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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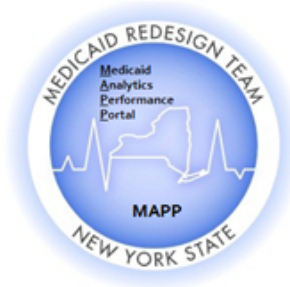Run Date : 09/24/2015
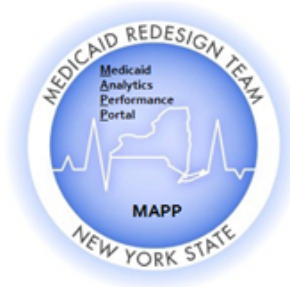
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**Run Date :** 09/24/2015

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

## Quarterly Report - Implementation Plan for Westchester Medical Center

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

### Status By Section

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

### Status By Project

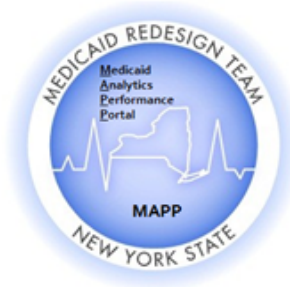| Project ID | Project Title | Status |
|------------|---------------|--------|
| 2.a.i | Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management | ✅ Completed |
| 2.a.iii | Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services | ✅ Completed |
| 2.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

**Instructions :**

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

| Budget Items | DY1 ($) | DY2 ($) | DY3 ($) | DY4 ($) | DY5 ($) | Total ($) |
|---|---|---|---|---|---|---|
| Waiver Revenue | 41,834,599 | 44,581,933 | 72,094,581 | 63,839,476 | 41,834,599 | 264,185,188 |
| Cost of Project Implementation & Administration | 20,353,727 | 27,360,548 | 28,863,585 | 27,444,338 | 22,021,458 | 126,043,656 |
| 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 | 32,123,005 | 96,439,308 |
| Cost of non-covered services | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 836,692 | 1,891,639 | 5,441,892 | 5,276,790 | 1,836,692 | 15,283,705 |
| Innovation Pool | 0 | 1,000,000 | 4,000,000 | 4,000,000 | 1,000,000 | 10,000,000 |
| Administration | 836,692 | 891,639 | 1,441,892 | 1,276,790 | 836,692 | 5,283,705 |
| Total Expenditures | 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 Name | File Description | Upload Date |
|---|---|---|---|
| No Records Found | | | |

**Narrative Text :**

**DSRIP Implementation Plan Project**

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☑ **IPQR Module 1.2 - PPS Flow of Funds**

**Instructions :**

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

- This table requires your funds flow projections on an annual basis. Subsequent quarterly reports will require you to submit your actual distribution of funds to these provider categories on a quarterly basis.

- These quarterly submissions of actual funds distribution will ultimately be required at the provider level (as opposed to the provider type level required here)

| Funds Flow Items | DY1 ($) | DY2 ($) | DY3 ($) | DY4 ($) | DY5 ($) | Total ($) |
|---|---|---|---|---|---|---|
| **Waiver Revenue** | 41,834,599 | 44,581,933 | 72,094,581 | 63,839,476 | 41,834,599 | 264,185,188 |
| Primary Care Physicians | 1,177,516 | 1,880,031 | 5,227,049 | 6,241,324 | 4,879,035 | 19,404,955 |
| Non-PCP Practitioners | 9,700 | 379,422 | 1,997,186 | 2,449,841 | 1,766,150 | 6,602,299 |
| Hospitals | 8,456,571 | 10,062,920 | 27,055,208 | 31,419,357 | 26,626,726 | 103,620,782 |
| Clinics | 229,625 | 928,908 | 4,007,835 | 5,175,345 | 3,332,301 | 13,674,014 |
| Health Home / Care Management | 0 | 327,562 | 2,220,431 | 2,854,148 | 2,348,610 | 7,750,751 |
| Behavioral 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 |
| Skilled Nursing Facilities / Nursing Homes | 0 | 20,000 | 80,000 | 80,000 | 20,000 | 200,000 |
| Pharmacies | 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 | 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 Name | File Description | Upload Date |
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**Narrative Text :**

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☑ **IPQR Module 1.3 - Prescribed Milestones**

**Instructions :**

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

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Milestone #1** Complete funds flow budget and distribution plan and communicate with network | In Progress | Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology. | 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. | In Progress | See Task. | 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. | In Progress | See Task. | 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 | 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 | 03/31/2016 | DY1 Q4 | |
| **Task** Step 5. Plan for annual updates. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

**Prescribed Milestones Current File Uploads**

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|
| No Records Found | | | | |

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**Prescribed Milestones Narrative Text**

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

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☑ **IPQR Module 1.4 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

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**IPQR Module 1.5 - IA Monitoring**

**Instructions :**

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## Section 02 – Governance

### ☑ IPQR Module 2.1 - Prescribed Milestones

**Instructions :**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones.  For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Milestone #1** Finalize governance structure and sub-committee structure | In Progress | This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board. | 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 | 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 | 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). | In Progress | See Task. | 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. | In Progress | 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 | 09/30/2015 | DY1 Q2 | |
| **Milestone #2** Establish a clinical governance structure, including clinical quality committees for each DSRIP project | In Progress | This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart | 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. | In Progress | Update as Required by IA: July, 2015 update: Chairs of the WMC PPS Quality Steering Committee and each of 8 Project Quality Advisory committees (PQAC) have been proposed and submitted to the Nominating Committee for approval.   Participant | 07/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| | | 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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 3. Develop meeting schedules, identify staff support, and draft charter for each Committee and Workgroup. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #3** Finalize bylaws and policies or Committee Guidelines where applicable | In Progress | This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | YES |
| **Task** Step 1. Draft charters for Executive Committees. | Completed | This task completed; see uploads. | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 | |
| **Task** Step 2. Establish process to communicate updates to PAC members. | In Progress | 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 | 09/30/2015 | DY1 Q2 | |
| **Task** Step 3. Incorporate Executive Committee feedback into final charter documents. | In Progress | Update as Required by IA: • Finance, IT, Workforce, and Quality Steering Committee charters,which includes details concerning committee by-laws and policies, have been finalized and are awaiting committee approval. | 07/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Milestone #4** Establish governance structure reporting and monitoring processes | In Progress | This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |
| **Task** | Completed | This task completed; see uploads. | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 | |

# New York State Department Of Health
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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| 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). | | | | | | | |
| **Task** Step 2. Send MSA to WMC PPS participants; host webinar to review. | In Progress | This task completed; see uploads. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** Step 3. Finalize MSA and execute with PPS participants. | In Progress | See Task. | 06/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** Step 4. Draft schedules that describe obligations of WMC PPS Participants. | In Progress | 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 | 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 | 06/30/2016 | DY2 Q1 | NO |
| **Task** Step 1. WMC PPS customizes Salesforce to support IDS network; establish provider type, geographic, and other categories. | In Progress | See Task. | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** Step 2. Convene Quality Committee and planning groups for local deployment councils. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 3. Conduct Focus groups with community consumers/residents and CBOs to help identify key access factors and effective communication | On Hold | 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 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

**NYS Confidentiality** – **High**

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective. | | 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. | | | | | |
| **Task** Step 4. Identify gaps in organization types (including public and non-provider, CBOs) by crosswalking exisitng network to needs identified in CNA . | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #6** Finalize partnership agreements or contracts with CBOs | In Progress | Signed CBO partnership agreements or contracts. | 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. | In Progress | 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. • Upon DOH reopening PPS network, pursue additional CBOs to join WMC network | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY 1 Q2 | |
| **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 | 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.) | In Progress | Agency Coordination Plan. | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO |
| **Task** Step 1. Convene Hudson Region DSRIP Public | Completed | Additional Information as Required by IA: Our PPS has had an ongoing relationship with local public agencies since last | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 | |

**NYS Confidentiality – High**

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| 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. | | 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. | | | | | |
| **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. | In Progress | Next meeting HVHRON August 27, 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, 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. | In Progress | See Task. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **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. | In Progress | See Task. | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #8** Inclusion of CBOs in PPS Implementation. | In Progress | Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network. | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Task** Step 1. CBOs will be represented on our PAC and recruited to participate on the Project Advisory Quality Committees, the HRDPHC, local deployment councils, and focus groups/community engagement sessions. | In Progress | See Task. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **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. | In Progress | See Task. | 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 | 03/31/2016 | DY1 Q4 | |
| **Milestone #9** Finalize workforce communication and engagement plan | In Progress | Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee). | 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 | 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 | 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 | In Progress | Additional Step/Task as Required by IA. | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| (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 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 | 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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|
| Finalize governance structure and sub-committee structure | thaodoan | 21_MDL0203_1_1_20150726120455_Executive Committee 5-26-15 minutes Final.doc | Executive Committee Meeting Minutes May 26: Identify Standing Committees. | 07/26/2015 12:04 PM |
| | thaodoan | 21_MDL0203_1_1_20150726120314_Executive Committee 4-28-15 minutes.doc | Executive committee Meeting Minutes April 28: Transitioning Executive Committee to Operational Committee | 07/26/2015 12:02 PM |
| Finalize bylaws and policies or Committee Guidelines where applicable | thaodoan | 21_MDL0203_1_1_20150726121150_WMC Workforce Committee Charter_Revised FINAL.docx | Workforce Committee Charter | 07/26/2015 12:11 PM |
| | thaodoan | 21_MDL0203_1_1_20150726121124_WMC Quality Committee and Quality Steering Committee Charter_FINAL.docx | Quality Committee Charter | 07/26/2015 12:11 PM |
| | thaodoan | 21_MDL0203_1_1_20150726121056_WMC IT Committee Charter_Revised FINAL.docx | IT Committee Charter | 07/26/2015 12:10 PM |
| | thaodoan | 21_MDL0203_1_1_20150726121030_WMC Finance Committee Charter FINAL.docx | Finance Committee Charter | 07/26/2015 12:10 PM |
| Establish governance structure reporting and monitoring processes | thaodoan | 21_MDL0203_1_1_20150726121538_WMC MSA review webinar_final_4 24 15.pdf | MSA Review Webinar | 07/26/2015 12:15 PM |
| | thaodoan | 21_MDL0203_1_1_20150726121436_WMC DSRIP draft MSA orientation webinar_final.pdf | MSA Draft Webinar | 07/26/2015 12:14 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.) | thaodoan | 21_MDL0203_1_1_20150726121936_MeetingMinutes_2015Apr16_HRDPHC SmokingCessationWorkgroup.doc | Meeting Minutes First Meeting HRDPHC | 07/26/2015 12:19 PM |

### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Finalize governance structure and sub-committee structure | |
| Establish a clinical governance structure, including clinical quality committees for each DSRIP project | |
| Finalize bylaws and policies or Committee Guidelines where applicable | |
| Establish governance structure reporting and monitoring processes | |

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**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement) | |
| Finalize partnership agreements or contracts with CBOs | |
| Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.) | |
| Finalize workforce communication and engagement plan | |
| Inclusion of CBOs in PPS Implementation. | |

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☑ **IPQR Module 2.2 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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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 |

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

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| Committee reports will also be provided to the Executive Committee. | | | | | | | |
| **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. | In Progress | See Task. | 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. | In Progress | Additional Step/Task Required by IA. | 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. | In Progress | Additional Step/Task Required by IA. | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** 5c. WMC will provide ongoing training to PPS providers via webinars. | In Progress | Additional Step/Task Required by IA. First training webinars held in April on MSA. | 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 | 03/31/2016 | DY1 Q4 | YES |
| **Task** Step 1. Identify core PMO and WMC staff to support ongoing financial health assessment | In Progress | See Task. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |

**NYS Confidentiality** – **High**

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| monitoring. | | | | | | | |
| **Task** Step 2. Establish Financial Assessment and Restructuring Workgroup of the Finance Committee  (as discussed in DSRIP application). | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | 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. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 4. Identify financially frail and potentially financially frail (those who exhibit certain risk factors) and review status with Finance Committee. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 6. Subsequent quarterly reports will track plans to address financial status of providers. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 4a. Identified financially fragile PPS partners will submit quarterly fiscal reports for WMC PPS monitoring | On Hold | Additional Step/Task as required by IA. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 4b. Based on submitted financial metrics, make funds available for financially fragile PPS Partners | On Hold | Additional Step/Task as required by IA. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #3** | In Progress | This milestone must be completed by 12/31/2015. Finalized Compliance Plan | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| Finalize Compliance Plan consistent with New York State Social Services Law 363-d | | (for PPS Lead). | | | | | |
| **Task** Step 1. Review New York State Social Services Law 363-d with Counsel. | In Progress | 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 | 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. | In Progress | 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 | 12/31/2015 | DY1 Q3 | |
| **Task** Step 3.  Implement monitoring protocols and annual compliance plan review procedure. | In Progress | See Task. | 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 | 03/31/2016 | DY1 Q4 | YES |
| **Task** Step 1. Review final State value-based payment roadmap with Finance and Executive Committees. | In Progress | See Task. | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** Step 2. Establish Value-Based Payment Task | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| 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 3. Conduct current state assessment of value-based payment  across all WMC PPS Participants. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | Additional Information/Step required by IA. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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). | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | Additional Information/Step required by IA. Summit date, November 5, 2015 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #5** Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest | On Hold | This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |
| **Task** Step 1. Review baseline assessment of Participants' value-based payment arrangements (and capabilities). | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 2. Conduct gap assessment to achieving | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| stated goal of 90% within five years. | | | | | | | |
| **Task** Step 3. PPS Draft VBP Plan, including MCO strategy, distributed for stakeholder feedback. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 4. Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 5. PPS will provide updates on implementation of VBP plan. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #6** Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation | On Hold | | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |
| **Milestone #7** Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher | On Hold | | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |
| **Milestone #8** >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher | On Hold | | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |

## Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

## Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Finalize PPS finance structure, including reporting structure | |

**NYS Confidentiality – High**

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**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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 | |
| Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy. | |
| Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest | |
| Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation | |
| Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher | |
| >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher | |

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☑ **IPQR Module 3.2 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

**Instructions :**

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

1. 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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## ☑ 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 oversight of the DSRIP programs for the PPS and Quality Committee |
| 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 | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Finalize cultural competency / health literacy strategy. | In Progress | This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should:<br>-- Identify priority groups experiencing health disparities (based on your CNA and other analyses);<br>-- Identify key factors to improve access to quality primary, behavioral health, and preventive health care<br>-- Define plans for two-way communication with the population and community groups through specific community forums<br>-- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and<br>-- Identify community-based interventions to reduce health disparities and improve outcomes. | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | YES |
| **Task**<br>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 | 06/30/2015 | DY1 Q1 | |
| **Task**<br>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. | In Progress | Need PHI data attribution from NYSDOH | 09/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>Step 3. Identify cultural competency and health literacy champions within the local deployment | In Progress | Will also work through Community Engagement Quality Advisory Committee. | 09/30/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| 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 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. | In Progress | Detailed provider survey will be finished DY1, Q4 | 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. | In Progress | See Task. | 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 approaches for patient self-management of disease risk factors that are culturally | In Progress | See Task. | 10/06/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| 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. | In Progress | See Task. | 10/06/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** Step 8. Obtain Executive Committee approval of Proposed Strategy. | In Progress | See Task. | 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. | In Progress | See Task. | 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. | In Progress | Additional Step/Task required by IA. | 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. | In Progress | Additional Step/Task required by IA. | 09/30/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #2** Develop a training strategy focused on | On Hold | This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | YES |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| addressing the drivers of health disparities (beyond the availability of language-appropriate material). | | -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy<br>-- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches | | | | | |
| **Task**<br>Step 1. Define a current state training need based on Steps 1, 2 and 5 of the cultural competency/health literacy strategy above. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task**<br>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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task**<br>Step 3. Obtain Executive Committee approval of Proposed Training Strategy. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task**<br>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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task**<br>Step 5. Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|
| Finalize cultural competency / health literacy strategy. | thaodoan | 21_MDL0403_1_1_20150726122217_Community Engagement Quality Advisory Committee roster for upload_2015Jul20.docx | Community Engagement Quality Advisory Committee List of Memebers | 07/26/2015 12:21 PM |

### Prescribed Milestones Narrative Text

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

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☑ **IPQR Module 4.2 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

**PPS Defined Milestones Current File Uploads**

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

**PPS Defined Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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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 | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>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 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task**<br>Step 1. WMC PPS convenes stakeholders (RHIO, network providers, WMC project teams, others) to develop assessment components including technical and functional information. | In Progress | See Task. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>Step 2. Issue RFP to identify and engage vendor to conduct assessment. | In Progress | See Task. | 05/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>Step 3. Establish IT governance structure. | In Progress | See Task. | 06/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>Step 4. Under the direction of WMC PPS, vendor creates assessment tool, survey and analytic plan. | In Progress | Additional Information as Required by IA:<br>Under the direction of WMC PPS Sr. Dir, IDS Operations, vendor creates assessment tools, survey, and analytic plan. | 09/15/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>Step 5. Vendor surveys WMC PPS network on current state. | In Progress | Additional Information as Required by IA:<br>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 | 03/31/2016 | DY1 Q4 | |
| **Task**<br>Step 6. Vendor analyzes and tabulates results | In Progress | See Task. | 01/12/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| 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. | In Progress | See Task. | 03/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Task** Step 7a. WMC PPS reconvenes IT governance group to budget for closing gaps and achieving interoperability. | In Progress | Additional Step/Task required by IA. | 03/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **Milestone #2** Develop an IT Change Management Strategy. | On Hold | IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | 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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 2. IT Committee, working through the PMO, assesses impact, risks, and effectiveness of IT changes and alignment with projects. | On Hold | 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). | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 3. Obtain Executive Committee Board approval of change management strategy. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #3** Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network | In Progress | Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a | 06/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | NO |

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| | | common clinical data set<br>-- 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**<br>Step 1. Establish IT governance structure. | In Progress | See Task. | 06/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>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. | In Progress | See Task. | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>Step 3. Implement interim reporting tool for DSRIP milestone reporting and engaged patient tracking. | In Progress | Additional Information as Required by IA:<br>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 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>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. | In Progress | Additional Information as Required by IA:<br>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 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>Step 5. Create PPS-wide data sharing roadmap. | In Progress | See Task. | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task**<br>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 | 06/30/2016 | DY2 Q1 | |
| **Task**<br>Step 7. WMC PPS in coordination with QE, | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| establishes plan to connect network partners to RHIO. | | | | | | | |
| **Task** Step 8. Create roadmap for data sharing and reporting using platform to support population health analytics. | On Hold | 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. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **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. | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Milestone #4** Develop a specific plan for engaging attributed members in Qualifying Entities | On Hold | 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. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | 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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 2. WMC PPS and QE identify appropriate measures to monitor RHIO consent. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** 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 | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| 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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 5. Obtain Executive Committee approval of QE engagement plan. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **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 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO |
| **Task** Step 1. WMC PPS evaluates alternatives (i.e., buy vs. build) for management of data security and confidentiality within PPS and across provider network. | In Progress | See Task. | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** Step 2. Based on current state assessment (milestone #1), create gap to goal for data security and confidentiality plan. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 3. Identify controls for data security and confidentiality risk mitigation. | In Progress | See Task. | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |
| **Task** Step 4. Establish PPS-wide protocols for protected data including data collection, data exchange, data use, data storage and disposal policies. | On Hold | 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. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 5. Develop plan for ongoing security and | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| testing throughout PPS network. | | | | | | | |
| **Task** Step 6. Obtain PPS Executive Committee approval for data security and confidentiality plan. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

**Prescribed Milestones Current File Uploads**

| Milestone Name | User ID | File Name | Description | Upload Date |
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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. | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 5.2 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

**Instructions :**

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

> 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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### ☑ 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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## Section 06 – Performance Reporting

### ✅ IPQR Module 6.1 - Prescribed Milestones

**Instructions :**

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

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Milestone #1** Establish reporting structure for PPS-wide performance reporting and communication. | In Progress | Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation | 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. | In Progress | See Task. | 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. | In Progress | See Task. | 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). | In Progress | See Task. | 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 | In Progress | See Task. | 11/05/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| designated project manager and PMO executive responsible for each project.. | | | | | | | |
| **Task** Step 5. Obtain Executive Committee approval of Reporting and Communications strategy. | In Progress | See Task. | 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 | 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 | 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 | 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 | 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 | 03/31/2016 | DY1 Q4 | |
| **Task** Step 3. Field based deployment will follow an academic detailing model including centrally based and locally deployed staff. | In Progress | See Task. | 04/12/2016 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| **Task** Step 4. PMO will monitor training roll-out and | In Progress | Additional Information as Required by IA: Partner feedback will be routinely solicited. Based on lessons learned and | 05/10/2016 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |

**NYS Confidentiality** – **High**

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| assess effectiveness via participant evaluation. | | 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. | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
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### Prescribed Milestones Narrative Text

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

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☑ **IPQR Module 6.2 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
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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 | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop Practitioners communication and engagement plan. | In Progress | Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide  professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task** 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 | 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 | 06/30/2015 | DY1 Q1 | |
| **Task** Step 3. Convene the WMC PPS project specific Advisory Quality Committees and  workgroups. | In Progress | See Task. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** Step 4. PPS creates a plan for the development and implementation of platforms to share administrative, milestone and project information with network partners. | In Progress | See Task. | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **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. | In Progress | See Task. | 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 | 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 | 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 | 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. | In Progress | See Task. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task** Step 2. Training on use of  MIX: As appropriate, committees and workgroups will set up group sites on the MIX. (HRDPHC tobacco cessation | In Progress | See Task. | 05/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | |

**NYS Confidentiality** – **High**

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| group already has a site.) All committee members will be offered MIX training. | | | | | | | |
| **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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 5. PMO will monitor training roll-out and assess effectivess via participant evaluation. | On Hold | 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. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

## Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|
| Develop Practitioners communication and engagement plan. | thaodoan | 21_MDL0703_1_1_20150727131334_WMC Quality Committee and Quality Steering Committee Charter_FINAL.docx | Quality Committee Charter_Clinical Governance | 07/27/2015 01:13 PM |

**NYS Confidentiality – High**

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**Prescribed Milestones Current File Uploads**

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|
| | thaodoan | 21_MDL0703_1_1_20150727131245_20150726_Clinical Governance Slide.pptx | Clinical Governance Slide | 07/27/2015 01:11 PM |

**Prescribed Milestones Narrative Text**

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

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### ✅ IPQR Module 7.2 - PPS Defined Milestones

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

**Instructions :**

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

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

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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 | WMC, PMO | Aligning integrated relationships with external physicians and group practices, hospital and health systems and insurance networks. |
| Quality Steering Committee | TBD, Various organizations | 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 | 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 | 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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **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." | On Hold | See Task and IT section. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 3. Obtain Executive Committee approval of Population Health Roadmap. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 4. The plan for achieving PCMH mirrors | In Progress | Additional Specificity as Required by IA: An  RFP was  issued 5/15/2015 for a vendor to do PCMH/APC readiness | 05/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| the 7th Milestone in the IDS Project Plan. | | 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**<br>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 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO |
| **Task**<br>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. | In Progress | See Task. | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>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 services, outreach/support including increased use of peer workers) for adults with serious BH disorders. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **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. | On Hold | 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. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 4. Present BSCH and HAHV medical village plans to the Executive Committee for approval. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

## Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

## Prescribed Milestones Narrative Text

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

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☑ **IPQR Module 8.2 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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

**Instructions :**

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

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 | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>Perform a clinical integration 'needs assessment'. | In Progress | Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including:<br>-- 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)<br>-- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration<br>-- Identify other potential mechanisms to be used for driving clinical integration | 07/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 | NO |
| **Task**<br>Step 1. Draft plan for needs assessment accounting for provider type, specialties and locations including social services and community based organizations. | In Progress | See Task. | 07/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | |
| **Task**<br>Step 2. Meet with Health Homes to assess capacity and links to other care providers: medical, behavioral health, social services. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task**<br>Step 3. Meet with partners to share clinical integration experiences and identify gaps and opportunities. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task**<br>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. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |

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

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| **Task** Step 5. Map provider network locations. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 6. Assess IT capacities of CBOs and social service agencies to share information. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Task** Step 7. PPS Quality Steering Committee review and approval of clinical integration needs assessment. | On Hold | See Task. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 | |
| **Milestone #2** Develop a Clinical Integration strategy. | In Progress | Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools | 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 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| **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 | 09/30/2016 | DY2 Q2 | |
| **Task** Step 3. Create roadmap for data sharing and reporting using platform to support population health analysis. | In Progress | See Task. | 08/01/2015 | 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 | 12/31/2016 | DY2 Q3 | |
| **Task** Step 5. PPS Quality Steering Committee review | In Progress | See Task. | 12/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 | |

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| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV |
|---|---|---|---|---|---|---|---|
| and approval of Clinical Integration Strategy. | | | | | | | |

### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
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| Milestone Name | Narrative Text |
|---|---|
| Perform a clinical integration 'needs assessment'. | |
| Develop a Clinical Integration strategy. | |

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☑ **IPQR Module 9.2 - PPS Defined Milestones**

**Instructions :**

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

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
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### PPS Defined Milestones Current File Uploads

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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
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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

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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 - 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 - Project Implementation Speed

