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

DSRIP Implementation Plan Project

Alliance for Better Health Care, LLC (PPS ID:3)

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Quarterly Report - Implementation Plan for Alliance for Better Health Care, LLC

Year and Quarter: DY2, Q4 **Quarterly Report Status:** Adjudicated

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.b.iii	ED care triage for at-risk populations	Completed
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
2.b.viii	Hospital-Home Care Collaboration Solutions	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.iv	Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs	Completed
3.d.ii	Expansion of asthma home-based self-management program	Completed
3.g.i	Integration of palliative care into the PCMH Model	Completed
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	Completed
4.b.i	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	Completed

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY

Instructions :

READ ONLY - The Baseline Budget table was left for ease of reference during reporting.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	37,539,017	40,004,254	64,691,899	57,284,429	37,539,017	237,058,615
Cost of Project Implementation & Administration	**9,384,532**	**10,001,313**	**16,172,947**	**14,321,329**	**9,385,732**	**59,265,853**
Implementation	3,603,660	4,720,620	10,059,573	8,936,509	5,856,697	33,177,059
PPS Administration	5,780,872	5,280,693	6,113,374	5,384,820	3,529,035	26,088,794
Revenue Loss	**3,753,813**	**8,001,051**	**16,172,947**	**17,758,448**	**13,515,455**	**59,201,714**
Internal PPS Provider Bonus Payments	**4,129,194**	**6,000,788**	**20,054,454**	**22,341,273**	**18,621,293**	**71,147,002**
Cost of non-covered services	**3,753,813**	**4,000,525**	**6,469,179**	**5,728,532**	**3,754,293**	**23,706,342**
Other	**3,739,248**	**3,985,960**	**6,454,614**	**5,713,967**	**3,739,725**	**23,633,514**
Contingency for unforeseen developments over the life of the DSRIP project	3,739,248	3,985,960	6,454,614	5,713,967	3,739,725	23,633,514
Total Expenditures	**24,760,600**	**31,989,637**	**65,324,141**	**65,863,549**	**49,016,498**	**236,954,425**
Undistributed Revenue	**12,778,417**	**8,014,617**	**0**	**0**	**0**	**104,190**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

New York State Department Of Health
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Alliance for Better Health Care, LLC (PPS ID:3)

IPQR Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY2	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
40,004,254	237,058,615	19,992,302	196,605,675

Budget Items	DY2 Q4 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**3,335,357**	**28,428,710**	**-10,010,639**	**-100.09%**	**30,837,143**	**52.03%**
Implementation	2,168,669					
PPS Administration	1,166,688					
Revenue Loss	**0**	**3,964,074**	**8,001,051**	**100.00%**	**55,237,640**	**93.30%**
Internal PPS Provider Bonus Payments	**0**	**4,360,394**	**6,000,788**	**100.00%**	**66,786,608**	**93.87%**
Cost of non-covered services	**0**	**1,849,881**	**4,000,525**	**100.00%**	**21,856,461**	**92.20%**
Other	**0**	**1,849,881**	**3,985,960**	**100.00%**	**21,783,633**	**92.17%**
Contingency for unforeseen developments over the life of the DSRIP project	0					
Total Expenditures	**3,335,357**	**40,452,940**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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Alliance for Better Health Care, LLC (PPS ID:3)

IPQR Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY

Instructions :

READ ONLY - The Baseline Funds Flow table was left for ease of reference during reporting.

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	37,539,017	40,004,254	64,691,899	57,284,429	37,539,017	237,058,615
Practitioner - Primary Care Provider (PCP)	6,113,343	6,514,815	10,535,273	9,328,944	6,113,343	38,605,718
Practitioner - Non-Primary Care Provider (PCP)	2,971,789	3,166,950	5,121,356	4,534,941	2,971,789	18,766,825
Hospital	13,264,484	14,135,581	22,859,008	20,241,563	13,264,484	83,765,120
Clinic	1,243,621	1,325,291	2,143,162	1,897,762	1,243,621	7,853,457
Case Management / Health Home	2,503,538	2,667,949	4,314,408	3,820,392	2,503,538	15,809,825
Mental Health	844,486	899,944	1,455,323	1,288,683	844,486	5,332,922
Substance Abuse	132,661	141,373	228,618	202,441	132,661	837,754
Nursing Home	201,935	215,197	348,000	308,153	201,935	1,275,220
Pharmacy	105,891	112,845	182,484	161,589	105,891	668,700
Hospice	11,547	12,305	19,899	17,621	11,547	72,919
Community Based Organizations	579,882	617,964	999,325	884,898	579,882	3,661,951
All Other	3,784,968	4,913,347	10,371,669	9,212,622	6,036,805	34,319,411
Uncategorized						0
PPS PMO	5,780,872	5,280,693	6,113,374	5,384,820	3,529,035	26,088,794
Total Funds Distributed	**37,539,017**	**40,004,254**	**64,691,899**	**57,284,429**	**37,539,017**	**237,058,616**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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Alliance for Better Health Care, LLC (PPS ID:3)

IPQR Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)

Instructions :

Please include updates on waiver revenue flow of funds for this quarterly reporting period by importing the PIT file and filling out the PPS PMO line manually. Reported actual fund distribution will be compared to baseline projections and deviations will be evaluated. Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

Benchmarks

Waiver Revenue DY2	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
40,004,254.00	237,058,615.00	24,743,732.17	201,357,104.17

Funds Flow Items	DY2 Q4 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q4 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	Percent Spent By Project											DY Adjusted Difference	Cumulative Difference
						Projects Selected By PPS												
						2.a.i	2.b.iii	2.b.iv	2.b.vii	2.d.i	3.a.i	3.a.iv	3.d.ii	3.g.i	4.a.iii	4.b.i		
Practitioner - Primary Care Provider (PCP)	0	0.00%	0	0.00%	2,100,000	0	0	0	0	0	0	0	0	0	0	0	6,514,815	36,505,718
Practitioner - Non-Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0	0	3,166,950	18,766,825
Hospital	0	0.00%	4,844,004	100.00%	10,844,004	0	0	0	0	0	0	0	0	0	0	0	9,291,577	72,921,116
Clinic	0	0.00%	3,771,513	100.00%	8,971,513	0	0	0	0	0	0	0	0	0	0	0	0	0
Case Management / Health Home	0	0.00%	85,964	47.31%	931,719	0	0	0	0	0	0	0	0	0	0	0	2,486,230	14,878,106
Mental Health	0	0.00%	1,212,309	100.00%	1,312,309	0	0	0	0	0	0	0	0	0	0	0	0	4,020,613
Substance Abuse	0	0.00%	405,036	100.00%	555,036	0	0	0	0	0	0	0	0	0	0	0	0	282,718
Nursing Home	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0	0	215,197	1,275,220
Pharmacy	0	0.00%	0	0.00%	0	0	0	0	0	0	0	0	0	0	0	0	112,845	668,700
Hospice	0	0.00%	0	0.00%	128,502	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	0	0.00%	0	0.00%	468,610	0	0	0	0	0	0	0	0	0	0	0	299,354	3,193,341
All Other	0	0.00%	99,060	100.00%	4,456,433	0	0	0	0	0	0	0	0	0	0	0	4,814,287	29,862,978
Uncategorized	0	0.00%	0	0.00%	54,353	0	0	0	0	0	0	0	0	0	0	0	0	0
Additional Providers	0	0.00%	0	0.00%	10,600													
PPS PMO	2,002,540	100.00%	4,334,815.83	100.00%	5,868,431.83												945,877.17	20,220,362.17
Total	**2,002,540**	**100.00%**	**14,752,701.83**	**96.67%**	**35,701,510.83**													

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Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

DY2Q4 Remediation Response: On the PPS Partner Engagement spreadsheet, cells highlighted in bright yellow correspond to provider engagement commitments embodied in the project requirements. Cells highlighted in tan are associated with project requirements due 3/31/2017.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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* Safety Net Providers in Green

Waiver Quarterly Update Amount By Provider		
Provider Name	**Provider Category**	**DY2Q4**
Practitioner - Primary Care Provider (PCP)		**0**
	Practitioner - Primary Care Provider (PCP)	0
Practitioner - Non-Primary Care Provider (PCP)		**0**
	Practitioner - Non-Primary Care Provider (PCP)	0
Hospital		**0**
	Hospital	0
Clinic		**0**
	Clinic	0
Case Management / Health Home		**0**
	Case Management / Health Home	0
Mental Health		**0**
	Mental Health	0
Substance Abuse		**0**
	Substance Abuse	0
Nursing Home		**0**
	Nursing Home	0
Pharmacy		**0**
	Pharmacy	0
Hospice		**0**
	Hospice	0
Community Based Organizations		**0**
	Community Based Organizations	0
All Other		**0**
	All Other	0
Uncategorized		**0**
	Uncategorized	0

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* Safety Net Providers in Green

Waiver Quarterly Update Amount By Provider			
Provider Name	**Provider Category**	**IA Provider Approval/Rejection Indicator**	**DY2Q4**
Additional Providers			**0**
City Mission Of Schenectady	Additional Providers	Approved	0
In Our Own Voices, Inc.	Additional Providers	Approved	0

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IPQR Module 1.5 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Completed	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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task 1. Staff of AFBHC in conjunction and under the direction of the Finance Committee will develop a funds flow model that will be used by the PPS to distribute DSRIP funds	Completed	1. Staff of AFBHC in conjunction and under the direction of the Finance Committee will develop a funds flow model that will be used by the PPS to distribute DSRIP funds	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Develop budget forms and collection tools to complete data requirements of flow of funds model	Completed	2. Develop budget forms and collection tools to complete data requirements of flow of funds model	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Communicate and engage providers in the flow of funds model to gather input and required data	Completed	3. Communicate and engage providers in the flow of funds model to gather input and required data	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Gather budget data from respective areas of PPS (provider network, projects, central office, etc.)	Completed	4. Gather budget data from respective areas of PPS (provider network, projects, central office, etc.)	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Develop further refined flow of funds and overall budget estimates by DY based upon contract arrangements with providers related to the projects	Completed	5. Develop further refined flow of funds and overall budget estimates by DY based upon contract arrangements with providers related to the projects	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Finance Committee finalizes flow of funds and	Completed	6. Finance Committee finalizes flow of funds and presents to	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

Alliance for Better Health Care, LLC (PPS ID:3)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
presents to AFBHC governing board		AFBHC governing board							
Task 7. AFBHC Governing Board approves funds flow budget and distribution plan	Completed	7. AFBHC Governing Board approves funds flow budget and distribution plan	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Communicate refined funds flow budget and distribution plan to network	Completed	8. Communicate refined funds flow budget and distribution plan to network	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)

Instructions :

This table contains five budget categories for non-waiver revenue baseline budget reporting . Please add rows to this table as necessary in order to identify sub-categories.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Non-Waiver Revenue	0	0	0	0	0	0
Cost of Project Implementation & Administration	**0**	**0**	**0**	**0**	**0**	**0**
Administration	0	0	0	0	0	0
Implementation	0	0	0	0	0	0
Revenue Loss	**0**	**0**	**0**	**0**	**0**	**0**
Internal PPS Provider Bonus Payments	**0**	**0**	**0**	**0**	**0**	**0**
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**	**0**
Total Expenditures	**0**	**0**	**0**	**0**	**0**	**0**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)

Instructions :

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

Benchmarks

Non-Waiver Revenue DY2	Total Non-Waiver Revenue	Undistributed Non-Waiver Revenue YTD	Undistributed Non-Waiver Revenue Total
0	0	0	0

Budget Items	DY2 Q4 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**0**	**0**	**0**		**0**	
Administration	0					
Implementation	0					
Revenue Loss	**0**	**0**	**0**		**0**	
Internal PPS Provider Bonus Payments	**0**	**0**	**0**		**0**	
Cost of non-covered services	**0**	**0**	**0**		**0**	
Other	**0**	**0**	**0**		**0**	
Total Expenditures	**0**	**0**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)

Instructions :

In the table below, please detail your PPS's projected flow of non-waiver funds by provider type.

