03/31/2020	10/15/2019	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
those who have not.								
Milestone 2. Convene a region-wide tobacco cessation campaign committee by DY1;	In Progress	Convene a region-wide tobacco cessation campaign committee by DY1;	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step1. In collaboration with Montefiore PPS, and Refuah PPS convene the Hudson River DSRIP Public Health Council (HRDPHC) tobacco cessation work group. HRDPHC includes representatives of all three Hudson valley PPSs (Montefiore, Refuah and WMCHealth) as well as representatives of County Health Departments and from the 8 Counties in the region.	In Progress	See Task	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone 3. Engage Medicaid MCOs around coverage and payment	In Progress	Engage Medicaid MCOs around coverage and payment	08/01/2015	12/31/2018	08/01/2015	12/31/2018	12/31/2018	DY4 Q3
Task Step 1. WMC PPS identifies Medicaid Managed Care Organizations (MCOs) doing business in our service area. .	Completed	See Task	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2. MCOs are invited to participate in committees, and work group working on tobacco cessation.	In Progress	See Task	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including coverage for smoking cessation treatment.	Not Started	See Task	05/15/2017	12/31/2018	05/15/2017	12/31/2018	12/31/2018	DY4 Q3
Milestone 4. Survey PPS Participants about USPSTF and PHS guidelines, use of EHRs to facilitate 5 A's, and referrals to the NYS Smokers' Quitline and subsequently promulgate best practices	Not Started	Survey PPS Participants about USPSTF and PHS guidelines, use of EHRs to facilitate 5 A's, and referrals to the NYS Smokers' Quitline and subsequently promulgate best practices	05/15/2016	03/31/2020	05/15/2016	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1. Develop contents of survey in consultation with HRD_PHC tobacco cessation workgroup and the provider groups represented in tobacco and asthma committees	Not Started	See Task	02/15/2019	09/30/2019	02/15/2019	09/30/2019	09/30/2019	DY5 Q2
Task Step 2. Incorporate survey in detailed assessment by PCMH vendor.	Not Started	See Task	02/15/2019	09/30/2019	02/15/2019	09/30/2019	09/30/2019	DY5 Q2
Task Step 3. In consultation with partner organizations and the tobacco cesssation workgroup, identify appropriate evidence based literature and best practices addressing implementation of the USPSTF and PHS guidelines on tobacco cessation, use of EHRs to prompt providers to complete "5As" and to promote referrrals to the NYS Quitline.	Not Started	See Task	05/15/2016	03/31/2017	05/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3. In consultation with partner organizations and the tobacco cesssation workgroup, identify appropriate evidence based literature and best practices addressing implementation of the USPSTF and PHS guidelines on tobacco cessation, use of EHRs to prompt providers to complete "5As" and to promote referrrals to the NYS Quitline.	Not Started	See Task	05/15/2016	03/31/2017	05/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4. Use PPS meetings and other forums to desseminate best practices to PPS partners concerning implementation of the USPSTF and PHS guidelines on tobacco cessation to PPS partners, use of EHRs to prompt providers to complete "5As" and to promote referrrals to the NYS Quitline.	Not Started	See Task	04/15/2017	03/31/2018	04/15/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 5. In consultation with partner	Not Started	See Task	03/31/2018	03/31/2020	03/31/2018	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