**Instructions :**

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

| Benchmarks |
|---|
| **100% Total Committed By** |
| DY3,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **DY1,Q1** | **DY1,Q2** | **DY1,Q3** | **DY1,Q4** | **DY2,Q1** | **DY2,Q2** | **DY2,Q3** | **DY2,Q4** | **DY3,Q1** | **DY3,Q2** |
| Primary Care Physicians | 609 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-PCP Practitioners | 1,878 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hospitals | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Clinics | 50 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Home / Care Management | 27 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Behavioral Health | 324 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Substance Abuse | 28 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Skilled Nursing Facilities / Nursing Homes | 43 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pharmacies | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hospice | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Based Organizations | 148 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All Other | 1,152 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Committed Providers** | **4,290** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Percent Committed Providers(%)** | | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **DY3,Q3** | **DY3,Q4** | **DY4,Q1** | **DY4,Q2** | **DY4,Q3** | **DY4,Q4** | **DY5,Q1** | **DY5,Q2** | **DY5,Q3** | **DY5,Q4** |
| Primary Care Physicians | 609 | 0 | 609 | 609 | 609 | 609 | 609 | 609 | 609 | 609 | 609 |
| Non-PCP Practitioners | 1,878 | 0 | 1,878 | 1,878 | 1,878 | 1,878 | 1,878 | 1,878 | 1,878 | 1,878 | 1,878 |

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| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Hospitals | 20 | 0 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 |
| Clinics | 50 | 0 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| Health Home / Care Management | 27 | 0 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 |
| Behavioral Health | 324 | 0 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 |
| Substance Abuse | 28 | 0 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 |
| Skilled Nursing Facilities / Nursing Homes | 43 | 0 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 |
| Pharmacies | 4 | 0 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Hospice | 7 | 0 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| Community Based Organizations | 148 | 0 | 148 | 148 | 148 | 148 | 148 | 148 | 148 | 148 | 148 |
| All Other | 1,152 | 0 | 1,152 | 1,152 | 1,152 | 1,152 | 1,152 | 1,152 | 1,152 | 1,152 | 1,152 |
| **Total Committed Providers** | **4,290** | **0** | **4,290** | **4,290** | **4,290** | **4,290** | **4,290** | **4,290** | **4,290** | **4,290** | **4,290** |
| **Percent Committed Providers(%)** | | **0.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** |

### Current File Uploads

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**Narrative Text :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

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

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1** All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy. | Project | N/A | In Progress | 04/01/2015 | 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 | | In Progress | 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 | | In Progress | 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 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. WMC PPS practitioner engagement and IDS teams reach out to potential new partners. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #2** Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS. | Project | N/A | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** PPS produces a list of participating HHs and ACOs. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** Participating HHs and ACOs demonstrate real service integration which | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS identifes Health Homes and assesses capabilities to underpin IDS including sharing systems and best practices. | Project | | In Progress | 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 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #3** Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Clinically Interoperable System is in place for all participating providers. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS trains staff on IDS protocols and processes. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** 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 | | In Progress | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #4** Ensure that all PPS safety net providers are actively sharing EHR systems with 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Non-PCP Practitioners | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Hospitals | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Skilled Nursing Facilities / Nursing Homes | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS uses alerts and secure messaging functionality. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS completes current state analysis of current EHR based | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality – High**

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| connections to RHIO. | | | | | | | |
| **Task** Step 3. PPS reviews and finalizes action plan. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Identify pilot partner/early adopter sites for QE connection. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Evaluate lessons learned from initial connections. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Plan phased implementation for network rollout. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 8. Implement Phase 1 of network rollout. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 9. Implement Phase 2 of network rollout. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 to activate functionality. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #5** Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** 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. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Provider | Safety Net Primary Care | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | | Physicians | | | | | |
| **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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Define functional reporting requirements for clinical projects. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Begin IT based population health reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2018 | DY3 Q4 |
| **Task** Primary care capacity increases improved access for patients seeking services - particularly in high-need areas. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards. | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.) | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment. | Project | | In Progress | 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 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 processes and services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #8** Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Medicaid Managed Care contract(s) are in place that include value-based payments. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS identifies and meets with MCOs doing business in our service area. | Project | | In Progress | 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 | | In Progress | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Identify lessons learned from PPS partner experiences with value based payment arrangements. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Per Financial Sustainability milestones contract with medicaid managed care organizations and other payors. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #9** Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| instituted. | | | | | | | |
| **Task** Step 1. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS and MCOs plan for sharing reports including establishing data sharing agreements. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. WMC PPS and MCOs establish a regular meeting schedule to review performance and develop action plans as appropriate. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #10** Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Providers receive incentive-based compensation consistent with DSRIP goals and objectives. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Review final State value-based payment roadmap with Finance and Executive Committees. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC aligns PPS payments for patient engagement for DSRIP projects. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Conduct current state assessment of value-based payment across all WMC PPS Participants. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Review baseline assessment of Participants' value-based payment | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

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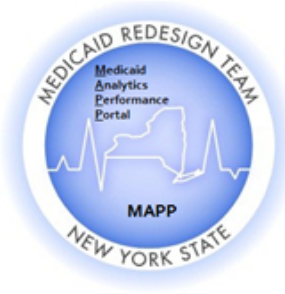| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| arrangements (and capabilities). | | | | | | | |
| **Task** Step 6. Conduct gap assessment to achieving stated goal of 90% within five years. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. PPS Draft VBP Plan, including MCO strategy, distributed for stakeholder feedback. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 8. WMC PPS establishes guidelines for calculating incentive payments. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 9. Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 10. WMC PPS working with performance reporting, network partners, and the MAPP development team, creates and deploys dashboards to support VBP. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #11** Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate. | Project | N/A | In Progress | 04/01/2015 | 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 | 12/31/2016 | DY2 Q3 |
| **Task** Step 1. Establish a Community Engagement Quality Advisory Committee. | Project | | Completed | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

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

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

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 identified process flow changes required to successfully implement IDS. | | | | | | | | | | |
| **Task** PPS has process for tracking care outside of hospitals to | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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 |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| requirements. | | | | | | | | | | |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task**<br>PPS uses alerts and secure messaging functionality. | | | | | | | | | | |
| **Task**<br>Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO. | | | | | | | | | | |
| **Task**<br>Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO. | | | | | | | | | | |
| **Task**<br>Step 3. PPS reviews and finalizes action plan. | | | | | | | | | | |
| **Task**<br>Step 4. Identify pilot partner/early adopter sites for QE connection. | | | | | | | | | | |
| **Task**<br>Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan. | | | | | | | | | | |
| **Task**<br>Step 6. Evaluate lessons learned from initial connections. | | | | | | | | | | |
| **Task**<br>Step 7. Plan phased implementation for network rollout. | | | | | | | | | | |
| **Task**<br>Step 8. Implement Phase 1 of network rollout. | | | | | | | | | | |
| **Task**<br>Step 9. Implement Phase 2 of network rollout. | | | | | | | | | | |
| **Task**<br>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**<br>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. | | | | | | | | | | |

**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** 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 of DY 3. | | | | | | | | | | |

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 payment arrangements across all WMC PPS participants. | | | | | | | | | | |

**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** 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 DSRIP projects. | | | | | | | | | | |

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements<br>(Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>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**<br>Step 4. Conduct current state assessment of value-based payment across all WMC PPS Participants. | | | | | | | | | | |
| **Task**<br>Step 5. Review baseline assessment of Participants' value-based payment arrangements (and capabilities). | | | | | | | | | | |
| **Task**<br>Step 6. Conduct gap assessment to achieving stated goal of 90% within five years. | | | | | | | | | | |
| **Task**<br>Step 7. PPS Draft VBP Plan, including MCO strategy, distributed for stakeholder feedback. | | | | | | | | | | |
| **Task**<br>Step 8. WMC PPS establishes guidelines for calculating incentive payments. | | | | | | | | | | |
| **Task**<br>Step 9. Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee. | | | | | | | | | | |
| **Task**<br>Step 10. WMC PPS working with performance reporting, network partners, and the MAPP development team, creates and deploys dashboards to support VBP. | | | | | | | | | | |
| **Milestone #11**<br>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**<br>Community health workers and community-based organizations utilized in IDS for outreach and navigation activities. | | | | | | | | | | |
| **Task**<br>Step 1. Establish a Community Engagement Quality Advisory Committee. | | | | | | | | | | |
| **Task**<br>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 | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **Task** Step 1. WMC PPS customizes Salesforce to support IDS network; establish provider type, geographic, and other | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **Milestone #3** Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |

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

**DSRIP Implementation Plan Project**

**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 | 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** 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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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** <br> Step 9. Implement Phase 2 of network rollout. | | | | | | | | | | |
| **Task** <br> 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** <br> 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** <br> EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | | | | | | | | | | |
| **Task** <br> PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** <br> 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** <br> Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider. | | | | | | | | | | |
| **Task** <br> 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** <br> 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** <br> PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task** <br> Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking. | | | | | | | | | | |
| **Task** <br> Step 2. Define functional reporting requirements for clinical projects. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 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 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. | | | | | | | | | | |

DSRIP Implementation Plan Project

## 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 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 | | | | | | | | | | |

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

## 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**<br>Step 1. Establish a Community Engagement Quality Advisory Committee. | | | | | | | | | | |
| **Task**<br>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**<br>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**<br>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**<br>Step 5. WMC PPS creates staffing plan to support patient engagement including documented human resource/workforce needs & reporting relationships. | | | | | | | | | | |
| **Task**<br>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 Name | Description | Upload Date |
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| No Records Found | | | | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**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 | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| an integrated system and establish value-based payment arrangements. | |
| Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform. | |
| Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes. | |
| Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate. | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

 **IPQR Module 2.a.i.4 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

## PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
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## PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
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DSRIP Implementation Plan Project

**Westchester Medical Center (PPS ID:21)**

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

**Instructions :**

**New York State Department Of Health**

**Delivery System Reform Incentive Payment Project**

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**Run Date :** 09/24/2015

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**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

DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

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.

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.a.iii.2 - Project Implementation Speed**

**Instructions :**

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

| Benchmarks |
| --- |
| **100% Total Committed By** |
| DY3,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
| Primary Care Physicians | 524 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-PCP Practitioners | 1,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Clinics | 29 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Home / Care Management | 27 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Behavioral Health | 75 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Substance Abuse | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pharmacies | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Based Organizations | 68 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All Other | 295 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Committed Providers** | **2,031** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Percent Committed Providers(%)** | | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** |

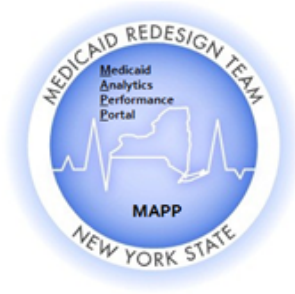| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Primary Care Physicians | 524 | 0 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 |
| Non-PCP Practitioners | 1,000 | 0 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 |
| Clinics | 29 | 0 | 29 | 29 | 29 | 29 | 29 | 29 | 29 | 29 | 29 |
| Health Home / Care Management | 27 | 0 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 |
| Behavioral Health | 75 | 0 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |

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

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Substance Abuse | 9 | 0 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |
| Pharmacies | 4 | 0 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Community Based Organizations | 68 | 0 | 68 | 68 | 68 | 68 | 68 | 68 | 68 | 68 | 68 |
| All Other | 295 | 0 | 295 | 295 | 295 | 295 | 295 | 295 | 295 | 295 | 295 |
| **Total Committed Providers** | **2,031** | **0** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** |
| **Percent Committed Providers(%)** | | **0.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** |

## Current File Uploads

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

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

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 500 | 1,000 | 5,000 | 600 | 4,000 | 5,000 | 10,000 | 750 | 7,500 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **2.50** | **5.00** | **25.00** | **3.00** | **20.00** | **25.00** | **50.00** | **3.75** | **37.50** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 10,000 | 20,000 | 800 | 8,000 | 10,000 | 20,000 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **50.00** | **100.00** | **4.00** | **40.00** | **50.00** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

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**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