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Non-Waiver Revenue	0	0	0	0	0	0
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0
Hospital	0	0	0	0	0	0
Clinic	0	0	0	0	0	0
Case Management / Health Home	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0
Substance Abuse	0	0	0	0	0	0
Nursing Home	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0
Hospice	0	0	0	0	0	0
Community Based Organizations	0	0	0	0	0	0
All Other	0	0	0	0	0	0
Uncategorized	0	0	0	0	0	0
PPS PMO	0	0	0	0	0	0
Total Funds Distributed	**0**	**0**	**0**	**0**	**0**	**0**
Undistributed Non-Waiver Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)

Instructions :

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

Benchmarks

Non-Waiver Revenue DY2	Total Non-Waiver Revenue	Undistributed Non-Waiver Revenue YTD	Undistributed Non-Waiver Revenue Total
0.00	0.00	0.00	0.00

Funds Flow Items	DY2 Q4 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q4 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	DY Adjusted Difference	Cumulative Difference
Practitioner - Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0
Practitioner - Non-Primary Care Provider (PCP)	0	0.00%	0	0.00%	0	0	0
Hospital	0	0.00%	0	0.00%	0	0	0
Clinic	0	0.00%	0	0.00%	0	0	0
Case Management / Health Home	0	0.00%	0	0.00%	0	0	0
Mental Health	0	0.00%	0	0.00%	0	0	0
Substance Abuse	0	0.00%	0	0.00%	0	0	0
Nursing Home	0	0.00%	0	0.00%	0	0	0
Pharmacy	0	0.00%	0	0.00%	0	0	0
Hospice	0	0.00%	0	0.00%	0	0	0
Community Based Organizations	0	0.00%	0	0.00%	0	0	0
All Other	0	0.00%	0	0.00%	0	0	0
Uncategorized	0	0.00%	0	0.00%	0	0	0
Additional Providers	0	0.00%	0	0.00%	0		

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Alliance for Better Health Care, LLC (PPS ID:3)

Funds Flow Items	DY2 Q4 Quarterly Amount - Update	Percentage of Safety Net Funds - DY2 Q4 Quarterly Amount - Update	Safety Net Funds Flowed YTD	Safety Net Funds Percentage YTD	Total Amount Disbursed to Date (DY1-DY5)	DY Adjusted Difference	Cumulative Difference
PPS PMO	0	0.00%	0	0.00%	0	0	0
Total	**0**		**0**		**0**		

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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* Safety Net Providers in Green

Non-Waiver Quarterly Update Amount By Provider		
Provider Name	**Provider Category**	**DY2Q4**
Practitioner - Primary Care Provider (PCP)		**0**
	Practitioner - Primary Care Provider (PCP)	0
Practitioner - Non-Primary Care Provider (PCP)		**0**
	Practitioner - Non-Primary Care Provider (PCP)	0
Hospital		**0**
	Hospital	0
Clinic		**0**
	Clinic	0
Case Management / Health Home		**0**
	Case Management / Health Home	0
Mental Health		**0**
	Mental Health	0
Substance Abuse		**0**
	Substance Abuse	0
Nursing Home		**0**
	Nursing Home	0
Pharmacy		**0**
	Pharmacy	0
Hospice		**0**
	Hospice	0
Community Based Organizations		**0**
	Community Based Organizations	0
All Other		**0**
	All Other	0
Uncategorized		**0**
	Uncategorized	0

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* Safety Net Providers in Green

Non-Waiver Quarterly Update Amount By Provider			
Provider Name	**Provider Category**	**IA Provider Approval/Rejection Indicator**	**DY2Q4**
Additional Providers			**0**
	Additional Providers		0

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IPQR Module 1.11 - IA Monitoring

Instructions :