organizations and the tobacco cesssation workgroup, the WMC PPC Quality Steering Committee (QSC) and local hub implementation groups develop a site specific plan to assist providers in implementation of the USPSTF and PHS guidelines on tobacco cessation, use of EHRs to prompt providers to complete "5As" and to promote referrrals to the NYS Quitline.								
Task Step 6. WMC PPS will work with NYS DOH Bureau of Tobacco Control's Health Systems for a Tobacco-Free NY contractors to make technical assistance on system improvements related to tobacco use cessation available to partners as they implement.	Not Started	See Task	03/31/2018	03/31/2020	03/31/2018	03/31/2020	03/31/2020	DY5 Q4
Milestone 5. Launch a campaign to promote tobacco cessation among all eligible providers	In Progress	Launch a campaign to promote tobacco cessation among all eligible providers	08/01/2015	06/30/2019	08/01/2015	06/30/2019	06/30/2019	DY5 Q1
Task Step 1. HRD_PHC tobacco cessation workgroup will develop a culturally competent communication strategy for patient and clinician education regarding availability of covered tobacco dependence treatment that encourages patients to use the services.	Not Started	See Task	03/15/2016	12/31/2017	03/15/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 2. WMC PPS will budget to support an outreach campaign inclulding dissemination of training and toolkits such as templates for incorporation of "5As" into EHRs.	In Progress	See Task	08/01/2015	06/30/2018	08/01/2015	06/30/2018	06/30/2018	DY4 Q1
Task Step 3. In consultation with partner organizations and the tobacco cesssation workgroup, the WMC PPC Quality Steering Committee (QSC) and local hub implementation groups develop a site specific	Not Started	See Task	05/15/2016	12/31/2018	05/15/2016	12/31/2018	12/31/2018	DY4 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
plans to support developent of site specific workflow to promote tobacco screeening and cessation counseling including identification of designated staff.								
Task Step 4. HRD_PHC tobacco cessation workgroup will develop sample policies to support tobacco cessation such as policies for a tobacco free out-doors, templates for EHRs, etc. Having sample policies available will facilitate adoption by partner organizations.	Not Started	See Task	03/15/2016	09/30/2017	03/15/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 5. In consultation wit the HRD_PHC tobacco cessation workgroup, the WMC PPS QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to supportive cessation therapy. Measures of success may be revised as appropriate. Metrics will incorporate daa from NYS quitline to the extent permitted by privacy regulations.	Not Started	See Task	06/15/2018	06/30/2019	06/15/2018	06/30/2019	06/30/2019	DY5 Q1
Milestone 6. Develop targeted outreach materials for special populations (dental, behavioral health, and DD patients)	In Progress	Develop targeted outreach materials for special populations (dental, behavioral health, and DD patients)	07/15/2015	12/31/2018	07/15/2015	12/31/2018	12/31/2018	DY4 Q3
Task Step 1. HRD_PHC tobacco cessation workgroup will develop a culturally competent communication strategy for patient education targeting the special needs of special popoulations to encourage patients to use the services to facililtat tobacco cessation. .	Not Started	See Task	03/15/2016	12/31/2017	03/15/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 2. WMC PPS will budget to support an outreach campaign to special populaitons.	Completed	See Task	07/15/2015	12/31/2015	07/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Not Started	See Task	11/15/2017	12/31/2018	11/15/2017	12/31/2018	12/31/2018	DY4 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 3. Partner and client feedback will be solicited. Based on lessons learned and feedback from beneficiaries, Partners and local deployment workgroups, the HRDPHC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.								