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

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1**<br>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 | 03/31/2017 | DY2 Q4 |
| **Task**<br>A clear strategic plan is in place which includes, at a minimum:<br>- Definition of the Health Home  At-Risk Intervention Program<br>- 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 | 03/31/2017 | DY2 Q4 |
| **Task**<br>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 | | In Progress | 06/30/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task**<br>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 | 03/31/2016 | DY1 Q4 |
| **Task**<br>Step 3. In consultation with PMO and HHPAQC develop staffing, training and implementation plan including roles of PCMH PCPs and HHs. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #2**<br>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 | Project | N/A | In Progress | 05/15/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| Demonstration Year (DY) 3. | | | | | | | |
| **Task** All practices meet NCQA 2014 Level 3 PCMH and APCM standards | Provider | Primary Care Physicians | In Progress | 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 | | In Progress | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #3** Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Non-PCP Practitioners | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Health Home / Care Management | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS uses alerts and secure messaging functionality. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| Step 3. PPS reviews and finalizes action plan. | | | | | | | |
| **Task** Step 4. Plan phased implementation for network rollout. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 08/17/2018 | 09/30/2018 | DY4 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). | Project | | In Progress | 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 Primary Care Physicians | In Progress | 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 current PCMH/APC certification if any and EHR and MU capabilities. | Project | | In Progress | 08/10/2015 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. WMC PPS creates roadmap for data sharing and reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Report and track actively engaged patients. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2018 | DY3 Q4 |
| **Task** Procedures to engage at-risk patients with care management plan instituted. | Project | | In Progress | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 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 evidence based literature and best practices for candidate care management plans, tools, components. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. In consultation with PMO and HHPAQC develop staffing, trianing and implementation plan including roles of PCMH PCPs and HHs. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. In consultation with partner organizations and PMO the HHPAQC will identify or develop metrics to assess success of project implementation. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #7** Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles | Project | N/A | In Progress | 09/15/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

**NYS Confidentiality** – **High**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| and responsibilities for both parties. | | | | | | | |
| **Task** Each identified PCP establish partnerships with the local Health Home for care management services. | Provider | Primary Care Physicians | In Progress | 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 | Health Home / Care Management | In Progress | 09/15/2015 | 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 (a workgroup of the WMC PPS Quality Committee), identify appropriate Health Home partners to provide care management services. | Project | | In Progress | 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 | 03/31/2016 | DY1 Q4 |
| **Task** Step 3. Explore successful models for information sharing between PCPs and Health Homes. | Project | | In Progress | 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has established partnerships to medical, behavioral health, and social services. | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has established partnerships to medical, behavioral health, and social services. | Provider | Health Home / Care Management | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS uses EHRs and HIE system to facilitate and document partnerships with needed services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Meet with Health Homes to assess capacity and links to other care providers: medical, behavioral health, social services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Meet with partners to share experiences and identify gaps and opportunities. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Identify by provider type and project role the clinical information to be shared among providers | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Create roadmap for data sharing and reporting | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Plan training for appropiate partners and staff | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #9** Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has included social services agencies in development of risk reduction and care practice guidelines. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Plan phased roll out of culturally competent materials adapted to local considerations. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program. | | | | | | | | | | |
| **Task** A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home  At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs | | | | | | | | | | |
| **Task** 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. | | | | | | | | | | |

## 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** 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 |

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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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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. 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 | | | | | | | | | | |

**NYS Confidentiality** – **High**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| transformation vendor creates an action plan for PCMH eligible 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 | | | | | | | | | | |

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Westchester Medical Center (PPS ID:21)

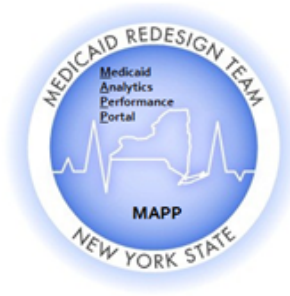| Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| staffing, trianing and implementation plan including roles of PCMH PCPs and HHs. | | | | | | | | | | |
| **Task** Step 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 | 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). | | | | | | | | | | |

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Task** PPS has established partnerships to medical, behavioral health, and social services. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** PPS has established partnerships to medical, behavioral health, and social services. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** PPS uses EHRs and HIE system to facilitate and document partnerships with needed services. | | | | | | | | | | |
| **Task** 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. | | | | | | | | | | |

**NYS Confidentiality** – **High**

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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. | | | | | | | | | | |

| Project 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 | | | | | | | | | | |

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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. 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 | 0 | 203 | 203 | 203 | 203 | 203 | 203 | 203 | 203 | 203 |

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| and/or APCM. | | | | | | | | | | |
| **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 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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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** 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 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. | | | | | | | | | | |

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

**DSRIP Implementation Plan Project**

**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 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 |
| **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 | | | | | | | | | | |

**NYS Confidentiality – High**

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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. | | | | | | | | | | |

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

### DSRIP Implementation Plan Project

### Westchester Medical Center (PPS ID:21)

#### Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

#### Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Develop 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. | As detailed in 2aiii Milestone 2, step 4, 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 & NCQA Level 3 PCMH standards. |
| 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 | |

**NYS Confidentiality** – **High**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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. | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.a.iii.5 - PPS Defined Milestones**

**Instructions :**

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

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

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### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

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Delivery System Reform Incentive Payment Project

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**Run Date :** 09/24/2015

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

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

**Instructions :**

Milestone 4: The IA suggests PPS to provide technical assistance towards achieving MU Stage 2 CMS requirements & NCQA Level 3 PCMH standards and/or APCM.

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

## 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.

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.a.iv.2 - Project Implementation Speed**

**Instructions :**

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

| Benchmarks |
|---|
| **100% Total Committed By** |
| DY4,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
| Expected Number of Medical Villages Established | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Committed Providers** | **2** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Percent Committed Providers(%)** | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Expected Number of Medical Villages Established | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 2 | 2 | 2 |
| **Total Committed Providers** | **2** | **0** | **0** | **0** | **0** | **0** | **2** | **2** | **2** | **2** | **2** |
| **Percent Committed Providers(%)** | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
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| No Records Found | | | |

**Narrative Text :**

## DSRIP Implementation Plan Project

### Westchester Medical Center (PPS ID:21)

✅ **IPQR Module 2.a.iv.3 - Patient Engagement Speed**

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 600 | 0 | 2,000 | 0 | 2,200 | 0 | 6,000 | 0 | 3,500 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **5.00** | **0.00** | **16.67** | **0.00** | **18.33** | **0.00** | **50.00** | **0.00** | **29.17** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 9,450 | 0 | 4,400 | 0 | 12,000 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **78.75** | **0.00** | **36.67** | **0.00** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

### Current File Uploads

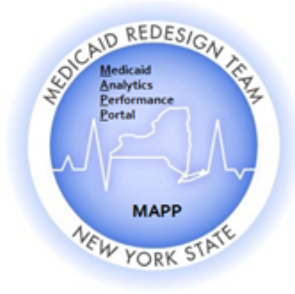| User ID | File Name | File Description | Upload Date |
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| No Records Found | | | |

**Narrative Text :**

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.a.iv.4 - Prescribed Milestones**

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1** 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 | 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 | 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 | 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 | 11/05/2015 | 12/31/2015 | DY1 Q3 |
| **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 | | In Progress | 04/01/2015 | 11/05/2015 | 12/31/2015 | DY1 Q3 |
| **Task** Step 3. Convene Medical Village Project team to review project plan, implementation timelines and deliverables against submitted capital Restructuring Financing Program submissions. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Once CRFP is approved, make adjustments to Medical Village | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Plan community presentations as town hall type review that will be open to neighbors and stakeholders. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Complete and submit Certificate of Need (CON) for bed reduction. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Once CON approved, maintain baseline bed capacity and periodic progress reports documenting bed reduction. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2018 | DY3 Q4 |
| **Task** All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment. | Provider | Primary Care Physicians | In Progress | 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 . | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

## Westchester Medical Center (PPS ID:21)

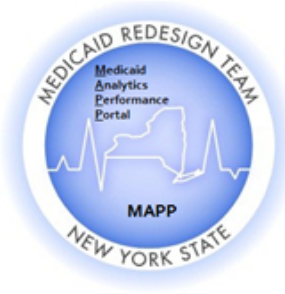| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| provider type, as well as current PCMH certification if any and EHR and MU capabilities. | | | | | | | |
| **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. | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Non-PCP Practitioners | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Hospitals | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. PPS reviews and finalizes action plan. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Identify pilot partner/early adopter sites for QE connection. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Evaluate lessons learned from initial connections. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Plan phased implementation for network rollout. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 8. Implement Phase 1 of network rollout. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #5** Use EHRs and other technical platforms to track all patients engaged in the project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 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 | 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 | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** Step 4. Begin IT based population health reporting. | Project | | In Progress | 12/31/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #6** Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. WMC PPS, based on findings of current state assessment finalizes | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | N/A | In Progress | 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 | 03/31/2017 | DY2 Q4 |
| **Task** Step 1. Review Community Needs Assessment to determine migration plan. | Project | | In Progress | 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 | 03/31/2017 | DY2 Q4 |
| **Task** Step 3. Policies and procedures are developed to determine  the frequency of updates to guidelines and protocols. | Project | | In Progress | 02/10/2017 | 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** 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 | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| standards. | | | | | | | | | | |
| **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. | | | | | | | | | | |
| **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. | | | | | | | | | | |
| **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. | | | | | | | | | | |

**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** 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

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DSRIP Implementation Plan Project

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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

## 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**<br>Step 3. Once CON approved, maintain baseline bed capacity and periodic progress reports documenting bed reduction. | | | | | | | | | | |
| **Milestone #3**<br>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**<br>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task**<br>Step 1. WMC PPS issues RFP for vendor to do a PCMH readiness assessment. | | | | | | | | | | |
| **Task**<br>Step 2. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH . | | | | | | | | | | |
| **Task**<br>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**<br>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**<br>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**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task**<br>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

**DSRIP Implementation Plan Project**

**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 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 #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. | | | | | | | | | | |

**NYS Confidentiality – High**

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

### DSRIP Implementation Plan Project

### 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 #6**<br>Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2 | | | | | | | | | | |
| **Task**<br>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | | | | | | | | | | |
| **Task**<br>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**<br>Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider. | | | | | | | | | | |
| **Task**<br>Step 3. WMC PPS, based on findings of current state assessment finalizes plan for procuring and rolling out certified EHRs. | | | | | | | | | | |
| **Milestone #7**<br>Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment. | | | | | | | | | | |
| **Task**<br>Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.). | | | | | | | | | | |
| **Task**<br>Step 1. Review Community Needs Assessment to determine migration plan. | | | | | | | | | | |
| **Task**<br>Step 2. Develop guidelines and protocols to ensure appropriate migration. | | | | | | | | | | |
| **Task**<br>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 Name | Description | Upload Date |
|---|---|---|---|---|
| No Records Found | | | | |

**NYS Confidentiality** – **High**

## Westchester Medical Center (PPS ID:21)

**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 | Response to IA Remediation Feedback (Milestone on HOLD; MAPP does not allow user to add tasks while milestone on HOLD; PPS plans to incorporate changes as soon as milestone started): <br><br> PPS will include procedures to monitor progress in meeting meaningful use requirements. The PPS will facilitate technical assistance and workforce training. The Current State Assessment and workforce survey will provide insight into the necessary technical assistance and training. |
| Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment. | |

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.a.iv.5 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

No Records Found

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**IPQR Module 2.a.iv.6 - IA Monitoring**

**Instructions :**

Milestone 6: The IA suggests for PPS to include procedures to monitor progress in meeting standards, technical assistance and workforce development in order to meet requirements. Plan should include narrative text

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

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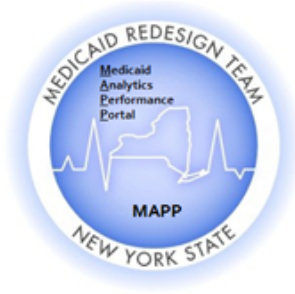
**New York State Department Of Health**
**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.b.iv.2 - Project Implementation Speed**

**Instructions :**

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

| Benchmarks |
|---|
| **100% Total Committed By** |
| DY3,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
| Primary Care Physicians | 524 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-PCP Practitioners | 1,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hospitals | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Home / Care Management | 27 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Based Organizations | 64 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All Other | 437 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Committed Providers** | **2,066** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Percent Committed Providers(%)** | | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Primary Care Physicians | 524 | 0 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 |
| Non-PCP Practitioners | 1,000 | 0 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 |
| Hospitals | 14 | 0 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 |
| Health Home / Care Management | 27 | 0 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 |
| Community Based Organizations | 64 | 0 | 64 | 64 | 64 | 64 | 64 | 64 | 64 | 64 | 64 |
| All Other | 437 | 0 | 437 | 437 | 437 | 437 | 437 | 437 | 437 | 437 | 437 |
| **Total Committed Providers** | **2,066** | **0** | **2,066** | **2,066** | **2,066** | **2,066** | **2,066** | **2,066** | **2,066** | **2,066** | **2,066** |
| **Percent Committed Providers(%)** | | **0.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

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

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 250 | 300 | 1,000 | 300 | 1,200 | 1,500 | 2,800 | 400 | 1,750 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **4.46** | **5.36** | **17.86** | **5.36** | **21.43** | **26.79** | **50.00** | **7.14** | **31.25** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 2,100 | 5,600 | 500 | 2,200 | 2,500 | 5,600 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **37.50** | **100.00** | **8.93** | **39.29** | **44.64** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

## Current File Uploads

| User ID | File Name | File Description | Upload Date |
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| No Records Found | | | |