New York State Department Of Health
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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1. Hold first AFBHC, LLC Governance meetings	Completed	a. Hold organizational meeting of Members (1) Ratify Operating Agreement (2) Ratify appointment of Board of Managers b. Hold organizational meeting of Board of Managers (1) Appoint Officers (Chairs, Vice Chair, Secretary) (2) Ratify a Board committee and task force structure	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Formally recognize previously-appointed PAC members	Completed	2. Formally recognize previously-appointed PAC members	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Agree on administrative/operating structure including CEO for interim and permanent terms	Completed	"a. Given that the AFBHC and IHANY (Innovative Health Alliance of New York, an ACO created by Ellis and St. Peter's Health Partners that is building a clinically integrated network and operating an MSSP) are now operational, there is concern over duplication of effort. Therefore, an evaluation of the current committee and task force structure will be conducted to develop a recommendation to the respective IHANY and the AFBHC Board of Managers that aligns both entities to the extent permissible under law and DSRIP rules. This evaluation is being done to coordinate patient care standards, to minimize duplication of effort, and to reduce the burden on the practitioner community. b. Present to the AFBHC and IHANY boards the final	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		recommendation for and aligned CEO leadership and committee structure solution. "							
Task 4. Install members of the agreed-upon Standing Committees which could include: Finance, Information Technology & Data, Clinical Integration & Quality, Workforce, Credentialing, Audit & Compliance.	Completed	4. Install members of the agreed-upon Standing Committees which could include: Finance, Information Technology & Data, Clinical Integration & Quality, Workforce, Credentialing, Audit & Compliance.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Schedule monthly meetings of the AFBHC Board of Managers to formally address the issues of the board and issues associated with this milestone demonstrating final accountability for policy and results.	Completed	5. Schedule monthly meetings of the AFBHC Board of Managers to formally address the issues of the board and issues associated with this milestone demonstrating final accountability for policy and results.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Write charters for Clinical Integration and Quality Committee and for each subsidiary Project Steering Committee, consider the following in writing charters:	Completed	a. Previously written Adequate Clinical Governance in Project Plan Application, Structure 3 b. Process for approving clinical protocols and best practices for all projects in collaboration with the Innovative Health Alliance of New York (IHANY) c. Define accountability for monitoring network's compliance with milestones and metrics	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Finalize proposed Subsidiary Project Steering committees groupings: Integrated Delivery System & Project 11 (2.a.i and 2.d.i); At Risk Population (2.b.iii, 2.b.iv, 2.b.viii, 3.d.ii, 3.g.i, and 4.b.i); Behavioral Health and Primary Care Integration (3.a.i, 3.a.iv, 4.a.iii)	Completed	2. Finalize proposed Subsidiary Project Steering committees groupings: Integrated Delivery System & Project 11 (2.a.i and 2.d.i); At Risk Population (2.b.iii, 2.b.iv, 2.b.viii, 3.d.ii, 3.g.i, and 4.b.i); Behavioral Health and Primary Care Integration (3.a.i, 3.a.iv, 4.a.iii)	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Finalize clinical organizational chart for Clinical Integration and Quality Committee and its subsidiary Project Steering Committees	Completed	3. Finalize clinical organizational chart for Clinical Integration and Quality Committee and its subsidiary Project Steering Committees	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 4. Install members of the Project Steering Subcommittees, consider current work groups and newly-interested practitioners for membership	Completed	4. Install members of the Project Steering Subcommittees, consider current work groups and newly-interested practitioners for membership	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Schedule and hold formal meetings of the Clinical Integration and Quality Committee with minutes	Completed	5. Schedule and hold formal meetings of the Clinical Integration and Quality Committee with minutes	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Identify performance metrics to be reviewed by clinical committees, content and frequency of reports to be reviewed, and define committee members' oversight responsibilities.	Completed	6. Identify performance metrics to be reviewed by clinical committees, content and frequency of reports to be reviewed, and define committee members' oversight responsibilities.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Schedule monthly meetings of the Clinical Integration and Quality Committee to formally address the issues associated with this milestone and issues brought up by the three clinical subcommittees.	Completed	7. Schedule monthly meetings of the Clinical Integration and Quality Committee to formally address the issues associated with this milestone and issues brought up by the three clinical subcommittees.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1. Ratify Operating Agreement by Members of the AFBHC.	Completed	1. Ratify Operating Agreement by Members of the AFBHC.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2. Create list of necessary AFBHC policies, develop policies and adoption schedule, and present for Board Approval according to schedule. Policies include but are not limited to: Conflict of Interest, Code of Conduct, Corporate Compliance, Whistleblower, Antitrust, Provider Termination for Non-Compliance-, Fund Distribution, HIPAA, Authority to Act, and clinical policies as identified by the Clinical Integration and Quality Committee. This list will continue to	Completed	2. Create list of necessary AFBHC policies, develop policies and adoption schedule, and present for Board Approval according to schedule. Policies include but are not limited to: Conflict of Interest, Code of Conduct, Corporate Compliance, Whistleblower, Antitrust, Provider Termination for Non-Compliance-, Fund Distribution, HIPAA, Authority to Act, and clinical policies as identified by the Clinical Integration and Quality Committee. This list will continue to evolve.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
evolve.									
Task 3. Ratify the Code of Conduct policy, Corporate Compliance policy, Whistleblower policy, Antitrust policy, and Authority to Act policy	Completed	3. Ratify the Code of Conduct policy, Corporate Compliance policy, Whistleblower policy, Antitrust policy, and Authority to Act policy	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 4. Ratify Conflict of Interest Policy and HIPAA Policy.	Completed	4. Ratify Conflict of Interest Policy and HIPAA Policy.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Create list of AFBHC committee charters for standing committees and subcommittees, develop, and present to Board of Managers for approval	Completed	5. Create list of AFBHC committee charters for standing committees and subcommittees, develop, and present to Board of Managers for approval	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Create list of AFBHC agreements, develop, and present agreements to Board for approval	Completed	6. Create list of AFBHC agreements, develop, and present agreements to Board for approval	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7. Develop formal communication channels to inform stakeholders of adopted policies to be implemented as part of daily operating procedures	Completed	7. Develop formal communication channels to inform stakeholders of adopted policies to be implemented as part of daily operating procedures	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 8. Upload board-approved operating agreement, policies, and committee charters onto Medicaid Analytics Performance Portal (MAPP)	Completed	8. Upload board-approved operating agreement, policies, and committee charters onto Medicaid Analytics Performance Portal (MAPP)	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Write policy on governance and committee structure reporting and monitoring inclusive of two-way communication. Reference Project Plan Application Governance, Structure 2	Completed	1. Write policy on governance and committee structure reporting and monitoring inclusive of two-way communication. Reference Project Plan Application Governance, Structure 2	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Define types of reports to be produced including dashboards, reference Performance	Completed	a. Identify key program metrics to evaluate workflow progress in workforce management, financial management, clinical management, and IT management	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Reporting Section of this Implementation Plan									
Task 3. Establish tools and processes for collecting data from providers, incorporating into reports, and deploying meaningful/actionable tools to appropriate parties including Community Based Organizations (CBOs) and social agencies	Completed	3. Establish tools and processes for collecting data from providers, incorporating into reports, and deploying meaningful/actionable tools to appropriate parties including Community Based Organizations (CBOs) and social agencies	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Write board recommendation for approval of governance structure, reporting, and monitoring policy	On Hold	4. Write board recommendation for approval of governance structure, reporting, and monitoring policy	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Completed	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1. Evaluate current composition of community engagement stakeholders and non-provider services to-date to determine their role in effectively implementing AFBHC project plans. Services could include and are not limited to: population health, food, clothing, shelter assistance. Consider additional recruitment of community based organizations providing these services	Completed	a. At a minimum engage those entities listed under the External Stakeholder Section, for example, the State Office of Alcoholism and Substance Abuse Services (https://www.oasas.ny.gov/). This list will evolve as the stakeholder plan is completed.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Develop community engagement plan referencing AFBHC Project Plan Application Governance Process 8 (How PPS Governing Body will Engage Stakeholders) including two-way communication	Completed	2. Develop community engagement plan referencing AFBHC Project Plan Application Governance Process 8 (How PPS Governing Body will Engage Stakeholders) including two-way communication	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Demonstrate implementation of community engagement plan through community forums, website, newsletter, and social media	Completed	3. Demonstrate implementation of community engagement plan through community forums, website, newsletter, and social media	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	4. Define a brand for AFBHC so there is awareness in the	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
4. Define a brand for AFBHC so there is awareness in the community of the activities of the PPS across the continuum regardless of the patients' entry point inside the continuum		community of the activities of the PPS across the continuum regardless of the patients' entry point inside the continuum							
Task 5. Schedule community engagement events for current year and subsequent year focusing on public and non-provider organizations	Completed	5. Schedule community engagement events for current year and subsequent year focusing on public and non-provider organizations	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #6 Finalize partnership agreements or contracts with CBOs	Completed	Signed CBO partnership agreements or contracts.	06/30/2016	12/31/2016	06/30/2016	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Write partnership agreements with performance addendums with CBOs	Completed	a. Develop list of provider types that need agreements via feedback from project committees b. Identify specific expectations per provider type in reference to project performance c. Obtain provider services agreement from IHANY as a base, adapt to AFBHC, LLC d. Identify general provider expectations to be included in agreement and AFBHC obligations e. Develop provider and CBO incentive principles and payment methodology, which is part of the funds flow policy. f. Obtain Finance Committee, Board of Managers, and Members' approval of funds flow policy"	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Conduct assessment of needed CBOs and develop contracting strategy	Completed	a. Identify CBOs for contracting, prepare contracts, and schedule negotiations meetings b. Hold meetings with CBOs with minutes, obtain signed agreements	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Develop process for obtaining signed agreements, storage, retrieval, and renewal	Completed	3. Develop process for obtaining signed agreements, storage, retrieval, and renewal	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Maintain list of active signed provider agreements with filed electronic copies	Completed	4. Maintain list of active signed provider agreements with filed electronic copies	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Develop and implement credentialing criteria and processes	On Hold	5. Develop and implement credentialing criteria and processes	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #7	Completed	Agency Coordination Plan.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
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.)									
Task 1. Develop list of state and local public sector agencies to be engaged in projects, reference Project Plan Application Workforce Section 2.6, Collaboration 1	Completed	a. Explore and select services from agencies such as the state Office for People with Developmental Disabilities (OPWDD) website that could fulfill AFBHC members' needs identified by projects (http://providerdirectory.opwdd.ny.gov/). Likewise, consider services provided by the services organization listed under the External Stakeholders of this section and in the AFBHC Community Needs Assessment. b. Invite to the planning process the External Stakeholders listed in this section. c. Identify key issues and services needed from public sector agencies. d. Determine the role that each entity may play in the projects and if a contract is necessary to obtain services. e. identify frequency of planning meetings with public sector agencies	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 2. Schedule meetings with pertinent public sector agencies and write minutes	Completed	2. Schedule meetings with pertinent public sector agencies and write minutes	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3. Develop plan and submit to the appropriate AFBHC Committees and to the Board of Managers for ratification.	Completed	3. Develop plan and submit to the appropriate AFBHC Committees and to the Board of Managers for ratification.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #8 Finalize workforce communication and engagement plan	Completed	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Develop Workforce Communication & Engagement Plan referencing material already written in the Workforce Project Plan Application Section 5.7 , Stakeholder & Worker Engagement. Include two-way communication with all levels of	Completed	1. Develop Workforce Communication & Engagement Plan referencing material already written in the Workforce Project Plan Application Section 5.7 , Stakeholder & Worker Engagement. Include two-way communication with all levels of workforce	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
workforce									
Task 2. Identify workforce groups and evaluate general needs for communication	Completed	a. Identify specific communication needs by workforce group and develop messages tailored to each group b. Identify methods and channels of communication best suited for each workforce group and develop distribution plan c. Discuss with employers and labor representatives impact of DSRIP on employees. d. Discuss with employers and labor representatives best methods to engage impacted and non-impacted staff early in the process considering principles of change management.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Write formal recommendation to the Workforce Committee for adoption of the Workforce Communication and Engagement Plan with ultimate Board approval. The plan will include target audience, vision, goals, objectives, modes of communication, risks, milestones, and how effectiveness will be measured	Completed	3. Write formal recommendation to the Workforce Committee for adoption of the Workforce Communication and Engagement Plan with ultimate Board approval. The plan will include target audience, vision, goals, objectives, modes of communication, risks, milestones, and how effectiveness will be measured	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Schedule workforce communication events throughout subsequent year	Completed	4. Schedule workforce communication events throughout subsequent year	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #9 Inclusion of CBOs in PPS Implementation.	Completed	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	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1. Building upon relationships developed through the health homes, the PPS intends to contract with approximately 50 CBOs that provide a wide range of services including: housing services for the homeless, food banks, religious service organizations, peer and family mental health advocacy organizations, local public health programs, recovery coaches, and senior support services.	Completed	1. Building upon relationships developed through the health homes, the PPS intends to contract with approximately 50 CBOs that provide a wide range of services including: housing services for the homeless, food banks, religious service organizations, peer and family mental health advocacy organizations, local public health programs, recovery coaches, and senior support services.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	2. Contracting with the bulk of CBOs is expected to be	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
2. Contracting with the bulk of CBOs is expected to be completed by DY1, Q3. CBOs with major roles in the PPS projects will be the first to be contracted and others will follow as the implementation process dictates. The names of the CBO's are listed under External Stakeholders below and a more comprehensive list is included under Section 3.7 Stakeholder & Community Engagement (Community 3 of the PPS Organizational Application).		completed by DY1, Q3. CBOs with major roles in the PPS projects will be the first to be contracted and others will follow as the implementation process dictates. The names of the CBO's are listed under External Stakeholders below and a more comprehensive list is included under Section 3.7 Stakeholder & Community Engagement (Community 3 of the PPS Organizational Application).							
Task 3. Representatives from local CBOs have been important participants in the PAC, project development and the PPS Steering Committee. Several selected projects involve community based services and the project teams are chaired by CBO leaders.	Completed	3. Representatives from local CBOs have been important participants in the PAC, project development and the PPS Steering Committee. Several selected projects involve community based services and the project teams are chaired by CBO leaders.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	
Finalize partnership agreements or contracts with CBOs	
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass (with Exception) & Complete	
Milestone #2	Pass & Complete	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Complete	
Milestone #5	Pass & Complete	
Milestone #6	Pass & Complete	
Milestone #7	Pass & Complete	
Milestone #8	Pass & Complete	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #9	Pass & Complete	

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IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Organizational Mid-Point Assessment narrative	Completed	Organizational Mid-Point Assessment narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Organizational Mid-Point Assessment narrative	

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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.

There has been significant progress in aligning IHANY and the Alliance. Some Committees (including Clinical Integration are fully integrated) to ensure coordination of patient care standards. PwC has been retained to further refine Governance and functional integration.

2) Although these is always the potential for conflict and dissension among partners partners, many of whom have been traditional competitors in the marketplace, Alliance has been operating in a constructive, collaborative, and effective manner. Every effort will be made to keep the partnership strong and moving forward in a cohesive fashion.

3) Effective data sharing. The effective sharing of data among the Seven Key Partners and other practitioners is a risk given the different technology platforms being used. The AFBHC Technology Plan will address an orderly approach to sharing data hopefully mitigating this risk.
4) Practitioner engagement and alignment. Engaging 1,400 practitioners to achieve their portion of each project will be a challenge and a risk. Responsibilities by provider types have been identified for each project. Substantial training sessions and communication through several media (planned through Practitioner Engagement Section) are being prepared to promote practitioner engagement and increase the probabilities of successful engagement and alignment with goals. It is also hoped that the targeted incentive program will promote practitioner engagement.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Major dependencies with Governance center on approval and decision-making processes that result from workstreams. All major decisions of the AFBHC PPS (except those reserved to Members) will come before the Board of Managers. Committee leadership will update the Board monthly to ensure alignment of workstreams. Care management processes and clinical guidelines will go before the Clinical Integration and Quality Committee and subsequent to presentation to the Board of Managers. The Board will be keenly focused on the accomplishment of goals through the project implementation efforts, support provided by IT Systems and Processes, how practitioners remain engaged throughout the implementation and operational phases of projects, ensuring that key health delivery practitioners remain financially viable to serve members, having appropriate levels of trained and engaged workers, and that members are served in a compassionate culturally-competent manner.