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Initially survey PPS Participants about their outdoor policies, share best practices, and re-survey participants to assess progress in implementing tobacco-free outdoor policies	
2. Convene a region-wide tobacco cessation campaign committee by DY1;	
3. Engage Medicaid MCOs around coverage and payment	
4. Survey PPS Participants about USPSTF and PHS guidelines, use of EHRs to facilitate 5 A's, and referrals to the NYS Smokers' Quitline and subsequently promulgate best practices	
5. Launch a campaign to promote tobacco cessation among all eligible providers	
6. Develop targeted outreach materials for special populations (dental, behavioral health, and DD patients)	

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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

Instructions :

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

1- Based on earlier experience of some partners, one challenge to meeting breast cancer screening goals is the two-step nature of the service: a doctor's order for a mammogram followed by a visit to a screening site. To overcome that obstacle, we will explore the feasibility of a "one-stop" model for Breast Cancer screening wherein a physician will be co-located at the screening site, allowing patients to obtain the order and the test at the same time. We propose to test variations of this model with several partners to identify a feasible solution.
#2- As second risk to this project is its dependence on PCMH achievement. As stated in the IDS implementation plan, preliminary data obtained from the RHIO and our CNA show that some number of practices are without EMRs. Without an EMR, practices will not be able to obtain PCMH certification, impacting achievement of IDS milestone #7, and greatly impeding connection to the RHIO, interoperability, and data sharing and other population level projects. To mitigate this risk, we plan a multifaceted and multistage process. First, EMR status will be captured in our current state assessment; results will show the magnitude of the gap across the PPS. Second, we will participate with the CIO council, as well as leverage the expertise of the RHIO, and the other PPSs in our region, coordinate our strategy with the region, the state, and overall best practices. Third, we will develop a strategy to close the gap, including a cost analysis and the comparison of various solutions. Finally, we will stage implementation of embedded cancer screening guidelines, alerts and reminders in EMRs to follow implementation of the needed technology as it cannot be completed without the technology in place.
#3- To be successful at improving cancer screening and follow-up, this project requires data sharing and streamlined referral processes among PCPs, Health Homes and other specialty providers. Our current planning relies on the QE for data sharing, however there is a risk that the QE will not be able to connect providers to the HIE within program timeframes. To mitigate the risk we will continue to work closely with our local QE, PCPs and Health Homes to develop a strategy to prioritize connections to the QE, and address technical and operational barriers to connection.
#4- Not having access to data for non-attributed members in our service area will impede our ability to proactively identify patients with gaps in cancer prevention care or other service needs, as well as monitor quality performance for the population at large. To mitigate this risk, we are exploring opportunities to obtain health plan or NYS claims data on the broader population served by the our network partners
#5-Because this is one of many projects to be implemented by the PPS and its affiliated primary care and other providers there is a risk that committees will be overwhelmed by the volume of guidelines to review, practices will be overwhelmed by the number of policies to be drafted and implemented and both PPS and partners will be overwhelmed by the volume of training to be accomplished. To mitigate risks, the PPS will initially concentrate on the public health aspect of cancer screening by developing outreach campaigns and other programs with the HRDPHC and in later years work with partners to implement evidence based guidelines and best practice policies in their organizations. Additionally, the PPS will dedicate resources to staffing committees, drafting model policies and to training to enhance the skills of the health care workforce. A final strategy will be to stage the development and production of materials—materials for some targeted audiences will be developed first and distributed, then materials for another population will be developed.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Development of a comprehensiveimplementation plan, DY1	In Progress	Development of a comprehensive implementation plan, DY1	08/10/2015	03/31/2018	08/10/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1. In consultation with partner organizations and the Cancer Screening Project Advisory Quality Committee (CPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing cancer screening including the NYS Prevention Agenda goals and objectives and experiences of Cancer Services Program. Notify partners of the intention to take action on this project and invite participation in the CPAQC and the Hudson Region DSRIP Public Health Council (HRD-PHC) .	In Progress	See Task	10/29/2015	06/30/2016	10/29/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Convene the (CPAQC to review and discuss the candidate best practices/ protocols /guidelines/ standards. The CPAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	In Progress	See Task	10/29/2015	09/30/2016	10/29/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. In consulation with the Hudson River DSRIP Public Health Council (HRDPHC), review DSRIP Hudson valley Community Needs assessment and other data to identify	Not Started	See Task	05/18/2016	12/31/2016	05/18/2016	12/31/2016	12/31/2016	DY2 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
gaps in cancer screening for Medicaid beneficiaries. HRDPHC includes representatives of all three Hudson valley PPSs (Montefiore, Refuah and WMCHealth) as well as representatives of County Health Departments and from the 8 Counties in the region. Gap analysis should seek to understand the drivers of low screening and follow-up.								
Task Step 4. Develop a private group on MIX to share strategies for Cancer Prevention and Management.	In Progress	See Task	11/05/2015	03/31/2016	11/05/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5. Plan phased roll out of best practices/protocols/ guidelines/standards adopted adapted to local considerations. To align incentives with identified needs, the plan should be tailored to address barriers to care identified from step 5. For example, if loss of eligibility for insurance coverage is a driver, then one component of the plan should promote public education around Exchange health insurance products and the Cancer Services (CSP) program for coverage of cancer screening and treatment for the uninsured; If NYS Medicaid or health plan benefit design is a barrier to care then the plan should address benefit deficiencies through advocacy or collaboration with MCOs to improve screening rates.	Not Started	See Task	08/17/2016	12/31/2017	08/17/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 6. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for coordination of services	In Progress	See Task	08/10/2015	03/31/2018	08/10/2015	03/31/2018	03/31/2018	DY3 Q4