**Narrative Text :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

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

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency. | Project | N/A | In Progress | 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 | 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 | 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 | 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 | 06/30/2016 | DY2 Q1 |
| **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. | Project | | In Progress | 08/17/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #2** | Project | N/A | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

**NYS Confidentiality – High**

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | 03/31/2018 | DY3 Q4 |

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #3** Ensure required social services participate in the project. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Required network social services, including medically tailored home food services, are provided in care transitions. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 referrals for use by care managers, hospitals, primary care and other network providers. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #4** Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Policies and procedures are in place for early notification of planned discharges. | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Policies and procedures are in place for early notification of planned discharges. | Provider | Non-PCP Practitioners | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Policies and procedures are in place for early notification of planned discharges. | Provider | Hospitals | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to notify of planned discharges and | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

## Westchester Medical Center (PPS ID:21)

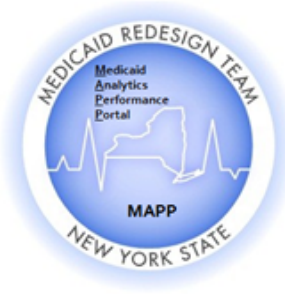| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| provide care manager visit prior to discharge to provide transition services. | | | | | | | |
| **Task** 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #5** Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS completes current state analysis of current EHR based connections to RHIO. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #6** Ensure that a 30-day transition of care period is established. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Phased roll out of best practices/protocols/ guidelines/standards will include a 30 day transition period. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #7** Use EHRs and other technical platforms to track all patients engaged in the project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **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 | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** Step 2. Define functional reporting requirements for care transition project. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. WMC PPS creates roadmap for data sharing and reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Begin reporting to track all activated patients. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| record. | | | | | | | | | | |
| **Task**<br>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**<br>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**<br>A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes. | | | | | | | | | | |
| **Task**<br>Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes. | | | | | | | | | | |
| **Task**<br>PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA. | | | | | | | | | | |
| **Task**<br>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**<br>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**<br>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**<br>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. | | | | | | | | | | |

**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** 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. | | | | | | | | | | |
| **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 |

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 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. | | | | | | | | | | |

**NYS Confidentiality** – **High**

**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** 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. | | | | | | | | | | |
| **Task** Step 4. Begin reporting to track all activated patients. | | | | | | | | | | |

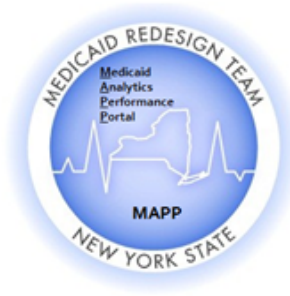| Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, 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 | | | | | | | | | | |

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

### DSRIP Implementation Plan Project

### 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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. | | | | | | | | | | |

**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 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. | | | | | | | | | | |
| **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 referrals 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 | | | | | | | | | | |

**DSRIP Implementation Plan Project**

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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 | | | | | | | | | | |

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

### DSRIP Implementation Plan Project

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **Task** Step 4. Begin reporting to track all activated patients. | | | | | | | | | | |

## Prescribed Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

## Prescribed Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| Develop standardized protocols for a Care Transitions Intervention Model with all participating | |

**NYS Confidentiality – High**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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. | Response to IA Remediation Feedback (Milestone on HOLD; MAPP does not allow user to add tasks while milestone on HOLD; PPS plans to incorporate changes as soon as milestone started):<br><br>As described in M1, S1 and M1, S2 in this project we will convene providers, from different care settings, under the auspices of the project advisory quality committee to identify appropriate evidence based literature and best practices addressing care transitions.  As described in M1, S2 the committee will review and discuss the candidate best best practices/protocols/guidelines/standards. This includes defining the specific information and clinical data between sending and receiving providers as the patient goes from one care setting to another to be part of the care transition record. We are aware of NTOCC and will include the NTOCC ToolBox among literature reviewed. |
| 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. | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.b.iv.5 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

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

DSRIP Implementation Plan Project

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**Run Date :** 09/24/2015

Westchester Medical Center (PPS ID:21)

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

**Instructions :**

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

**Westchester Medical Center (PPS ID:21)**

**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.

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 2.d.i.2 - Project Implementation Speed**

**Instructions :**

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

| Benchmarks |
| --- |
| **100% Total Committed By** |
| DY2,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | **DY1,Q1** | **DY1,Q2** | **DY1,Q3** | **DY1,Q4** | **DY2,Q1** | **DY2,Q2** | **DY2,Q3** | **DY2,Q4** | **DY3,Q1** | **DY3,Q2** |
| PAM(R) Providers | 275 | 0 | 3 | 20 | 80 | 120 | 160 | 200 | 275 | 275 | 275 |
| **Total Committed Providers** | **275** | **0** | **3** | **20** | **80** | **120** | **160** | **200** | **275** | **275** | **275** |
| **Percent Committed Providers(%)** | | **0.00** | **1.09** | **7.27** | **29.09** | **43.64** | **58.18** | **72.73** | **100.00** | **100.00** | **100.00** |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | **DY3,Q3** | **DY3,Q4** | **DY4,Q1** | **DY4,Q2** | **DY4,Q3** | **DY4,Q4** | **DY5,Q1** | **DY5,Q2** | **DY5,Q3** | **DY5,Q4** |
| PAM(R) Providers | 275 | 275 | 275 | 275 | 275 | 275 | 275 | 275 | 275 | 275 | 275 |
| **Total Committed Providers** | **275** | **275** | **275** | **275** | **275** | **275** | **275** | **275** | **275** | **275** | **275** |
| **Percent Committed Providers(%)** | | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** |

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

## Delivery System Reform Incentive Payment Project

### DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

### ✅ IPQR Module 2.d.i.3 - Patient Engagement Speed

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 5,000 | 5,001 | 12,000 | 5,000 | 10,000 | 10,001 | 25,000 | 5,000 | 20,000 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **6.13** | **6.14** | **14.72** | **6.13** | **12.27** | **12.27** | **30.67** | **6.13** | **24.54** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 20,001 | 45,000 | 5,000 | 30,000 | 30,001 | 81,500 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **24.54** | **55.21** | **6.13** | **36.81** | **36.81** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

### Current File Uploads

| User ID | File Name | File Description | Upload Date |
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| No Records Found | | | |

**Narrative Text :**

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

✅ **IPQR Module 2.d.i.4 - Prescribed Milestones**

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1** 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 | 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 | 04/01/2015 | 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 | 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 | 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 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | 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. | Project | N/A | In Progress | 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 | 03/31/2016 | DY1 Q4 |
| **Task** Step 1. Conduct trainings with Core PAM Team. | Project | | In Progress | 06/01/2015 | 08/11/2015 | 09/30/2015 | DY1 Q2 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **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 | 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 | 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 | 03/31/2017 | DY2 Q4 |
| **Task** Step 2. Collaborate with CBOs through the (Community Engagement Quality Advisory) Committee as per Milestone 1 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #4** Survey the targeted population about healthcare needs in the PPS' region. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Community engagement forums and other information-gathering mechanisms established and performed. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers". | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **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 | 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 | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 2. WMC PPS and MCOs plan for sharing reports to help reconnect benificaries to designated PCPs including establishing data sharing agreements. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 3. Review with respective MCOs and PCPs outreach materials. | Project | | In Progress | 04/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

**NYS Confidentiality – High**

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #8** Include beneficiaries in development team to promote preventive care. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #9** Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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DSRIP Implementation Plan Project

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| he/she visits the PPS designated facility or "hot spot" area for health service. <br> • 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. <br> • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. <br> • The cohort must be followed for the entirety of the DSRIP program. <br> • 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. <br> • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. <br> • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. <br> • 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** <br> Performance measurement reports established, including but not limited to: <br> - Number of patients screened, by engagement level <br> - Number of clinicians trained in PAM(R) survey implementation <br> - Number of  patient: PCP bridges established <br> - Number of  patients identified, linked by MCOs to which they are associated <br> - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis <br> - Member engagement lists to DOH (for NU & LU populations) on a monthly basis <br> - Annual report assessing individual member and the overall cohort's level of engagement | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** <br> 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** <br> Step 2. Based on MAPP portal data, WMC PPS identifies MCOs whose | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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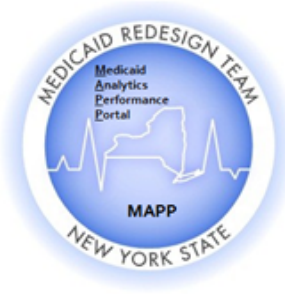| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| members have been attributed to our PPS (see Milestone #6) | | | | | | | |
| **Task** Step 3. As 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 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Generate reports and submit to Department of Health | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Volume of non-emergent visits for UI, NU, and LU populations increased. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Community navigators identified and contracted. | Provider | PAM(R) Providers | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Contract with CBOs as described in Milestone 1 | Provider | PAM(R) Providers | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Develop preliminary training strategy (e.g., scale, timing, scope, | Provider | PAM(R) Providers | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #12** Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Policies and procedures for customer service complaints and appeals developed. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS will follow WMC policy on Patient Complaints and Grievances, policy # RI-11A. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** List of community navigators formally trained in the PAM(R). | Provider | PAM(R) Providers | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Core team will train community navigators who will be responsible for performing PAM. | Provider | PAM(R) Providers | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | Provider | PAM(R) Providers | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** | Provider | PAM(R) Providers | In Progress | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

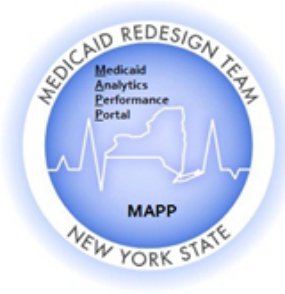| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas. | | | | | | | |
| **Task** Step 1. Identify hot spots as indicated in Milestone 3 | Provider | PAM(R) Providers | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 2. Train navigators as indicated in Milestone 5, 11 and 13 | Provider | PAM(R) Providers | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 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. | Provider | PAM(R) Providers | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #15** Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Navigators educated about insurance options and healthcare resources available to populations in this project. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Train navigators as indicated in Milestones 5, 11, 13 and 14 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Timely access for navigator when connecting members to services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Plan training for navigators on care transition protocols | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Follow care transition strategy as outlined in 2biv Milestone #2 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 08/01/2015 | 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. | Project | | In Progress | 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 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| to management of EHRs. | | | | | | | |
| **Task** Step 3. WMC PPS creates roadmap for data sharing and reporting to support population health analytics. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Begin IT based population health reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

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

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

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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 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** 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. | | | | | | | | | | |

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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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

**NYS Confidentiality** – **High**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| access factors and   effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective. | | | | | | | | | | |
| **Milestone #9**<br>Measure PAM(R) components, including:<br>• 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.<br>• 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.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• 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.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• 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**<br>Performance measurement reports established, including but not limited to:<br>- Number of patients screened, by engagement level<br>- Number of clinicians trained in PAM(R) survey implementation<br>- Number of  patient: PCP bridges established<br>- Number of  patients identified, linked by MCOs to which they are associated<br>- Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis<br>- Member engagement lists to DOH (for NU & LU populations) on a monthly basis<br>- Annual report assessing individual member and the overall cohort's level of engagement | | | | | | | | | | |

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** Community navigators trained in connectivity to healthcare | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| coverage and community healthcare resources, (including primary and preventive services), as well as patient education. | | | | | | | | | | |
| **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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **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 | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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 | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | | | | | | |
| **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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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. 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 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 | | | | | | | | | | |

**New York State Department Of Health**
**Delivery System Reform Incentive Payment 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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** 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 | | | | | | | | | | |

**NYS Confidentiality – High**

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

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|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **Task** Step 1. The Community Engagement Quality Advisory Committee through the local deployment council will provide oversight to include beneficiaries in the development process. | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|
| **Task**<br>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**<br>Measure PAM(R) components, including:<br>• 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.<br>• 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.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• 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.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• 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**<br>Performance measurement reports established, including but not limited to:<br>- Number of patients screened, by engagement level<br>- Number of clinicians trained in PAM(R) survey implementation<br>- Number of  patient: PCP bridges established<br>- Number of  patients identified, linked by MCOs to which they are associated<br>- Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis<br>- Member engagement lists to DOH (for NU & LU populations) | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| on a monthly basis<br>- Annual report assessing individual member and the overall cohort's level of engagement | | | | | | | | | | |
| **Task**<br>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**<br>Step 2. Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS (see Milestone #6) | | | | | | | | | | |
| **Task**<br>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**<br>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**<br>Step 5. Generate reports and submit to Department of Health | | | | | | | | | | |
| **Milestone #10**<br>Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons. | | | | | | | | | | |
| **Task**<br>Volume of non-emergent visits for UI, NU, and LU populations increased. | | | | | | | | | | |
| **Task**<br>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**<br>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**<br>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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