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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
Members (e.g., owners)	Ellis Medicine, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young Jr Health Center, Hometown Health Centers. (See individuals' names in key stakeholders section)	Reserved powers, e.g.: amendment of governing documents, disposition of substantially all company's assets, mergers, dissolution, admission of new Member, the adoption or amendment of any methodology for the allocation of DSRIP funds, removal of a manager, appointment of CEO
Board of Managers	Seven Key Partners: (Ellis Medicine, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young, Jr. Health Center, Inc., Hometown Health Centers, Capital Care Medical Group, P.C., Community Care Physicians, P.C.), two Independent Practitioners, and PAC representative. (See individuals' names in key stakeholders section)	"Oversight of strategic direction, performance and achievement per Implementation Plan. Oversight of PPS Chief Executive Officer, strategic direction, Implementation Plan execution including milestones and metrics, short and long-term financial performance and health of the PPS and key providers, staffing, workforce development and engagement. Development of policies, provider agreements, fund distributions. "
Clinical Integration and Quality Committee (AFBHC and IHANY)	Clinical representatives will serve on a fully integrated IHANY/Alliance Clinical Integration and Quality Committee to promote the development of cohesive clinical protocols.	Clinical Integration in AFBHC and IHANY. Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network.
Finance Committee	CFOs from Board of Managers entities and other community based organizations will serve on the Finance Committee.	Oversee the financial sustainability and health of the AFBHC and practitioners ensuring the short and long term viability of the organization.
Health Homes	St. Mary's Healthcare Amsterdam, Samaritan Health Home, Care Central Health Home	Promotion of care coordination and access to social services. Single point of entry for referral to CBOs.
Project Advisory Committee	Over 34 members on PAC	Provide the community and overall stakeholder perspective, provide input and guidance over project development. Patients/beneficiaries can participate in ad hoc committees to enhance strategic direction of PPS.
Community Based Organizations	Approximately 50 CBOs	Access to social non-provider services. Deliver social services and coordinate with Health Homes and other providers
IT Committee	CIOs from Board of Manager entities, RHIO, and other providers	Technology support, making population health and clinical communication possible. Oversee the development and implementation of technology plan to ensure the support for clinical

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		workflows and timely, safe exchange of patient information.
Compliance Officer and Audit and Compliance Committee members	Colleen Susko	Compliance with federal and state laws and other regulations. Ensuring privacy protection and development and oversight of related policies.

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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		
Ellis Medicine	Paul Milton, Acting CEO,AFBHC, LLC Member and Board of Managers	Founding member, leadership, Board of Managers participant, committee participation.
Samaritan Hospital of Troy New York	Jim Reed, M. D., CEO, AFBHC, LLC Member and Board of Managers	Founding member, leadership, Board of Managers participant, committee participation.
St. Mary's Healthcare	Victor Giulianelli, CEO, AFBHC Board Chair, LLC Member and Board of Managers	Founding member, leadership, Board of Managers participant, committee participation.
Whitney M. Young, Jr. Health Center	David Shippee, CEO, AFBHC, LLC Member and Board of Managers	Founding member, leadership, Board of Managers participant, committee participation.
Capital Care Medical Group, P.C.	Lou Snitkoff, M. D., AFBHC, LLC Member and Board of Manager, and Secretary of the Board	Founding member, leadership, Board of Managers participant, committee participation.
Community Care Physicians, P.C.	Richard Scanu, COO/CFO, AFBHC, LLC Board of Managers	Leadership, Board of Managers participant, committee participation.
Hometown Health Center	Joe Gambino, CEO, AFBHC, LLC Member and Board of Managers, and Vice Chair of the Board	Leadership, Board of Managers participant, committee participation.
Independent Practitioners	AFBHC, LLC Board of Managers	Leadership, Board of Managers participant, committee participation.
Project Advisory Committee (PAC) representative	Kathy G. Alonge-Coons, LCSWR, Commissioner, Rensselaer County Mental Health, LLC Board of Managers	Leadership, Board of Managers participant, committee participation.
External Stakeholders		
Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga counties Health Departments	Participation and advice in all projects, and in particular 3.d.ii Asthma project and 4.b.i Tobacco cessation.	Project participation, performance, advice
Offices for the Aging (Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga)	Participation and advice in all projects, and in particular 3.g.i Palliative Care	Project participation, performance, advice
Rensselaer County Department of Mental Health	Kathy G. Alonge-Coons, LCSWR, Commissioner, serves on the PAC and represents the PAC on the AFBHC Board of Managers. In this role, she brings the perspective of mental health, substance use, and community services to the Board of Managers. In addition Ms. Coons and RCMH staff are instrumental in the development of projects: 3.a.i integration of BH and PC; 3.a.iv	Governance, project participation, performance, advice

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
	Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.	
Albany County Department of Mental Health	Stephen J. Giordano, Ph. D., Director, and staff participate in the project implementation plans and are instrumental in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse and 4.b.i Promote tobacco use cessation, 2.d.i Patient activation. Assist in the development of the community engagement plan.	Project participation, performance, advice
NYS Office of Mental Health	The NYS Dept. of Mental Health was represented during the development of the integration of behavioral health and primary care. The Department guidance will continue to be sought as the project is implemented. Assist in the development of the community engagement plan.	Advice in project development and implementation, overall advice on topic.
Schenectady Office of Community Services and Montgomery, Fulton, Saratoga counties Departments of Mental Health.	Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.	Project participation, performance, advice
State Office of Alcoholism and Substance Abuse Services (OASAS).	Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.	Project participation, performance, advice
State Office for People with Developmental Disabilities (OPWDD) which serves individuals with intellectual disabilities and developmental disabilities (ID/DD).	Participation in the development and implementation of 3.a.i integration of BH and PC; 3a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.	Project participation, performance, advice
Unity House of Troy, human services agency including services for the homeless.	Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.	Project participation, performance, advice
Equinox, Inc.. Provides comprehensive treatment, services, and support in the areas of substance use and mental health, youth shelter, and homeless services.	Provide guidance in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.	Project participation, performance, advice

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
New York State Division of Criminal Justice System (http://www.criminaljustice.ny.gov/opca/justice-mental-health.htm)	Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.	Project participation, performance, advice
Bureau of Housing and Support Services (BHSS) (https:otda.ny.gov/programs/housing/)	Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.	Project participation, performance, advice
Health Plans: MVP, Fidelis, CDPHP	Payers for entering into value based payment options and achieving care management goals	Value-based payment contracts. Collaboration in achieving care management protocols
Project Advisory Committee (PAC)	Advisory to Board of Managers	Advice on project plan implementation, provide pulse of the community

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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.

IT infrastructure is an essential component of creating the appropriate governance structure within and between the PPs within the Albany region. IT infrastructure will be developed to support the following population health management processes: (1) financial and clinical risk stratification; (2) care delivery and coordination; (3) patient engagement; (4) monitoring outcomes; and (5) assessing impact of intervention(s) on overall cost of care. The primary pre-requisite for enabling these processes is acquisition and aggregation of data from across the AFBHC and for the AFBHC attributed population as they receive services outside of the AFBHC. This task is complicated by the many IT systems that are being used across the PPS. In order to better determine the role of HIXNY and other data aggregation platforms, a comprehensive data assessment will be conducted. In parallel to the data assessment, a functionality needs assessment will be conducted at the DSRIP program level to prioritize the IT capabilities needed to support the individual programs. The needs of these individual projects will vary widely, but each will require several IT components to successfully report and sustain the requirements of the individual projects. The data assessment and the functionality needs assessment will drive decision-making about IT infrastructure and IT planning to support population health management program initiatives. The assessment will begin on the capability of using Hixny, the RHIO, to aggregate data about the attributed patients as they receive services inside and outside of the AFBHC. In support of the potential requirement for tracking patients beyond the AFBHC, the PPS will align required IT platforms with the state RHIO to provide event notifications to AFBHC providers for DSRIP patients as they move in and out of care settings throughout this and other State PPS's.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

The Governance work stream will be successful when all Board and Committee members are fully installed, are well educated about their roles and are able to execute effectively on their oversight responsibility after receiving meaningful written and verbal reports, and the PPS is in control of outcomes. This requires the timely formation of a governance structure with PPS-relevant committees. To be successful in their oversight role, the Board and Committee members must receive timely actionable dashboards and reports so that they can discuss, deliberate and take appropriate action in an effective and efficient manner. To be successful and measure progress, reporting will have to be PPS-wide including the areas of workforce, clinical and projects, finance, administrative, compliance, credentialing, and human resources.

9-24-15 Remediation Response: The PPS will develop a balance score card methodology to track where each project is on a monthly basis. This dashboard will be shared with the Board of Managers (BOM) at their monthly meetings. In addition, each organization will be provided the metrics that they need to achieve for each reporting period and there will be expectations that those metrics are reported to the Alliance on a certain date

each month. Key committees such as the Clinical Integration and Quality Committee (CIQC) will review metrics at their meetings and the PAC will be updated on a quarterly basis when they meet. The intent is for the entire organization to be aware of each party's performance so that the Alliance can begin to evolve into an organization that has codependencies with each other.