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and improvement of cancer screening rates.								
Milestone 2. Analysis of CSP best practices and lessons learned, DY1	In Progress	Analysis of CSP best practices and lessons learned, DY1	10/29/2015	12/31/2017	10/29/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 1. Invite community leaders with experience in NYS Cancer Services Program (CSP) to join the Cancer Screening Project Advisory Quality Committee to share experience and lessons learned.	In Progress	See Task	10/29/2015	06/30/2016	10/29/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Convene the (CPAQC to review and discuss the candidate best practices/ protocols /guidelines/ standards including experiences in CSP to inform development of a region wide roll-out of best-practices for cancer screening.	Not Started	See Task	08/17/2016	12/31/2017	08/17/2016	12/31/2017	12/31/2017	DY3 Q3
Milestone 3. Development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs	Not Started	Development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs	05/15/2018	03/31/2019	05/15/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 1. WMC PPS creates roadmap for data sharing and reporting to support cancer screening including plans to embed cancer screening templates and alerts into EHRs.	Not Started	See Task	05/15/2018	12/31/2018	05/15/2018	12/31/2018	12/31/2018	DY4 Q3
Task Step 2. The CPACQ and/or the QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to appropriate care. Measures of success may be revised as appropriate.	Not Started	See Task	05/15/2018	03/31/2019	05/15/2018	03/31/2019	03/31/2019	DY4 Q4
Milestone 4. Identification of functional requirements for the cancer screening registry; DY1	Not Started	See Task	05/15/2019	12/31/2019	05/15/2019	12/31/2019	12/31/2019	DY5 Q3
Task Step 1. Define functional reporting	Not Started	See Task	05/15/2019	12/31/2019	05/15/2019	12/31/2019	12/31/2019	DY5 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements for cancer screening projects.								
Milestone 5. Piloting rapid cycle evaluation of our PPS' care management function DY1	Not Started	Piloting rapid cycle evaluation of our PPS' care management function DY1	02/15/2017	09/30/2019	02/15/2017	09/30/2019	09/30/2019	DY5 Q2
Task Step 1. The PPS "care management" function is based on implementation of the Health Home at risk project that will first be piloted in a few large practices and will seek to include appropriate cancer screening in the gaps in care section of the comprehensive care plan. Pilot implementation to begin by end of year 1.	Not Started	See Task	02/15/2017	09/30/2019	02/15/2017	09/30/2019	09/30/2019	DY5 Q2
Milestone 6. Selection of an analytics platform to support patient identification	In Progress	Selection of an analytics platform to support patient identification	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	In Progress	See Task	08/08/2015	03/31/2017	08/08/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2. Aligned with IT development for project 2 ai the WMC PPS begins IT based population health reporting.	Not Started	See Task	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3. Begin phased roll-out of embedded templates and alerts; share templates of early adopters with others to speed adoption.	In Progress	See Task	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone 7. Roll-out of a one-stop screening pilot	Not Started	Roll-out of a one-stop screening pilot	08/15/2018	03/31/2020	08/15/2018	03/31/2020	03/31/2020	DY5 Q4
Task Step 1. Based on past experience we hypothesize that one obstacle to breast cancer screening is getting the referring physician to write a script or an order for the consulting radiologist. If the gap analysis from M1 of this project supports that hypothesis We	Not Started	See Task	08/15/2018	12/31/2019	08/15/2018	12/31/2019	12/31/2019	DY5 Q3

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will examine the feasibility of having a cancer surgeon examine patients, order the mammogram and fu with pt and PCP. Develop proposal with model.								
Task Step 2. Identify potential sites and partners to test "one stop Breast cancer screening model"	Not Started	See Task	11/30/2018	09/30/2019	11/30/2018	09/30/2019	09/30/2019	DY5 Q2
Task Step 3. Plan for role-out of pilot test of one-stop Breast Cancer Screening. .	Not Started	See Task	02/10/2019	03/31/2020	02/10/2019	03/31/2020	03/31/2020	DY5 Q4
Milestone 8. Wider roll-out of CSP-adapted protocols DY2 and preliminary evaluation of results. By the end of DY3 the PPS will ensure all providers have developed or adopted PCMH or team-based care models.	In Progress	Wider roll-out of CSP-adapted protocols DY2 and preliminary evaluation of results. By the end of DY3 the PPS will ensure all providers have developed or adopted PCMH or team-based care models.	08/08/2015	12/31/2018	08/08/2015	12/31/2018	12/31/2018	DY4 Q3
Task Step 1. Gather lessons learned and feedback from Partners and local deployment workgroups; CPAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans for wider roll out in consultation with PMO staff.	Not Started	See Task	05/15/2018	12/31/2018	05/15/2018	12/31/2018	12/31/2018	DY4 Q3
Task Step 2. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.	Completed	See Task	08/08/2015	09/30/2015	08/08/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH or APC model.	In Progress	See Task	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4. WMC PPS completes current state analysis of network partners; included will be	In Progress	See Task	08/08/2015	03/31/2016	08/08/2015	03/31/2016	03/31/2016	DY1 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
determination as to eligibility for PCMH or APC based on practice characteristics, as well as current PCMH or APC certification if any and EHR and MU capabilities.								
Task Step 5. WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	Not Started	See Task	05/18/2016	12/31/2017	05/18/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 6. Identify pilot partner/early adopter sites to achieve PCMH or APCM by DY3.	Completed	See Task	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 7. Evaluate lessons learned from initial connections; plan phased rollout.	Not Started	See Task	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8. Implement Phase 1 of network rollout PCMH/APCM	Not Started	See Task	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9. Implement Phase 2 of network rollout PCMH/APCM	Not Started	See Task	03/31/2017	03/31/2018	03/31/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 10. Document PCMH or APC certification among eligible providers.	Not Started	See Task	01/01/2018	12/31/2018	01/01/2018	12/31/2018	12/31/2018	DY4 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Development of a comprehensiveimplementation plan, DY1	
2. Analysis of CSP best practices and lessons learned, DY1	
3. Development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs	
4. Identification of functional requirements for the cancer screening registry; DY1	
5. Piloting rapid cycle evaluation of our PPS' care management function DY1	
6. Selection of an analytics platform to support patient identification	
7. Roll-out of a one-stop screening pilot	
8. Wider roll-out of CSP-adapted protocols DY2 and preliminary evaluation of results. By the end of DY3 the PPS will ensure all providers have developed or adopted PCMH or team-based care models.	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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Attestation