## 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** Community navigators identified and contracted. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **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 | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## 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 #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 | | | | | | | | | | |
| **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 | | | | | | | | | | |

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**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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. | |
| 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 | |

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**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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).<br>• 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.<br>• 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:<br>• 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.<br>• If the beneficiary is UI, does not have a registered | |

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**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.<br>• Individual member's score must be averaged to calculate a baseline measure for that year's cohort.<br>• The cohort must be followed for the entirety of the DSRIP program.<br>• 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.<br>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.<br>• PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes.<br>• 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. | |

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**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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. | |
| 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. | |

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☑ **IPQR Module 2.d.i.5 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

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**Westchester Medical Center (PPS ID:21)**

**IPQR Module 2.d.i.6 - IA Monitoring**

**Instructions :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

## 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.

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#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

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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 - Project Implementation Speed

**Instructions :**

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

| Benchmarks |
|---|
| **100% Total Committed By** |
| DY3,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
| Primary Care Physicians | 100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-PCP Practitioners | 100 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Clinics | 25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Behavioral Health | 115 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Substance Abuse | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Based Organizations | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| All Other | 200 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Committed Providers** | **571** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Percent Committed Providers(%)** | | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Primary Care Physicians | 100 | 0 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Non-PCP Practitioners | 100 | 0 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Clinics | 25 | 0 | 25 | 25 | 25 | 25 | 25 | 25 | 25 | 25 | 25 |
| Behavioral Health | 115 | 0 | 115 | 115 | 115 | 115 | 115 | 115 | 115 | 115 | 115 |
| Substance Abuse | 11 | 0 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 |
| Community Based Organizations | 20 | 0 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 |
| All Other | 200 | 0 | 200 | 200 | 200 | 200 | 200 | 200 | 200 | 200 | 200 |

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### DSRIP Implementation Plan Project

### Westchester Medical Center (PPS ID:21)

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Total Committed Providers | 571 | 0 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 |
| Percent Committed Providers(%) | | 0.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |

### Current File Uploads

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

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

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 2,000 | 2,500 | 5,000 | 1,000 | 5,000 | 6,000 | 12,000 | 2,000 | 9,000 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **6.45** | **8.06** | **16.13** | **3.23** | **16.13** | **19.35** | **38.71** | **6.45** | **29.03** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 10,000 | 23,000 | 5,000 | 19,000 | 20,000 | 31,000 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **32.26** | **74.19** | **16.13** | **61.29** | **64.52** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

**New York State Department Of Health**
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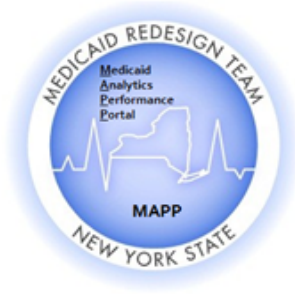**Westchester Medical Center (PPS ID:21)**

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

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| **Milestone #1** Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3. | Model 1 | Project | N/A | In Progress | 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 | Primary Care Physicians | In Progress | 05/15/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
| **Task** Behavioral health services are co-located within PCMH/APC practices and are available. | | Provider | Behavioral Health | In Progress | 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 | | In Progress | 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 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #2** | Model 1 | Project | N/A | In Progress | 05/18/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| 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. | | Project | | In Progress | 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 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3.Compare status of current practice among participating partners   to identified best practices | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #3** Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | Model 1 | Project | N/A | In Progress | 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 | 03/31/2018 | DY3 Q4 |

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| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| **Task** Screenings are documented in Electronic Health Record. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** 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 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task** Step 2. Assess barriers to screening,  to  completing "warm transfer" for patients screening positive and  to recording screening and transfer in EHR. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 of credentials and experience relevant to the project. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Summarize lessons learned from early adoption sites, | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality – High**

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| 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. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Agree to collaborate with other PPSs toshare best practices, educationalmaterials, training strategies and strategies to overcome project implementation barriers. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #4** Use EHRs or other technical platforms to track all patients engaged in this project. | Model 1 | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** EHR demonstrates integration of medical and behavioral health record within individual patient records. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | Project | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **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 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** Step 2. Identify by provider type and project role the clinical information to be shared among providers. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Create roadmap for data sharing and reporting using platform to support population health analytics. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #5** | Model 2 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| 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. | | Provider | Primary Care Physicians | On Hold | 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 | Primary Care Physicians | On Hold | 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 | Behavioral Health | On Hold | 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 | 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 | 03/31/2020 | DY5 Q4 |
| **Task** Coordinated evidence-based care protocols are in place, including a medication management and care engagement process. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #7** Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs. | Model 2 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Screenings are documented in Electronic Health Record. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record. | | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #8** | Model 2 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

DSRIP Implementation Plan Project

Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| 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. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #9** Implement IMPACT Model at Primary Care Sites. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has implemented IMPACT Model at Primary Care Sites. | | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #10** Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager. | | Project | | On Hold | 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 | 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 | 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 | 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 | 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 | 03/31/2020 | DY5 Q4 |

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|---|
| **Task** All IMPACT participants in PPS have a designated Psychiatrist. | | Project | | On Hold | 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 | 03/31/2020 | DY5 Q4 |
| **Task** At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT). | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #14** Provide "stepped care" as required by the IMPACT Model. | Model 3 | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** 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 | 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 | 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 | 03/31/2020 | DY5 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

| Project 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 | | | | | | | | | | |

**NYS Confidentiality – High**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| APC model readiness assessment. | | | | | | | | | | |
| **Task**<br>Step 2. Conduct current state analysis of BH services, if any, at PPS participating primary care sites & identifies co-location staffing needs. | | | | | | | | | | |
| **Task**<br>Step 3. WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH or APC model. | | | | | | | | | | |
| **Task**<br>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**<br>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**<br>Develop collaborative evidence-based standards of care including medication management and care engagement process. | | | | | | | | | | |
| **Task**<br>Regularly scheduled formal meetings are held to develop collaborative care practices. | | | | | | | | | | |
| **Task**<br>Coordinated evidence-based care protocols are in place, including medication management and care engagement processes. | | | | | | | | | | |
| **Task**<br>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**<br>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. | | | | | | | | | | |

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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) 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 | | | | | | | | | | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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, 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. | | | | | | | | | | |

**NYS Confidentiality – High**

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 |
| **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 | | | | | | | | | | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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. | | | | | | | | | | |

**NYS Confidentiality – High**

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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** 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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 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 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 | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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) 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. | | | | | | | | | | |

## 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**<br>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**<br>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**<br>Step 7. Summarize lessons learned from early adoption sites, through discussions among partners in local deployment workgroups. | | | | | | | | | | |
| **Task**<br>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**<br>Step 5. Agree to collaborate with other PPSs toshare best practices, educationalmaterials, training strategies and strategies to overcome project implementation barriers. | | | | | | | | | | |
| **Milestone #4**<br>Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task**<br>EHR demonstrates integration of medical and behavioral health record within individual patient records. | | | | | | | | | | |
| **Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |
| **Task**<br>Step 1. Implement interim reporting tool for DSRIP milestone reporting and performance taking into account all project compliant services for DY1. | | | | | | | | | | |
| **Task**<br>Step 2. Identify by provider type and project role the clinical information to be shared among providers. | | | | | | | | | | |
| **Task**<br>Step 3. Create roadmap for data sharing and reporting using | | | | | | | | | | |

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

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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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 |
| **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 | | | | | | | | | | |

**NYS Confidentiality** – **High**

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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. | | | | | | | | | | |

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**DSRIP Implementation Plan Project**

**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 #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** 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 Name | Description | Upload Date |
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**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. | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**Prescribed Milestones Narrative Text**

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 3.a.i.5 - PPS Defined Milestones**

**Instructions :**

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

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

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### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

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Westchester Medical Center (PPS ID:21)

**IPQR Module 3.a.i.6 - IA Monitoring**

**Instructions :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

## 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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**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 3.a.ii.2 - Project Implementation Speed**

**Instructions :**

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

| Benchmarks |
|---|
| **100% Total Committed By** |
| DY3,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **DY1,Q1** | **DY1,Q2** | **DY1,Q3** | **DY1,Q4** | **DY2,Q1** | **DY2,Q2** | **DY2,Q3** | **DY2,Q4** | **DY3,Q1** | **DY3,Q2** |
| Expected Number of Crisis Intervention Programs Established | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Committed Providers** | **7** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Percent Committed Providers(%)** | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **DY3,Q3** | **DY3,Q4** | **DY4,Q1** | **DY4,Q2** | **DY4,Q3** | **DY4,Q4** | **DY5,Q1** | **DY5,Q2** | **DY5,Q3** | **DY5,Q4** |
| Expected Number of Crisis Intervention Programs Established | 7 | 0 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| **Total Committed Providers** | **7** | **0** | **7** | **7** | **7** | **7** | **7** | **7** | **7** | **7** | **7** |
| **Percent Committed Providers(%)** | | 0.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

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**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

### ☑ IPQR Module 3.a.ii.3 - Patient Engagement Speed

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 150 | 151 | 500 | 100 | 250 | 251 | 750 | 300 | 1,000 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **4.76** | **4.79** | **15.87** | **3.17** | **7.94** | **7.97** | **23.81** | **9.52** | **31.75** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 1,001 | 2,000 | 400 | 1,200 | 500 | 3,150 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **31.78** | **63.49** | **12.70** | **38.10** | **15.87** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

### Current File Uploads

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

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

### DSRIP Implementation Plan Project

### Westchester Medical Center (PPS ID:21)

☑ **IPQR Module 3.a.ii.4 - Prescribed Milestones**

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1** 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 | 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 | 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 | | In Progress | 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 | 03/31/2018 | DY3 Q4 |
| **Task** Step 3. Convene HRD Behavioral Health Crisis Leadership Group | Project | | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task** Step 4. Work with counties to determine if gaps exist. | Project | | In Progress | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Plan for implementation of services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Monitor completeness of implementation plan. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Task** Step 6a: Apply road map to improve services implementation. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7a: Monitor road map/ implementation plan by county to determine if gaps in services and geographic areas are being addressed. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments). | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Convene the Project Advisory Committee to review and discuss best practices for diversion management processes. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3.PPS works with counties, health homes, and hospitals to review best practices for diversion management processes. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Compare status of current diversion practice among participating partners to identified best practices. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5: Plan phased rollout of diversion management processes. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Provide training resources for key personnel and finalize protocols. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Document diversion management  protocols. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #3** | Project | N/A | In Progress | 04/01/2015 | 03/31/2019 | 03/31/2019 | DY4 Q4 |

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | In Progress | 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 | 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 | | In Progress | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Review options for coverage through the HARPs and HCBS for Medicaid recipients. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 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 | 03/31/2017 | DY2 Q4 |
| **Task** Coordinated treatment care protocols are in place. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **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. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 2. Convene BHCAQC to review and discuss the best practice options for implementation. | Project | | In Progress | 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 | 03/31/2017 | DY2 Q4 |

# New York State Department Of Health
## Delivery System Reform Incentive Payment Project
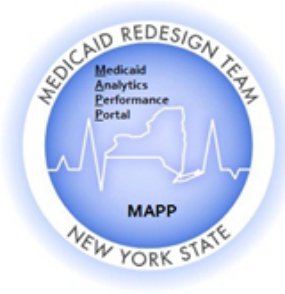
### DSRIP Implementation Plan Project

### Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Task** Step 4: Plan phased rollout of best practices adapted to local considerations. | Project | | In Progress | 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 | 03/31/2017 | DY2 Q4 |
| **Task** Step 6. Document treatment practices. | Project | | In Progress | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 Hospitals | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | Project | | In Progress | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2019 | DY4 Q4 |
| **Task** PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Provider | Safety Net Hospitals | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality – High**

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | | | | | | | |
| **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 Clinics | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 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 | 03/31/2018 | DY3 Q4 |
| **Task** Step 3. PPS will work to identify a hospital outpatient or off campus crisis residence that could provide an opportunity to provide access. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 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 | 03/31/2019 | DY4 Q4 |
| **Task** Coordinated evidence-based care protocols for mobile crisis teams are in place. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. In consultation with the Behavioral Health Crisis & Primary Care | Project | | In Progress | 07/01/2015 | 12/31/2018 | 12/31/2018 | DY4 Q3 |

**NYS Confidentiality – High**

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

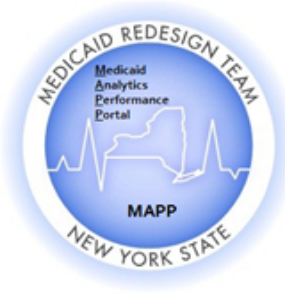| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| Integration Project Quality Advisory Committee (a workgroup of the WMC PPS Quality Committee), review 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Work with counties, the Hudson Region DSRIP (HRD) Leadership Group and providers to review practices and procedures. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4: Plan phased roll out of best practices and procedures adapted to local considerations. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Provide training resources for key personnel and finalize best practices and procedures. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Document evidence based protocols. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | On Hold | 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 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Non-PCP Practitioners | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Hospitals | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