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Finalize Finance Committee Charter.	Completed	1. Finalize Finance Committee Charter.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Develop financial budgeting and reporting process working with providers, partners and project leads.	Completed	2. Develop financial budgeting and reporting process working with providers, partners and project leads.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Finance Committee briefs AFBHC Governance Board on budgeting and reporting process; process adopted by Board.	Completed	3. Finance Committee briefs AFBHC Governance Board on budgeting and reporting process; process adopted by Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Communicate reporting process to provider network	Completed	4. Communicate reporting process to provider network	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Begin reporting structure for AFBHC	Completed	5. Begin reporting structure for AFBHC	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Completed	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	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers							
Task 1. Request updated financial reports from all providers of the network with significant attributable lives	Completed	1. Request updated financial reports from all providers of the network with significant attributable lives	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Receive and analyze latest financial reports from major PPS partners and the other providers with significant attributable lives within the PPS that are critical to the projects being implemented.	Completed	2. Receive and analyze latest financial reports from major PPS partners and the other providers with significant attributable lives within the PPS that are critical to the projects being implemented.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Providers demonstrating fiscal distress, based upon industry benchmarks as selected, will be contacted by AFBHC finance to discuss condition and develop strategies for regaining financial stability	Completed	3. Providers demonstrating fiscal distress, based upon industry benchmarks as selected, will be contacted by AFBHC finance to discuss condition and develop strategies for regaining financial stability	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Additional data as needed collected from financially distressed providers including the completion of the DPP where determined needed.	Completed	4. Additional data as needed collected from financially distressed providers including the completion of the DPP where determined needed.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Finalize Distressed Provider Plan (DPP) report and process for monitoring	Completed	5. Finalize Distressed Provider Plan (DPP) report and process for monitoring	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Finance Committee presents network financial	Completed	6. Finance Committee presents network financial assessment to AFBHC Governing board	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
assessment to AFBHC Governing board									
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Develop Audit/Compliance Committee Charter	Completed	1. Develop Audit/Compliance Committee Charter	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. AFBHC Governing Board to appoint Audit/Compliance Committee and Compliance Officer	Completed	2. AFBHC Governing Board to appoint Audit/Compliance Committee and Compliance Officer	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Develop Compliance Program for AFBHC incorporating the 8 elements required by New York State Social Services Law 363-d, and present to AFBHC Audit/Compliance Board	Completed	3. Develop Compliance Program for AFBHC incorporating the 8 elements required by New York State Social Services Law 363-d, and present to AFBHC Audit/Compliance Board	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Monitor completion of performance program on a quarterly basis	Completed	4. Monitor completion of performance program on a quarterly basis	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Complete annual Compliance Certification required by OMIG	Completed	5. Complete annual Compliance Certification required by OMIG	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Compliance Officer to provide overview to AFBHC Governing Board on regular basis	Completed	6. Compliance Officer to provide overview to AFBHC Governing Board on regular basis	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop a Value Based Payments Needs Assessment ("VNA")	Completed	Administer VBP activity survey to network	08/01/2016	08/31/2016	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	YES
Task 1. AFBHC staff, in collaboration with Finance Committee, gather baseline revenue and	Completed	1. AFBHC staff, in collaboration with Finance Committee, gather baseline revenue and methods of reimbursement to determine fee for service and value based payment streams	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
methods of reimbursement to determine fee for service and value based payment streams									
Task 2. Review and analyze the VBP arrangements currently in existence within the AFBHC providers to determine if working as intended with providers involved in the VBP arrangements.	Completed	2. Review and analyze the VBP arrangements currently in existence within the AFBHC providers to determine if working as intended with providers involved in the VBP arrangements.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Using analysis of VBP arrangements and provider input, determine if modifications or enhancements are needed to existing arrangements as well as how new arrangements might be developed for the AFBHC.	Completed	3. Using analysis of VBP arrangements and provider input, determine if modifications or enhancements are needed to existing arrangements as well as how new arrangements might be developed for the AFBHC.	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 4. AFBHC staff and Finance Committee develop an education and communication strategy for the PPS network including educational materials to be shared with provider network.	Completed	4. AFBHC staff and Finance Committee develop an education and communication strategy for the PPS network including educational materials to be shared with provider network.	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Present educational materials to the provider community to assist providers in understanding VBP systems and gather input on preferred compensation modalities.	Completed	5. Present educational materials to the provider community to assist providers in understanding VBP systems and gather input on preferred compensation modalities.	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 6. Providers share input using survey tool on VBP methods, contracting and preferred compensation modalities which is compiled by AFBHC staff.	Completed	6. Providers share input using survey tool on VBP methods, contracting and preferred compensation modalities which is compiled by AFBHC staff.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. AFBHC finalize revenue assessment analysis and VBP data and generate report for Finance	Completed	7. AFBHC finalize revenue assessment analysis and VBP data and generate report for Finance Committee	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Committee									
Task 8. Finance Committee reviews report and provides comments.	Completed	8. Finance Committee reviews report and provides comments.	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 9. Generate final revenue assessment report	Completed	9. Generate final revenue assessment report	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 10. Present baseline revenue assessment report to AFBHC governing board for review and approval	Completed	10. Present baseline revenue assessment report to AFBHC governing board for review and approval	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Milestone #5 Develop an implementation plan geared towards addressing the needs identified within your VNA	In Progress	Submit VBP support implementation plan	08/01/2016	08/31/2016	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	YES
Task 1. Establish VBP workgroup to develop plan starting with prioritization of potential opportunities and providers for value based arrangements	Completed	1. Establish VBP workgroup to develop plan starting with prioritization of potential opportunities and providers for value based arrangements	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Engage Medicaid Managed Care Organizations in dialog on value based payment methodologies	Completed	2. Engage Medicaid Managed Care Organizations in dialog on value based payment methodologies	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Identify VBP accelerators and challenges within AFBHC PPS related to implementation of the VBP models including existing ACO and MCO model, shared savings arrangements, IT structure requirements and contracting complexities	Completed	3. Identify VBP accelerators and challenges within AFBHC PPS related to implementation of the VBP models including existing ACO and MCO model, shared savings arrangements, IT structure requirements and contracting complexities	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task	Completed	4. Align providers and projects where VBP accelerators and	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
4. Align providers and projects where VBP accelerators and challenges exist to develop timeline for VBP implementation		challenges exist to develop timeline for VBP implementation							
Task 5. Assess all data and development of VBP timeline with MCOs, AFBHC Finance Committee and staff, and providers workgroup	Completed	5. Assess all data and development of VBP timeline with MCOs, AFBHC Finance Committee and staff, and providers workgroup	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 6. Completion of VBP timeline and draft plan by workgroup	Completed	6. Completion of VBP timeline and draft plan by workgroup	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 7. Present timeline and plan to Finance Committee for review and comment	Completed	7. Present timeline and plan to Finance Committee for review and comment	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 8. Draft plan developed for presentation to boards of AFBHC and MCOs	Completed	8. Draft plan developed for presentation to boards of AFBHC and MCOs	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 9. Agreement between AFBHC and MCOs on plan	Completed	9. Agreement between AFBHC and MCOs on plan	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task 10. Agreement between AFBHC and MCOs on plan approved by respective governing boards	Completed	10. Agreement between AFBHC and MCOs on plan approved by respective governing boards	08/01/2016	08/31/2016	08/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Milestone #6 Develop partner engagement schedule for partners for VBP education and training	In Progress	Initial Milestone Completion: Submit VBP education/training schedule Ongoing Reporting: Submit documentation to support implementation of scheduled trainings, including training materials and attendance sheets through quarterly reports	12/31/2016	06/30/2017	12/31/2016	06/30/2017	06/30/2017	DY3 Q1	YES
Milestone #7 ≥50% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 8%* (blended for 15% target for fully	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
capitated plans (MLTC and SNPS) and 5% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher									
Milestone #8 ≥80% of total MCO payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 20%* (blended for 35% target for fully capitated plans (MLTC and SNPS) and 15% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
Finalize PPS finance structure, including reporting structure	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a Value Based Payments Needs Assessment ("VNA")	mccarrol	Documentation/Certification	3_DY2Q4_FS_MDL31_PRES4_DOC_R2_Fin_Sustn_M4_AFBH_VBP_Survey_15854.pdf	DY2Q4 Remediation Response	06/21/2017 09:27 AM
	mccarrol	Documentation/Certification	3_DY2Q4_FS_MDL31_PRES4_DOC_R2_Fin_Sustn_M4_AFBH_VBP_Assessment_-_Copy_15853.pdf	DY2Q4 Remediation Response	06/21/2017 09:27 AM
	mccarrol	Documentation/Certification	3_DY2Q4_FS_MDL31_PRES4_DOC_M#4_AFBH_VBP_Assessment_10042.pdf	Administer VBP activity survey to network.	04/12/2017 02:53 PM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	
Develop a Value Based Payments Needs Assessment ("VNA")	Based on the revised VBP milestones published in December 2016 and the VBP Adoption Needs Assessment Survey template released by the New York State Department of Health, Alliance for Better Health (Alliance) conducted a VBP needs assessment, described in greater detail below and in materials, attached. In March 2017, Alliance disseminated a needs assessment survey to 40 PPS partners. The survey included several questions designed to obtain an assessment of the current state of VBP in the PPS, including current participation in VBP arrangements, revenue derived from VBP arrangements, and the compensation modalities used in these VBP arrangements. Additional questions covered current resources being offered and used for care coordination, technology and analytic resources currently utilized, and the education needs of the PPS. The survey data was analyzed and will be utilized to help inform the educational sessions occurring in the current Demonstration Year. The attached slide deck provides aggregated data based on responses received through 3/31/2017 and constitutes a summary of the VBP Assessment conducted. Please see attached documents: R2 Fin Sustn M4 AFBH VBP Assessment R2 Fin Sustn M4 AFBH VBP Survey
Develop an implementation plan geared towards addressing the needs identified within your VNA	Milestone end date modified pursuant to DOH guidance.
Develop partner engagement schedule for partners for VBP education and training	
≥50% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 8%* (blended for 15% target for fully capitated plans (MLTC and SNPS) and 5% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	
≥80% of total MCO payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 20%* (blended for 35% target for fully capitated plans (MLTC and SNPS) and 15% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	
Milestone #2	Pass & Complete	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Complete	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	The PPS must revise deadline once PPS has defined the milestone per DOH guidance issued December 19, 2016.
Milestone #8	Pass & Ongoing	The PPS must revise deadline once PPS has defined the milestone per DOH guidance issued December 19, 2016.

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Organizational strategies required for the financial sustainability work stream could impact AFBHC PPS' efforts to achieve the outcome measure targets. Implementation of the financial reporting systems needed to monitor the financial stability of the network is key among these risks. Meaningful progress has been made in developing a common vision of the overall goals of DSRIP and the financial structure in place. Education and communication will continue to insure continuous improvement. A robust IT system supporting collection and analysis of the finances and flow of funds is critical to the success of this work stream. We are currently working with the IT committee in the development of an integrated IT system to not only support the financial work stream, but the full integration of project data and reporting functions. We submitted a capital request under the CRFP offered by DOH, that will be critical in the mitigation of this risk. One of the largest risks is the move from a fee for service payment system to a value based payment system in collaboration with the providers and the MCOs. This collaboration will be difficult as both the PPS and the MCOs have a financial interest in the outcomes, and prior to DSRIP, much of that process has been competitive and not collaborative. In addition, providers currently negotiate payments with MCOs individually, but under DSRIP, it is anticipated that some if not all of the negotiations for VBPs will be done at the PPS level. There will be major hurdles to overcome for this to change and become effective. This change in philosophy will take time and significant communication and support from DOH.

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.)

The financial success of this PPS and the achievement of the goals set forth, will be very dependent on all the other workstreams involved in the PPS. Communication and collaboration among all these workstreams will depend on timely and open communication along with the development of plans that effectively intertwine all the workstreams. The Board of Managers must provide a fully supportive governance process to establish the roles and responsibilities of the AFBHC committees. Information Technology is integral to the success of the projects selected by the PPS. Finance must insure that funds are available for this workstream. The workforce team is currently reviewing an implementation plan related to the impacts, strategies, and costs related to successful transition of the workforce. This will require open and frequent communication with the finance workstream to be successful. Clinical integration is vital for all of the projects and finance must understand how to best support this clinical integration in the most effective and cost efficient way.