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

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

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

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

☐ **I here by attest, as the Lead Representative of the 'Westchester Medical Center', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	WESTCHESTER MED CTR
Secondary Lead PPS Provider:	
Lead Representative:	June Keenan
Submission Date:	03/16/2016 10:19 AM

Comments:	

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	June Keenan	mrurak	03/31/2016 05:17 PM
DY1, Q3	Submitted	June Keenan	keenanj1	03/16/2016 10:19 AM
DY1, Q3	Returned	June Keenan	mrurak	03/01/2016 05:17 PM
DY1, Q3	Submitted	June Keenan	keenanj1	02/03/2016 10:29 AM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1Q3 Quarterly Report.	mrurak	03/31/2016 05:17 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	mrurak	03/01/2016 05:17 PM

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

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

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

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

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

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

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget Report (Baseline)	Pass & Complete	
	Module 1.2 - PPS Budget Report (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds (Baseline)	Pass & Complete	
	Module 1.4 - PPS Flow of Funds (Quarterly)	Pass (with Exception) & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Ongoing	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Ongoing	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Fail	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Ongoing	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Pass & Ongoing	

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

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

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

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Pass & Ongoing	
	Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	Pass & Ongoing	
	Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Pass & Ongoing	
	Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Pass & Ongoing	
	Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	Pass & Ongoing	
	Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Pass & Ongoing	
2.a.iv	Module 2.a.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.a.iv.3 - Prescribed Milestones		
	Milestone #1 Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.	Pass & Ongoing	
	Milestone #2 Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.	Pass & Ongoing	
	Milestone #3 Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	Pass & Ongoing	
	Milestone #4 Ensure that all safety net providers participating in Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Pass & Ongoing	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
	Milestone #6 Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2	Pass & Ongoing	
	Milestone #7 Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.	Pass & Ongoing	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals,	Pass & Ongoing	

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	partnering with a home care service or other appropriate community agency.		
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Ongoing	
	Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Ongoing	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Ongoing	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Fail	
	Module 2.d.i.3 - Prescribed Milestones		
	Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Pass & Ongoing	
	Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Pass & Ongoing	
	Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Pass & Ongoing	
	Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Pass & Ongoing	
	Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Pass & Ongoing	
	Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Pass & Ongoing	
	Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Pass & Ongoing	
	Milestone #8 Include beneficiaries in development team to promote preventive care.	Pass & Ongoing	

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	Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	Pass & Ongoing	
	Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Pass & Ongoing	
	Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Pass & Ongoing	
	Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Pass & Ongoing	
	Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Pass & Ongoing	
	Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Pass & Ongoing	
	Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Pass & Ongoing	
	Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Pass & Ongoing	
	Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	

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	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.a.ii	Module 3.a.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.ii.3 - Prescribed Milestones		
	Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Pass & Ongoing	
	Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	Pass & Ongoing	
	Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Pass & Ongoing	
	Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	Pass & Ongoing	
	Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Pass & Ongoing	
	Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	Pass & Ongoing	

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	Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	Pass & Ongoing	
	Milestone #8 Ensure that all PPS safety net providers have actively connected 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 Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Pass & Ongoing	
	Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Pass & Ongoing	
	Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.c.i	Module 3.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.c.i.3 - Prescribed Milestones		
	Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Pass & Ongoing	
	Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Pass & Ongoing	
	Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Pass & Ongoing	
	Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	Pass & Ongoing	
	Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Pass & Ongoing	
	Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	Pass & Ongoing	
3.d.iii	Module 3.d.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.iii.3 - Prescribed Milestones		
	Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	Pass & Ongoing	
	Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Pass & Ongoing	
	Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.	Pass & Ongoing	
	Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	population.		
	Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
4.b.i	Module 4.b.i.2 - PPS Defined Milestones	Pass & Ongoing	
4.b.ii	Module 4.b.ii.2 - PPS Defined Milestones	Pass & Ongoing	