**Westchester Medical Center (PPS ID:21)**

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. PPS reviews and finalizes action plan. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Identify pilot partner/early adopter sites for QE connection. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. In accordance with IT & Systems workstream, obtain PPS Board Approval:  Data Security and Confidentiality Plan. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Evaluate lessons learned from initial connections. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Plan phased implementation for network rollout. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 8. Implement Phase 1 of network rollout. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 9. Implement Phase 2 of network rollout. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2019 | DY4 Q4 |
| **Task** PPS has implemented central triage service among psychiatrists and behavioral health providers. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Work with communities to identify existing triage services within their jurisdiction. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task** Step 2. Identify gaps in existing triage services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Identify opportunities and partnerships to expand or better coordinate | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| triage services. | | | | | | | |
| **Task** Step 4. Work with partners to establish agreements for triage services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2017 | DY2 Q4 |
| **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. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Service and quality outcome measures are reported to all stakeholders including PPS quality committee. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality – High**

**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #11** Use EHRs or other technical platforms to track all patients engaged in this project. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS creates roadmap for data sharing and reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

**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** 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. | | | | | | | | | | |

**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** 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 | | | | | | | | | | |

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |

**NYS Confidentiality – High**

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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. | | | | | | | | | | |

**New York State Department Of Health**
**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |

**NYS Confidentiality – High**

# New York State Department Of Health
## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 | | | | | | | | | | |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | | | | | | |

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

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 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. | | | | | | | | | | |
| **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. | | | | | | | | | | |

**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** 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 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| implements improvement steps. | | | | | | | | | | |
| **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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

**NYS Confidentiality** – **High**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

DSRIP Implementation Plan Project

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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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** 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. | | | | | | | | | | |

**NYS Confidentiality – High**

## 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 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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 Name | Description | Upload Date |
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**DSRIP Implementation Plan Project**

## Westchester Medical Center (PPS ID:21)

### 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. | |

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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. | |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

 **IPQR Module 3.a.ii.5 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|

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**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**IPQR Module 3.a.ii.6 - IA Monitoring**

**Instructions :**

Milestone 1: The IA suggests that the PPS develop more detailed steps toward improved service implementation once the PPS determines gaps in terms of services and geographic areas.

**DSRIP Implementation Plan Project**

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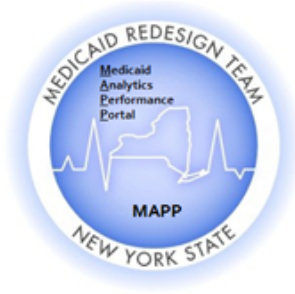
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PPS based project management, analytics, and care management platforms.

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## Westchester Medical Center (PPS ID:21)

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

**Instructions :**

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

| Benchmarks |
| --- |
| **100% Total Committed By** |
| DY2,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
| Primary Care Physicians | 524 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 524 | 524 | 524 |
| Non-PCP Practitioners | 800 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 800 | 800 | 800 |
| Clinics | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13 | 13 | 13 |
| Health Home / Care Management | 27 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 27 | 27 | 27 |
| Behavioral Health | 109 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 109 | 109 | 109 |
| Substance Abuse | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 11 | 11 |
| Pharmacies | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 4 | 4 |
| Community Based Organizations | 65 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 65 | 65 | 65 |
| All Other | 478 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 478 | 478 | 478 |
| **Total Committed Providers** | **2,031** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **2,031** | **2,031** | **2,031** |
| **Percent Committed Providers(%)** | | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **100.00** | **100.00** | **100.00** |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Primary Care Physicians | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 |
| Non-PCP Practitioners | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 |
| Clinics | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| Health Home / Care Management | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 |
| Behavioral Health | 109 | 109 | 109 | 109 | 109 | 109 | 109 | 109 | 109 | 109 | 109 |

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| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Substance Abuse | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 |
| Pharmacies | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Community Based Organizations | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 |
| All Other | 478 | 478 | 478 | 478 | 478 | 478 | 478 | 478 | 478 | 478 | 478 |
| **Total Committed Providers** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** | **2,031** |
| **Percent Committed Providers(%)** | | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** | **100.00** |

### Current File Uploads

| User ID | File Name | File Description | Upload Date |
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**Narrative Text :**

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

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 0 | 500 | 700 | 1,250 | 500 | 2,700 | 3,000 | 8,039 | 500 | 2,700 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **6.22** | **8.71** | **15.55** | **6.22** | **33.59** | **37.32** | **100.00** | **6.22** | **33.59** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Patients Engaged | 3,000 | 8,039 | 500 | 2,700 | 3,000 | 8,039 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **37.32** | **100.00** | **6.22** | **33.59** | **37.32** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

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**Narrative Text :**

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

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1** Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings. | Project | N/A | In Progress | 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 | 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 | 03/31/2017 | 03/31/2017 | DY2 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 | 03/31/2016 | DY1 Q4 |
| **Task** Step 3. Compare status of current practice among partners to identified best practices. | Project | | In Progress | 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 | | In Progress | 05/10/2016 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **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. | Project | | In Progress | 11/10/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Milestone #2** Engage at least 80% of primary care providers within the PPS in the | Project | N/A | In Progress | 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 | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| implementation of disease management evidence-based best practices. | | | | | | | |
| **Task** PPS has engaged at least 80% of their PCPs in this activity. | Provider | Primary Care Physicians | In Progress | 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 | | In Progress | 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 | | In Progress | 05/10/2016 | 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 | | In Progress | 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 | | In Progress | 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 | 03/31/2017 | DY2 Q4 |
| **Task** Clinically Interoperable System is in place for all participating providers. | Project | | In Progress | 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 | 03/31/2017 | DY2 Q4 |
| **Task** Care coordination processes are established and implemented. | Project | | In Progress | 05/10/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** Step 1. Identify by provider type and project role the clinical information to be shared among providers. | Project | | In Progress | 05/10/2016 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **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 | 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 | Project | | In Progress | 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 | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | In Progress | 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 | | In Progress | 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 | | In Progress | 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** If applicable, PPS has established linkages to health homes for targeted patient populations. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Identify participating partners providing the Stanford Model Diabetes Self-Management Program. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

## DSRIP Implementation Plan Project

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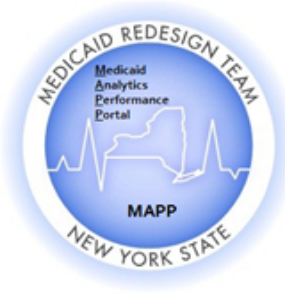| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Task** Step 4. Convene DPAQC with network partners and stakeholders to discuss the roles and responsibilities of PCP and HH and protocols for referring patients to ensure coordination. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Meet with Stanford Disease Self Management programs to identify ways to support, promote and expand model in the Hudson Valley. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Prioritize locations to conduct diabetes self-management programs based on diabetes hot spotting evidence from step 2 above. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Develop education materials for PCPs and Health Home providers regarding local standard disease self-management programs available for their clients. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 8. Provide ongoing support to partners implementing or referring patients to the Stanford Diabetes Self-Management programs. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #5** Ensure coordination with the Medicaid Managed Care organizations serving the target population. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #6** Use EHRs or other technical platforms to track all patients engaged in this | Project | N/A | In Progress | 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 | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| project. | | | | | | | |
| **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 | 03/31/2017 | DY2 Q4 |
| **Task** PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | 03/31/2016 | DY1 Q4 |
| **Task** Step 2. Define functional reporting requirements for diabetes projects. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. WMC PPS creates roadmap for data sharing and reporting. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Report and track actively engaged patients. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #7** Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | Provider | Safety Net Non-PCP Practitioners | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | Provider | Safety Net Behavioral Health | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Task** Step 2. WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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, 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 | | | | | | | | | | |

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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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. | | | | | | | | | | |

**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** <br> Step 5. Meet with Stanford Disease Self Management programs to identify ways to support, promote and expand model in the Hudson Valley. | | | | | | | | | | |
| **Task** <br> Step 6. Prioritize locations to conduct diabetes self-management programs based on diabetes hot spotting evidence from step 2 above. | | | | | | | | | | |
| **Task** <br> Step 7. Develop education materials for PCPs and Health Home providers regarding local standard disease self-management programs available for their clients. | | | | | | | | | | |
| **Task** <br> Step 8. Provide ongoing support to partners implementing or referring patients to the Stanford Diabetes Self-Management programs. | | | | | | | | | | |
| **Milestone #5** <br> Ensure coordination with the Medicaid Managed Care organizations serving the target population. | | | | | | | | | | |
| **Task** <br> 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** <br> 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** <br> 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** <br> 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** <br> Use EHRs or other technical platforms to track all patients engaged in this project. | | | | | | | | | | |
| **Task** <br> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | | | | | | | | | | |

**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 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. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | 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. | | | | | | | | | | |

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

## DSRIP Implementation Plan Project

## 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 #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 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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 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 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 | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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- | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 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. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Task** EHR meets connectivity to RHIO/SHIN-NY requirements. | 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. | | | | | | | | | | |

**Prescribed Milestones Current File Uploads**

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|
| No Records Found | | | | |

**NYS Confidentiality – High**

DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

### Prescribed Milestones Narrative Text

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

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 3.c.i.5 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

**PPS Defined Milestones Current File Uploads**

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

**PPS Defined Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|

No Records Found

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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Run Date : 09/24/2015

**IPQR Module 3.c.i.6 - IA Monitoring**

**Instructions :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

## 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.

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#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. Relying solely on data from NYS through MAPP the PPS would not have information needed to meet the needs of Medicaid patients served by

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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.

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

## DSRIP Implementation Plan Project

### Westchester Medical Center (PPS ID:21)

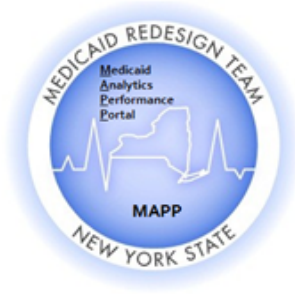### ☑ IPQR Module 3.d.iii.2 - Project Implementation Speed

**Instructions :**

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

| Benchmarks |
| --- |
| **100% Total Committed By** |
| DY2,Q4 |

| Provider Type | Total Commitment | Year,Quarter (DY1,Q1 – DY3,Q2) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
| Primary Care Physicians | 524 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 524 | 524 | 524 |
| Non-PCP Practitioners | 800 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 800 | 800 | 800 |
| Clinics | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 15 | 15 |
| Health Home / Care Management | 27 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 27 | 27 | 27 |
| Pharmacies | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 4 | 4 |
| Community Based Organizations | 35 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35 | 35 | 35 |
| All Other | 455 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 455 | 455 | 455 |
| **Total Committed Providers** | **1,860** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1,860** | **1,860** | **1,860** |
| **Percent Committed Providers(%)** | | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **100.00** | **100.00** | **100.00** |

| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Primary Care Physicians | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 |
| Non-PCP Practitioners | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 | 800 |
| Clinics | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| Health Home / Care Management | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 |
| Pharmacies | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Community Based Organizations | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 |
| All Other | 455 | 455 | 455 | 455 | 455 | 455 | 455 | 455 | 455 | 455 | 455 |

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| Provider Type | Total Commitment | Year,Quarter (DY3,Q3 – DY5,Q4) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| Total Committed Providers | 1,860 | 1,860 | 1,860 | 1,860 | 1,860 | 1,860 | 1,860 | 1,860 | 1,860 | 1,860 | 1,860 |
| Percent Committed Providers(%) | | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
|---|---|---|---|
| No Records Found | | | |

**Narrative Text :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

☑ **IPQR Module 3.d.iii.3 - Patient Engagement Speed**

**Instructions :**

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

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

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patients Engaged | 0 | 500 | 600 | 1,200 | 700 | 2,500 | 2,600 | 6,800 | 700 | 2,500 |
| **Percent of Expected Patient Engagement(%)** | **0.00** | **7.35** | **8.82** | **17.65** | **10.29** | **36.76** | **38.24** | **100.00** | **10.29** | **36.76** |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patients Engaged | 2,600 | 6,800 | 700 | 2,500 | 2,600 | 6,800 | 0 | 0 | 0 | 0 |
| **Percent of Expected Patient Engagement(%)** | **38.24** | **100.00** | **10.29** | **36.76** | **38.24** | **100.00** | **0.00** | **0.00** | **0.00** | **0.00** |

**Current File Uploads**

| User ID | File Name | File Description | Upload Date |
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| No Records Found | | | |

**Narrative Text :**

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☑ **IPQR Module 3.d.iii.4 - Prescribed Milestones**