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IPQR Module 3.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Finance Committee Member	Mary Connelly - CFO/Whitney M. Young Health Center	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Rusty Senecal - CFO/Capital Care Medical Group	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Rick Scanu - CFO/Community Care Physicians	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Eric Burton - CFO/Hometown Health Center	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Rick Henze - CFO/St Mary's Healthcare	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Thomas Schuhle - CFO/St. Peter's Health Partners	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Mark Mesick - CFO/Ellis	Board level oversight and responsibility for the PPS Finance

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	In Progress/Clinical Representative	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	In Progress/Clinical Representative	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Millie Ferriter/Community Representative	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Sheila Nelson/CDPHP (MCO)	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Joseph Twardy/CBO Stakeholder	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Paul Milton/Governance Representative	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	"Anoush Koroghlian-Scott; Julieann Diamond; Robert Swidler /Legal Representative (Rotating Every Six Months)"	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Finance Committee Member	Michele Kelly/Community Representative	Board level oversight and responsibility for the PPS Finance function; review and approval of finance related policies and procedures; oversight of PPS Lead role, responsibilities and deliverables; oversight of audit and compliance related processes
Chief Financial Officer	Dan Rinaldi (Interim)/AFBHC Finance Office	Provide guidance and oversight for the Funds Flow Plan, the Financial Stability Plan, and other relevant processes. The

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		responsibilities include managing and distributing funds according to the approved plan, ensuring reporting requirements are met, and that communication regarding the Finance related functions is timely and accurate.
Accounting Manager	John Gahan (Interim) /AFBHC Finance Office	Responsible for the daily operations of the Finance Office, including programmatic development of the infrastructure tools critical to the Funds Flow Plan and the related banking, accounts payable and general ledger functions.
Accountant/Financial Analyst	Donna Choiniere (Interim)/AFBHC Finance Office	Responsible for assisting Accounting Manager with the day to day activities related to banking, accounts payable and general ledger functions
Financial Analyst	In Progress/AFBHC Finance Office	Responsible for assisting Accounting Manager with the day to day activities related to banking, accounts payable and general ledger functions
Compliance Officer	Colleen Susko/AFBHC Compliance Officer	Responsible for the development and oversight of AFBHC Compliance Plan and related training, and education; responsible for annual OMIG Compliance Certification
Data Analyst	In Progress/AFBHC Finance Office	Responsible for assisting with data analyses, financial sustainability monitoring and reporting required for DSRIP plan implementation
Data Analyst	In Progress/AFBHC Finance Office	Responsible for assisting with data analyses, financial sustainability monitoring and reporting required for DSRIP plan implementation
VBP Project Manager	In Progress/VBP Committee	Coordinate overall development of VBP baseline assessment and plan for achieving value based payments
VP of Performance Operations	Tom McCarroll (Interim)/AFBHC Performance Office	Provide guidance and oversight for the Performance Operations of AFBHC. Works closely with Finance in determing Funds Flow methodology and its relationship to the performance of PPS providers.
VP of Clinical Operations	Brenda Maynor (Interim)/AFBHC Clinical Office	Provide guidance and oversight for the Clinical Operations of AFBHC. Works closely with Finance in determing the financial implications of the projects and the budgetary needs for project success.

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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		
Joe Twardy/Project Lead	Develop budgets, and provide guidance and support for projects 2.a.i and 2.b.viii workstream	Budgets and reporting for projects; Communication to project management office
Scott Friedlander/Project Lead	Develop budgets, provide guidance and support for project 2.b.iii workstream	Budgets and reporting for projects; Communication to project management office
Brenda Maynor/Project Lead	Develop budgets, provide guidance and support for project 2.b.iv workstream	Budgets and reporting for projects; Communication to project management office
Millie Ferriter/Project Lead	Develop budgets, provide guidance and support for project 3.g.i. workstream	Budgets and reporting for projects; Communication to project management office
Dave Shippee/Project Lead	Develop budgets, provide guidance and support for project 3.a.1 and 3.d.ii workstream	Budgets and reporting for projects; Communication to project management office
Patrick Carrese/Project Lead	Develop budgets, provide guidance and support for project 3.a.iv workstream	Budgets and reporting for projects; Communication to project management office
Keith Brown/Project Lead	Develop budgets, provide guidance and support for project 3.a.iv workstream	Budgets and reporting for projects; Communication to project management office
Erin Simao/Project Lead	Develop budgets, provide guidance and support for project 2.d.i workstream	Budgets and reporting for projects; Communication to project management office
Pamela Rehak/Project Lead	Develop budgets, provide guidance and support for project 2.a.i workstream	Budgets and reporting for projects; Communication to project management office
Katherine Alonge-Coons/Project Lead	Develop budgets, provide guidance and support for project 4.a.iii workstream	Budgets and reporting for projects; Communication to project management office
Amanda Mulhern/Project Lead	Develop budgets, provide guidance and support for project 4.b.i workstream	Budgets and reporting for projects; Communication to project management office
In Progress/Clinical Integration and Quality Committee Member	Advisement on clinical integration issues related to financial matters	Reports on clinical integration and the effect on financial matters; Communication to clinical staff
In Progress/Workforce Committee	Provide input and data related to financial impacts due to workforce modifications	Budgets and reporting for training, redeployment and related workforce issues; Communication to workforce regarding financial matters
In Progress/AFBHC IT Manager	Provide appropriate software and system tools for all finance functions	Information Technology related requirements for the finance function; access to data for the finance function reporting

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		requirements
Vic Giulianelli	SMHA CEO and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
William Mayer, MD	SMHA CMO and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Paul Milton	Ellis CEO and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Roger Barrowman, MD	Ellis VP/, CEO of Ellis Medical Group, and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Dave Shippee	Whitney Young CEO and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Theodore Zeltner, MD	Whitney Young MD and Theodore Zeltner, MD	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Lou Snitfoff, MD	Capital Care MD and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Rusty Senecal	Capital Care Director of Finance and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Rick Scanu	Community Care CFO/COO and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Barbara A. Morris, MD	Community Care MD and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Joe Gambino	Hometown Health CEO and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
David Skory, MD	Hometown Health MD and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Jim Reed, MD	SPHP CEO and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
Paul Barbarotto, DO	SPHP Physician and AFBHC Board of Managers	PPS Network Provider partners' BOM have overall responsibility for their organizations' execution of their DSRIP responsibilities, they will contribute to the success of the finance function and finance related strategies
TBD/AFBHC PMO	Project Management Office	PMO oversight and leadership for oversight of DSRIP initiatives for the PPS
TBD	Internal Audit	Oversight of internal controls functions related to funds flow, network provider reporting and other finance related control processes
External Stakeholders		
Sheila Nelson/CDPHP	Participation in development of value based financial models	Attendance at meetings, providing financial reports and analysis input
Timothy Tilton/Fidelis	Participation in development of value based financial models	Attendance at meetings, providing financial reports and analysis input
Jordan Estey/MVP	Participation in development of value based financial models	Attendance at meetings, providing financial reports and analysis input
Karla Austen/MVP	Participation in development of value based financial models	Attendance at meetings, providing financial reports and analysis input
Michele Kazala/MVP	Participation in development of value based financial models	Attendance at meetings, providing financial reports and analysis input
PAC Representatives	Input and feed back to assist finance committee	Participation and Communication with PAC committee members
Keith Brown /Catholic Charities of the Diocese of	Participate on AFBHC committees	Represent the community through participation in AFBHC DSRIP

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Albany		committees
Aaron Howland/ Catholic Charities of the Diocese of Albany	Participate on AFBHC committees	Represent the community through participation in AFBHC DSRIP committees
Robert Schaffer/ PYHIT	Participate on AFBHC committees	Represent the community through participation in AFBHC DSRIP committees
Jennifer Sauders/ Liberty ARC	Participate on AFBHC committees	Represent the community through participation in AFBHC DSRIP committees
Michael Countryman/ The Family Counseling Center	Participate on AFBHC committees	Represent the community through participation in AFBHC DSRIP committees
Greg DeWitt/ Iroquois Healthcare Alliance	Workforce Consultant	Workforce data collection and reporting. Education partnerships.
In Progress/External Auditor	External Auditor	Responsible for External Audit function
Steve Shepherd / Rensselaer County Department of Mental Health	Government agency and safety net provider	County Agency with oversight and influence on DSRIP related areas
DSRIP Support Team/ NYS DOH	Government Agency/Regulator	State Agency and regulatory body with oversight and influence on DSRIP, including waivers of regulations, strategy and support
NYS DOH	Government Agency/Regulator	State Agency and regulatory body with oversight and influence on DSRIP, including providing data needed for developing and monitoring success of DSRIP projects, construction/renovation projects and support
NYS OMIG	Government Agency/Regulator	State Agency and regulatory body with oversight and influence on DSRIP compliance issues
NYS OASAS	Government Agency/Regulator	State Agency and regulatory body with oversight and influence on alcohol and substance abuse DSRIP projects
NYS OMH	Government Agency/Regulator	State Agency and regulatory body with oversight and influence on alcohol and substance abuse DSRIP projects
HANYS	Healthcare Association	Provide leadership, representation and services to member health care providers
Iroquois Healthcare	Healthcare Alliance	Serve as a resource and provide support to members and the communities they serve through advocacy, education, information, cost-saving initiatives and business solutions

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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.

The development of a shared IT infrastructure across the PPS is a major pillar that needs to be built and supported in order for the PPS to be successful. This IT integration will allow real time patient data to be shared by the partners in the PPS, such as a patient portal and population health modules that are involved in the various projects undertaken by the PPS. This integration of IT will also allow for the reporting of needed financial and budget information across the PPS in an efficient and expedient manner thus allowing the financial sustainability to be monitored, as well as the flow of DSRIP funding among categories, projects and providers.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

We will align our AFBHC PPS financial management and sustainability progress reporting with the reporting and oversight structures in place for the DSRIP projects, through the AFBHC PMO. The staff of the AFBHC will be responsible for monitoring progress against project requirements and process measures at a provider level. This information will be shared with the Finance Committee of the AFBHC for review and input, and reports will be generated and shared on a regular basis with the Governing Board of AFBHC to provide input and guidance as well as corrective action if needed. The success of the financial workstream will be measured by the timeliness of the reporting as set forth in the plan, the development and implementation of proactive steps to determine financial sustainability, the avoidance of financial instability of partners, and the communication of this reporting to the partners and community in a timely fashion.

IPQR Module 3.9 - IA Monitoring

Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Establish a Task Force with representation from PPS partners and community based organizations to review and refine AFBHC's Cultural Competence / Health Literacy / Community Engagement strategy.	Completed	1. Establish a Task Force with representation from PPS partners and community based organizations to review and refine AFBHC's Cultural Competence / Health Literacy / Community Engagement strategy.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Refine PPS strategy defined in the Cultural Competency/Health Literacy DSRIP application. Plan will include the following:	Completed	2. Refine PPS strategy defined in the Cultural Competency/Health Literacy DSRIP application. Plan will include the following:	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	3. Develop schedule and support the Seven Key Partners	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
3. Develop schedule and support the Seven Key Partners (Ellis Hospital, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young, Jr. Health Center, Inc., Hometown Health Centers, Capital Care Medical Group, P.C., Community Care Physicians, P.C.) to conduct a Cultural Competency, Health Literacy, Engagement Self-Assessment to establish baseline current state. Based on results, refine tactical plan to accomplish strategy. (Using/adapting assessment tools from NWICA Cultural Competency Organizational Questionnaire, Emory University Health Plan Organizational Assessment of Health Literacy Activities, and the Carmen, et. al. "Multidimensional Framework for Patient and Family Engagement in Health and Health Care.")		(Ellis Hospital, Samaritan Hospital of Troy, New York, St. Mary's Healthcare, Whitney M. Young, Jr. Health Center, Inc., Hometown Health Centers, Capital Care Medical Group, P.C., Community Care Physicians, P.C.) to conduct a Cultural Competency, Health Literacy, Engagement Self-Assessment to establish baseline current state. Based on results, refine tactical plan to accomplish strategy. (Using/adapting assessment tools from NWICA Cultural Competency Organizational Questionnaire, Emory University Health Plan Organizational Assessment of Health Literacy Activities, and the Carmen, et. al. "Multidimensional Framework for Patient and Family Engagement in Health and Health Care.")							
Task "4. Develop Health Literacy Guideline: Standardize literacy screening by adding the SILS (Single Item Literacy Screener) to admission / intake processes and documentation; define interventions per literacy level; standardize / align patient materials and caregiver tools; begin to track outcomes by literacy "	Completed	"4. Develop Health Literacy Guideline: Standardize literacy screening by adding the SILS (Single Item Literacy Screener) to admission / intake processes and documentation; define interventions per literacy level; standardize / align patient materials and caregiver tools; begin to track outcomes by literacy "	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task "5. Develop Cultural Competency Guideline: Refine demographic characteristics assessed on admission / intake to more accurately capture cultural needs; define interventions according to population's needs; standardize / align patient materials and caregiver tool; begin to track outcomes for disparate population groups "	Completed	"5. Develop Cultural Competency Guideline: Refine demographic characteristics assessed on admission / intake to more accurately capture cultural needs; define interventions according to population's needs; standardize / align patient materials and caregiver tool; begin to track outcomes for disparate population groups "	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	Completed	"6. Establish standards and expectations for community	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
"6. Establish standards and expectations for community advisory roles; implement advisory processes at governance level, program, unit , and practice levels as indicated		advisory roles; implement advisory processes at governance level, program, unit , and practice levels as indicated							
Task 7. Review suggested structure, process, and outcome evaluation measures and develop cultural comp/health lit/ engagement dashboard. Include health outcomes for defined disparate groups.	Completed	7. Review suggested structure, process, and outcome evaluation measures and develop cultural comp/health lit/ engagement dashboard. Include health outcomes for defined disparate groups.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Explore adding cultural competency & health literacy item set to HCAHPS survey	Completed	8. Explore adding cultural competency & health literacy item set to HCAHPS survey	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 9. Cultural Competency and Health Literacy Task force reviews strategy	Completed	9. Cultural Competency and Health Literacy Task force reviews strategy	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 10. Submit the cultural competency / health literacy strategy to PPS board for approval.	Completed	10. Submit the cultural competency / health literacy strategy to PPS board for approval.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Completed	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task 1. Determine baseline cultural competency training needs of staff, including those working with special populations (Behavioral Health, ID/IDD, substance use), through evidence-based cultural competency assessments and advisement from state agencies and CBOs.	Completed	1. Determine baseline cultural competency training needs of staff, including those working with special populations (Behavioral Health, ID/IDD, substance use), through evidence-based cultural competency assessments and advisement from state agencies and CBOs.	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Identify best practices throughout the PPS for	Completed	2. Identify best practices throughout the PPS for training staff about cultural and linguistic sensitive behavior for working	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
training staff about cultural and linguistic sensitive behavior for working with ethnic minorities, persons in poverty, LGBTQ, disabilities, substance abuse. Evaluate best practices for deployment across the PPS.		with ethnic minorities, persons in poverty, LGBTQ, disabilities, substance abuse. Evaluate best practices for deployment across the PPS.							
Task 3. Staff: Using the Standards for Culturally and Linguistically Appropriate Services (CLAS) as a guide, coordinate with the Workforce Workstream to design training goals, curriculum, target audience, methods, system for tracking completion, training schedule, and evaluation plan to prepare staff to be culturally and linguistically competent.	Completed	3. Staff: Using the Standards for Culturally and Linguistically Appropriate Services (CLAS) as a guide, coordinate with the Workforce Workstream to design training goals, curriculum, target audience, methods, system for tracking completion, training schedule, and evaluation plan to prepare staff to be culturally and linguistically competent.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task "4. Patients: Research strategies such as a Self-Management Education Program (ex. Standard Self-Management Model) that are administered from the PPS level to increase capacity and flexibility of offerings. Research models that have been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self Management model or similar program) "	Completed	"4. Patients: Research strategies such as a Self-Management Education Program (ex. Standard Self-Management Model) that are administered from the PPS level to increase capacity and flexibility of offerings. Research models that have been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self Management model or similar program) "	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Conduct assessment of identified CBOs to determine capacity to assist with training, outreach and engagement activities to the target populations and develop contracting strategy.	Completed	5. Conduct assessment of identified CBOs to determine capacity to assist with training, outreach and engagement activities to the target populations and develop contracting strategy.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Community Health Workers (CHW): Using NY benchmarks as guide, establish expectations, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Explore and adapt innovative outreach strategies to engage diverse	Completed	6. Community Health Workers (CHW): Using NY benchmarks as guide, establish expectations, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Explore and adapt innovative outreach strategies to engage diverse populations (e.g. promotoras for the Hispanic/Latino community).	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
populations (e.g. promotoras for the Hispanic/Latino community).									
Task 7. Patient, Family, Community Engagement. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide, develop a training program for advisor roles in the PPS.	Completed	7. Patient, Family, Community Engagement. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide, develop a training program for advisor roles in the PPS.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8. Cultural Competency and Health Literacy Task force reviews training plan.	Completed	8. Cultural Competency and Health Literacy Task force reviews training plan.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9. Submit plan to AFBHC Board for approval.	Completed	9. Submit plan to AFBHC Board for approval.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 10. Determine roll-out logistics and implement strategy.	Completed	10. Determine roll-out logistics and implement strategy.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

NYS Confidentiality – High

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
appropriate material).	

Milestone Review Status

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

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

One risk in implementing the Cultural Competency / Health Literacy Strategy and training is that historically, programs for reducing health disparities and improving outcomes for underserved and marginalized populations have depended on time-limited grant and program funding. As a mitigation strategy, the PPS will identify sustainable funding for key programs addressing health disparities. Because cultural competence is tied to one's own individual value system, lack of workforce and provider engagement in behavior change is a risk for successfully implementing the cultural competency/health literacy/engagement strategy. To mitigate this risk, the CCO will partner with the Schenectady Bridges Out of Poverty Program to train frontline workers, community service providers and healthcare providers to understand the barriers experienced by people living in poverty. The CCO will use a training-the-trainer philosophy and approach to promote peer to peer learning and extend the network of expertise throughout the PPS. Patient education materials will be aligned and standardized to ensure that frontline workers and providers have easy access to the tools they need. To embed cultural competency, health literacy and patient engagement into daily patient / client interfaces, guidelines are being developed that will be triggered by an intake / admission assessment, similar to risks for medical conditions like assessing risk for deep vein thrombosis (DVT) on hospital admission.

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.)

Cultural competency must be integrated into the PPS's overall strategic planning. In selecting projects, the PPS considered those marginalized populations identified in the CNA: persons with or at risk for mental, emotional and behavior health disorders; persons with substance abuse disorders; persons living in poverty or low-income; persons without access to primary care; and ethnic minorities. Individuals in one or more of these populations often have multiple chronic illnesses and are high health care utilizers. The Cultural Competency Office (CCO) will continue program development and evaluation of projects to support these subpopulations. Planning and executing the training strategy will be coordinated with the Workforce workstream to leverage existing training resources and infrastructure and to track training participation and completion. The cultural competency strategy is a cross-cutting intervention that applies to all DSRIP projects and will be embedded into each project planning and implementation plan through policies and procedures, workflow design, and workforce selection.

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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
PPS cultural competency / health literacy / community engagement lead / Project 11 (2.d.i) lead	Erin Simao	Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training
Cultural Competency and Health Literacy Task force	In Progress	Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training
Project lead for 2.b.iii, 2.b.iv, 3.g.i	Scott Friedlander	Integrate cultural competency and health literacy protocols in the implementation of the projects
Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i	In Progress	Integrate cultural competency and health literacy protocols in the implementation of the projects
Community based organizations	Approximately 50 CBOs to be engaged	"Collaborate for CHW recruitment, training and placement Participate in community advisory committees, inform training curriculum and conduct components of the training "
Workforce Committee	In Progress	"Collaborate for CHW recruitment, training and placement Collaborate for organizing, delivering and tracking training and participation"
IT & Data Committee	CIOs from Board of Manager entities, RHIO, and other providers	Technology support, making population health and clinical communication possible. Oversee the development and implementation of technology plan to ensure the support for clinical workflows and timely and safe exchange of patient information.
Participation and advice in all projects, and in particular 3.d.ii Asthma project and 4.b.i Tobacco cessation.	Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga counties Health Departments	Project participation, performance, advice
Participation and advice in all projects, and in particular 3.g.i Palliative Care	Offices for the Aging (Schenectady, Albany, Rensselaer, Montgomery, Fulton, Saratoga)	Project participation, performance, advice
Ms. Kathy G. Alonge-Coons, LCSWR, Commissioner, serves on the PAC and represents the PAC on the AFBHC Board of Managers. In this role, she brings the perspective of mental health, substance use, and community services to the Board of Managers. In addition Ms. Coons and RCMH staff are instrumental in the development of projects: 3.a.i integration of BH	Rensselaer County Department of Mental Health	Governance, project participation, performance, advice

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.		
Stephen J. Giordano, Ph. D., Director, and staff participate in the project implementation plans and are instrumental in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse and 4.b.i Promote tobacco use cessation, 2.d.i Patient activation. Assist in the development of the community engagement plan.	Albany County Department of Mental Health	Project participation, performance, advice
The NYS Dept. of Mental Health was represented during the development of the integration of behavioral health and primary care. The Department guidance will continue to be sought as the project is implemented. Assist in the development of the community engagement plan.	NYS Office of Mental Health	Advice in project development and implementation, overall advice on topic.
Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.	Schenectady Office of Community Services and Montgomery, Fulton, Saratoga counties Departments of Mental Health.	Project participation, performance, advice
Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.	State Office of Alcoholism and Substance Abuse Services (OASAS).	Project participation, performance, advice
Participation in the development and implementation of 3.a.i integration of BH and PC; 3a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.	State Office for People with Developmental Disabilities (OPWDD) which serves individuals with intellectual disabilities and developmental disabilities (ID/DD).	Project participation, performance, advice
Participation in the development and implementation of 3.a.i integration of BH and PC;	Unity House of Troy, human services agency including services for the homeless.	Project participation, performance, advice

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.		
Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.	Equinox, Inc.. Provides comprehensive treatment, services, and support in the areas of substance use and mental health, youth shelter, and homeless services.	Project participation, performance, advice
Participation in the development and implementation of 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i Patient Activation. Assist in the development of the community engagement plan.	New York State Division of Criminal Justice System (http://www.criminaljustice.ny.gov/opca/justice-mental-health.htm)	Project participation, performance, advice
Provide guidance I in the development of projects: 3.a.i integration of BH and PC; 3.a.iv Development of Withdrawal Mgt. centers, 4.a.iii Strengthen Mental Health and Substance Abuse, 2.d.i patient activation. Assist in development of community engagement plan.	Bureau of Housing and Support Services (BHSS) (https:otda.ny.gov/programs/housing/)	Project participation, performance, advice