**Instructions :**

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

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Milestone #1** 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 | 03/31/2017 | DY2 Q4 |
| **Task** PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** All participating practices have a Clinical Interoperability System in place for all participating providers. | Provider | Primary Care Physicians | In Progress | 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 | Non-PCP Practitioners | In Progress | 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Compare status of current practice among participating partners to identified best practices. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4: Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**
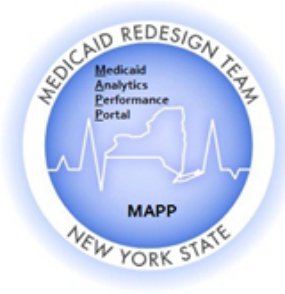
## DSRIP Implementation Plan Project

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| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **Task** Step 5. Identify by provider type and project role the clinical information to be shared among providers. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Create roadmap for data sharing and reporting using platform to support population health analytics. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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 | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Agreements with asthma specialists and asthma educators are established. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | Provider | Safety Net Non-PCP Practitioners | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 1. Identify AE-C's and Asthma specialists WMC PPS network. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. WMC PPS completes Current state analysis of current EHR based connections to RHIO. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. WMC PPS in coordination with QE, establishes plan to connect network partners to RHIO. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Asthma project participants to be included among early adopters/pilot for QE connections | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Identify gaps in care that might be addressed by telemedicine based geographyl on availability of specialists or other factors. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 8. Establish whether telemedicine may be the best alternative to provide these services to these geographic areas. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 9. Make plan to implement a pilot program using telemedicine if it is found to be a likely successful endeavor | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #3** Deliver educational activities addressing asthma management to participating primary care providers. | Project | N/A | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Participating providers receive training in evidence-based asthma management. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | 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. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Identify a subgroup of key personnel within provider network who can be initially trained. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Collect feedback from key personnel and if necessary revise education protocol and guidelines. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|---|
| **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 | 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 | 03/31/2016 | DY1 Q4 |
| **Task** Step 1. WMC PPS identifies MCOs and Health Homes serving Medicaid beneficiaries in our service area. | Project | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 | | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone #5** Use EHRs or other technical platforms to track all patients engaged in this project. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
| **Task** PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting. | Project | | In Progress | 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 | 03/31/2016 | 03/31/2016 | DY1 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 | | In Progress | 05/18/2016 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task** Step 3. WMC PPS creates roadmap for data sharing and reporting. | Project | | In Progress | 08/10/2016 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
| **Task** Step 4. Report and track actively engaged patients. | Project | | In Progress | 11/06/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| **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 |
| **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 | | | | | | | | | | |

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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 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. | 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** 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. | | | | | | | | | | |

**New York State Department Of Health**
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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. 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. | | | | | | | | | | |
| **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. | | | | | | | | | | |

**NYS Confidentiality – High**

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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 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 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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

## 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** 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 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** 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. | | | | | | | | | | |

**DSRIP Implementation Plan Project**

**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 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. | | | | | | | | | | |
| **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 | | | | | | | | | | |

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

**DSRIP Implementation Plan Project**

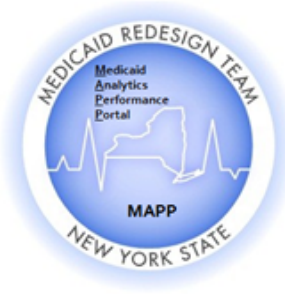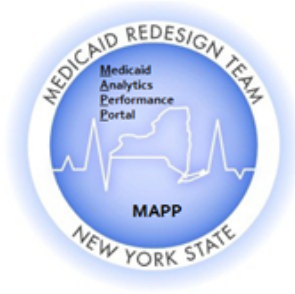**Westchester Medical Center (PPS ID:21)**

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 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 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 | |

**NYS Confidentiality – High**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**Prescribed Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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. | |

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

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☑ **IPQR Module 3.d.iii.5 - PPS Defined Milestones**

**Instructions :**

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
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### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
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**DSRIP Implementation Plan Project**

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**IPQR Module 3.d.iii.6 - IA Monitoring**

**Instructions :**

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

### DSRIP Implementation Plan Project

### Westchester Medical Center (PPS ID:21)

**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 - PPS Defined Milestones**

**Instructions :**

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

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| **Milestone** 1. 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 | 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 | 07/01/2015 | 07/31/2015 | 09/30/2015 | DY1 Q2 |
| **Task** Step 1. Develop contented of survey in consultation with HRD_PHC and the provider groups represented in tobacco and asthma committees | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Incorporate survey in detailed assessment by PCMH vendor. Y1Q4 | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. Use PPS meetings and other forums to desseminate best practices on tobacco free outdoor policies to PPS partners. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 5. Resurvey those who responded in round 1 re Outdoor smoking policies Y2Q1-2; | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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## Westchester Medical Center (PPS ID:21)

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| Step 6. Develop plan to facilitate those who have succeeded with outdoor policies assist those who have not. Y2Q4 | | | | | | |
| **Milestone** 2. Convene a region-wide tobacco cessation campaign committee by DY1; | Completed | Convene a region-wide tobacco cessation campaign committee by DY1; | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 |
| **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. | Completed | See Task | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1 |
| **Milestone** 3. Engage Medicaid MCOs around coverage and payment by the end of DY1; Y1Q4 | In Progress | Engage Medicaid MCOs around coverage and payment by the end of DY1; Y1Q4 | 07/01/2015 | 07/31/2015 | 09/30/2015 | DY1 Q2 |
| **Task** Step 1. WMC PPS identifies  Medicaid Managed Care Organizations (MCOs)  doing business in our service area. . | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. MCOs  are invited to participate in committees,  and work group  working on tobacco cessation. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 by mid DY1; and  Subsequently promulgate best practices by DY2. | On Hold | Survey PPS Participants about USPSTF and PHS guidelines, use of EHRs to facilitate 5 A's, and referrals to the NYS Smokers' Quitline by mid DY1; and Subsequently promulgate best practices by DY2. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**New York State Department Of Health**
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**Westchester Medical Center (PPS ID:21)**

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| **Task**<br>Step 1. Develop contents of survey in consultation with HRD_PHC tobacco cessation workgroup and the provider groups represented in tobacco and asthma committees | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>Step 2. Incorporate survey in detailed assessment by PCMH vendor. Y1Q4 | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>Step 5. In consultation with partner organizations and the tobacco cesssation workgroup, the WMC PPC Quality Steering Committee (QSC) and local hub implementation | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| 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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone** 5. Launch a campaign to promote tobacco cessation among all eligible providers by late DY1 | On Hold | Launch a campaign to promote tobacco cessation among all eligible providers by late DY1 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS will budget to support an outreach campaign including dissemination of training and toolkits such as templates for incorporation of "5As" into EHRs. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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 plans to support development of site specific workflow to promote tobacco screeening and cessation counseling including identification of designated staff. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 4. HRD_PHC tobacco cessation | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| 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. | | | | | | |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone** 6. Develop targeted outreach materials for special populations (dental, behavioral health, and DD patients) by DY2 | On Hold | Develop targeted outreach materials for special populations (dental, behavioral health, and DD patients) by DY2 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. . | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS will budget to support an outreach campaign to special populaitons. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** 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 | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**NYS Confidentiality** – **High**

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

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**Westchester Medical Center (PPS ID:21)**

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| staff. | | | | | | |

### PPS Defined Milestones Current File Uploads

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|

No Records Found

### PPS Defined Milestones Narrative Text

| Milestone Name | Narrative Text |
|---|---|
| 1. 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 | |
| 2. Convene a region-wide tobacco cessation campaign committee by DY1; | |
| 3. Engage Medicaid MCOs around coverage and payment by the end of DY1; Y1Q4 | |
| 4. Survey PPS Participants about USPSTF and PHS guidelines, use of EHRs to facilitate 5 A's, and referrals to the NYS Smokers' Quitline by mid DY1; and  Subsequently promulgate best practices by DY2. | |
| 5. Launch a campaign to promote tobacco cessation among all eligible providers by late DY1 | |
| 6. Develop targeted outreach materials for special populations (dental, behavioral health, and DD patients) by DY2 | |

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Delivery System Reform Incentive Payment Project

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**Run Date :** 09/24/2015

**IPQR Module 4.b.i.2 - IA Monitoring**

**Instructions :**

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

**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 - PPS Defined Milestones

**Instructions :**

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

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| **Milestone**<br>1. Development of a comprehensiveimplementation plan, DY1 | On Hold | Development of a comprehensive implementation plan, DY1 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>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) . | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task**<br>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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| 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 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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 6. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**DSRIP Implementation Plan Project**

**Westchester Medical Center (PPS ID:21)**

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for coordination of services and improvement of cancer screening rates. | | | | | | |
| **Milestone** 2. Analysis of CSP best practices and lessons learned, DY1 | On Hold | Analysis of CSP best practices and lessons learned, DY1 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone** 3. Development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs; DY1 | On Hold | Development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone** 4. Identification of functional requirements for the cancer screening registry; DY1 | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| Step 1. Define functional reporting requirements for cancer screening projects. | | | | | | |
| **Milestone** 5. Piloting rapid cycle evaluation of our PPS' care management function DY1 | On Hold | Piloting rapid cycle evaluation of our PPS' care management function DY1 | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone** 6. Selection of an analytics platform to support patient identification; DY2 | In Progress | Selection of an analytics platform to support patient identification; DY2 | 07/01/2015 | 07/30/2015 | 09/30/2015 | DY1 Q2 |
| **Task** Step 1. WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. Aligned with IT development for project 2 ai the WMC PPS begins IT based population health reporting. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Begin phased roll-out of embedded templates and alerts; share templates of early adopters with others to speed adoption. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Milestone** 7. Roll-out of a one-stop screening pilot; DY2 | On Hold | Roll-out of a one-stop screening pilot; DY2 | 04/01/2015 | 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 will examine the feasibility of having a cancer surgeon examine patients, order the | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

## Westchester Medical Center (PPS ID:21)

| Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
|---|---|---|---|---|---|---|
| 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" | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 3. Plan for role-out of pilot test of one-stop Breast Cancer Screening. . | On Hold | See Task | 04/01/2015 | 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. | On Hold | 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. | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 2. WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 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. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

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**Westchester Medical Center (PPS ID:21)**

| Milestone/Task Name | Status | Description | 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. | | | | | | |
| **Task** Step 6. Identify pilot partner/early adopter sites to achieve PCMH or APCM by DY3. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 7. Evaluate lessons learned from initial connections; plan phased rollout. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 8. Implement Phase 1 of network rollout PCMH/APCM | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 9. Implement Phase 2 of network rollout PCMH/APCM | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |
| **Task** Step 10. Document PCMH or APC certification among eligible providers. | On Hold | See Task | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4 |

**PPS Defined Milestones Current File Uploads**

| Milestone Name | User ID | File Name | Description | Upload Date |
|---|---|---|---|---|
| No Records Found | | | | |

**PPS Defined Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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; DY1 | |

**NYS Confidentiality – High**

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**PPS Defined Milestones Narrative Text**

| Milestone Name | Narrative Text |
|---|---|
| 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; DY2 | |
| 7. Roll-out of a one-stop screening pilot; DY2 | |
| 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. | |

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**Run Date :** 09/24/2015

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**Westchester Medical Center (PPS ID:21)**

**IPQR Module 4.b.ii.2 - IA Monitoring**

**Instructions :**

# Delivery System Reform Incentive Payment Project

## DSRIP Implementation Plan Project

## Westchester Medical Center (PPS ID:21)

**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**.

| | |
|---|---|
| **Primary Lead PPS Provider:** | WESTCHESTER MED CTR |
| **Secondary Lead PPS Provider:** | |
| **Lead Representative:** | June Keenan |
| **Submission Date:** | 09/24/2015 09:53 AM |

**Comments:**

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| Status Log | | | | |
|---|---|---|---|---|
| **Quarterly Report (DY,Q)** | **Status** | **Lead Representative Name** | **User ID** | **Date Timestamp** |
| DY1, Q1 | Submitted | June Keenan | keenanj1 | 09/24/2015 09:53 AM |
| DY1, Q1 | Returned | June Keenan | sv590918 | 09/08/2015 07:54 AM |
| DY1, Q1 | Submitted | June Keenan | keenanj1 | 08/06/2015 09:44 AM |
| DY1, Q1 | In Process | | system | 07/01/2015 12:12 AM |

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**Westchester Medical Center (PPS ID:21)**

| Comments Log | | | |
|---|---|---|---|
| **Status** | **Comments** | **User ID** | **Date Timestamp** |
| Returned | Please address the IA comments provided in the specific sections of your Implementation Plan during the remediation period. | sv590918 | 09/08/2015 07:54 AM |

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

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

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

## Westchester Medical Center (PPS ID:21)

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

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

**NYS Confidentiality** – **High**