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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		
Board of Managers	Leadership	"Approve organizational structure with Cultural Competency / Health Literacy / Engagement office and staff Approve Cultural Competency / Health Literacy / Engagement strategy"
Ellis Medicine	AFBHC partner	Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices
St. Peters Health Partners	Active Parent of AFBHC partner	Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices
Whitney M. Young, Jr. Health Center	AFBHC partner	Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices
Hometown Health Centers	AFBHC partner	Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices
St. Mary's Healthcare	AFBHC partner	Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices
Community Care Physicians, P.C.	AFBHC partner	Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures and practices
Capital Care Medical Group, P.C.	AFBHC partner	Conduct current state assessment; support staff and providers to attend training; demonstrate cultural competency/health literacy/engagement views in administrative policies, procedures

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		and practices
Innovative Health Alliance of New York, LLC (IHANY)	Innovative Health Alliance of New York LLC (IHANY) is an Accountable Care Organization (ACO) participating in the Medicare Shared Savings Program (MSSP). IHANY has the same service area and many of the same partners and providers as AFBHC, so the two entities expect to share appropriate functions to maximize efficiency and effectiveness.	Include cultural competency / health literacy / patient engagement perspectives in clinical guidelines (i.e. ethnic groups at risk for certain diseases)
PPS members and affiliates	Carry out cultural competency / health literacy / community engagement strategy	"Deliver culturally and language appropriate services to improve health outcomes "
External Stakeholders		
PAC	Advisor	Provide input and feedback from community
SHIP and PHIPS Programs	Subject matter and training expertise	Collaborate on training development and delivery
Bridges Out of Poverty	Subject matter expertise	Collaborate on training development and delivery
US Committee for Refugees and Immigrants	Subject matter expertise	English as a Second Language training
Healthy Capital District Initiative	Subject matter expertise	Collaborate on training development and delivery
"Schenectady Community College SUNY"	Contribute experience from the HPOG demonstration project	Post-secondary program collaboration

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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.

Information technology expectations include 1) the ability to identify and document additional socio-economic characteristics and health literacy status on intake and admissions fields to flag patient status for staff, care providers, and care givers and activate cultural competency/health literacy guidelines; 2) the ability to sort outcomes according to disparate population characteristics; and 3) use of the educational platform to offer, track and manage educational and training offerings. Additionally, information technology will develop the infrastructure to support a multi-pronged, multi-platform, and multi-lingual approach to improving patient health literacy and adherence to plans of care through patient engagement modalities such as text messaging of appointment reminder.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

We will measure the success of this workstream by the timely completion of the milestones. We are also refining the demographic, socio-economic, and literacy assessment on the intake / process. These fields will trigger their respective guidelines for frontline workers and providers. Differentiating disparities more clearly will allow the PPS to sort and track clinical data according to disparate groups. Based on the results of baseline cultural competency assessments, we will develop an Organizational Cultural Competence Assessment Profile (prepared for the U.S. Department of Health and Human Services by The Lewin Group, Inc., 2002) to be used by the Seven Key Partners. This profile will outline the structure, process and output required to provide culturally competent care across seven domains (organizational values, governance, planning and monitoring/evaluation, communication, staff development, organizational infrastructure and services/interventions). It will serve as a roadmap for implementation and a tool for measuring progress. As described above, a cultural comp/health lit/engagement dashboard will also be developed. The dashboard will track process measures such as number of staff attending training, compliance with new admission assessment questions, and compliance with guidelines

IPQR Module 4.9 - IA Monitoring

Instructions :

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Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Completed	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	NO
Task 1) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to EHR adoption and Meaningful Use, including current manual processes used; collaborate with PCMH accreditation process	Completed	1) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to EHR adoption and Meaningful Use, including current manual processes used; collaborate with PCMH accreditation process	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2) Review strategies needed for DSRIP specific Patient Engagement set by the DSRIP projects	Completed	2) Review strategies needed for DSRIP specific Patient Engagement set by the DSRIP projects	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to Patient Engagement Tool and Strategies including patient portals, existing state-based tools (e.g., Curam), telehealth, and existing manual processes	Completed	3) Perform IT Assessment and Issue Resolution Planning with PPS Partners related to existing technologies and overlap with DSRIP specific to Patient Engagement Tool and Strategies including patient portals, existing state-based tools (e.g., Curam), telehealth, and existing manual processes	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4) Perform current state assessment with Hixny specific to DSRIP reporting and connectivity	Completed	4) Perform current state assessment with Hixny specific to DSRIP reporting and connectivity requirements to include: 1. Determine what data is available to support the DSRIP	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
requirements to include: 1. Determine what data is available to support the DSRIP reporting, 2. Determine what providers are connected to Hixny, 3. Determine how the data is currently captured and measures would be created (e.g., central vs. individual PPS partners)		reporting, 2. Determine what providers are connected to Hixny, 3. Determine how the data is currently captured and measures would be created (e.g., central vs. individual PPS partners)							
Task 5) From gap analysis resulting from current state assessment, determine options for filling gaps including state-based tools (e.g., MAPP), RHIO (i.e., Hixny), and 3rd party solutions	Completed	5) From gap analysis resulting from current state assessment, determine options for filling gaps including state-based tools (e.g., MAPP), RHIO (i.e., Hixny), and 3rd party solutions	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	NO
Task 1) Create governance (e.g., committees, decision making process) for making IT decisions at two levels: the Alliance for Better Health Care and the PPS member levels	Completed	1) Create governance (e.g., committees, decision making process) for making IT decisions at two levels: the Alliance for Better Health Care and the PPS member levels	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2) Perform data governance assessment including defining appropriate data stewards and tools for managing data specific to population health	Completed	2) Perform data governance assessment including defining appropriate data stewards and tools for managing data specific to population health	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3) Develop an Education and Training Plan with the population health tool vendors specific to the new tools	In Progress	3) Develop an Education and Training Plan with the population health tool vendors specific to the new tools	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 4) Develop a Communication Plan, including stakeholder analysis (including those within IT	Completed	4) Develop a Communication Plan, including stakeholder analysis (including those within IT and those affected by IT) and matching stakeholders to appropriate communication	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and those affected by IT) and matching stakeholders to appropriate communication method (e.g., newsletter, roadshows) to Inform all Stakeholders and Users		method (e.g., newsletter, roadshows) to Inform all Stakeholders and Users							
Task 5) Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks	In Progress	5) Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 6) Develop a process for determining operational readiness of the PPS partners to implement the various changes	In Progress	6) Develop a process for determining operational readiness of the PPS partners to implement the various changes	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 7) Develop a process for prioritizing changes needed, including appropriate governance and input from PPS membership	Completed	7) Develop a process for prioritizing changes needed, including appropriate governance and input from PPS membership	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8) Develop a workflow process for authorizing and implementing IT changes leveraging governance structures	Completed	8) Develop a workflow process for authorizing and implementing IT changes leveraging governance structures	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Completed	Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO

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Task 1) Use IT Assessment to develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements to support data sharing and implementation of interoperable IT platform	Completed	1) Use IT Assessment to develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements to support data sharing and implementation of interoperable IT platform	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2) Review IT Assessment based on the DSRIP project needs specific to new systems needed or changes to existing systems; note where RHIO connectivity is needed and/or new Electronic Health Record	Completed	2) Review IT Assessment based on the DSRIP project needs specific to new systems needed or changes to existing systems; note where RHIO connectivity is needed and/or new Electronic Health Record	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3) Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs	Completed	3) Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4) Develop governance framework with overarching rules for road to interoperability and clinical data sharing	Completed	4) Develop governance framework with overarching rules for road to interoperability and clinical data sharing	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5) Validate existing data exchange legal and compliance framework to ensure that it supports DSRIP data exchange requirements that meet patient consent needs including: care management records (complete subcontractor Data Exchange Applications and Agreement (DEAAs) with all Medicaid providers within PPS; contracts with all Community Based Organizations (CBOs) including a BAA documenting the level of Patient Health Information (PHI) to be shared and the purpose of this data sharing	Completed	5) Validate existing data exchange legal and compliance framework to ensure that it supports DSRIP data exchange requirements that meet patient consent needs including: care management records (complete subcontractor Data Exchange Applications and Agreement (DEAAs) with all Medicaid providers within PPS; contracts with all Community Based Organizations (CBOs) including a BAA documenting the level of Patient Health Information (PHI) to be shared and the purpose of this data sharing	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6) Determine technical standards and	Completed	6) Determine technical standards and implementation guidance for sharing and using a common clinical data set	12/31/2015	03/31/2016	12/31/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
implementation guidance for sharing and using a common clinical data set through Electronic Health Records and/or other PHM tools		through Electronic Health Records and/or other PHM tools							
Task 7) Perform gap analysis and develop associated roadmap of data types and content required to support DSRIP project requirements compared to current and planned data from HIXNY	Completed	7) Perform gap analysis and develop associated roadmap of data types and content required to support DSRIP project requirements compared to current and planned data from HIXNY	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8) Perform gap analysis and develop associated roadmap of interoperability and integration needs between HIXNY and selected tools (including PHM and EHR)	Completed	8) Perform gap analysis and develop associated roadmap of interoperability and integration needs between HIXNY and selected tools (including PHM and EHR)	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 9) Conduct proof of concept/IT systems testing to validate capability to achieving clinical data sharing and interoperable systems across PPS network	Completed	9) Conduct proof of concept/IT systems testing to validate capability to achieving clinical data sharing and interoperable systems across PPS network	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 10) Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes	Completed	10) Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Completed	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1) Review and incorporate attribution methodology for attributed lives to define which providers should engage which members	Completed	1) Review and incorporate attribution methodology for attributed lives to define which providers should engage which members	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 2) Define member segments and associated specific engagement needs (e.g., geo-access assessment, cultural/linguistic needs); develop segment specific to different patient behavior needs: patients who do not use services appropriately as opposed to patients who need	Completed	2) Define member segments and associated specific engagement needs (e.g., geo-access assessment, cultural/linguistic needs); develop segment specific to different patient behavior needs: patients who do not use services appropriately as opposed to patients who need reminders to go to an appointment with the PCP	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
reminders to go to an appointment with the PCP									
Task 3) Determine appropriate methods and incremental technological services needed for engaging patients and delivering care (e.g., patient portal, text messages) for different member segments	Completed	3) Determine appropriate methods and incremental technological services needed for engaging patients and delivering care (e.g., patient portal, text messages) for different member segments	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 4) Incorporate different member segments needs in selecting appropriate technologies	Completed	4) Incorporate different member segments needs in selecting appropriate technologies	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 5) Develop appropriate, multi-lingual patient education materials and content and disseminate using appropriate communication methods (e.g. Patient portal, text messages)	Completed	5) Develop appropriate, multi-lingual patient education materials and content and disseminate using appropriate communication methods (e.g. Patient portal, text messages)	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 6) Conduct proof of concept to validate patient engagement strategy and appropriate technology solutions	Completed	6) Conduct proof of concept to validate patient engagement strategy and appropriate technology solutions	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 7) Develop plan for technology rollout and patient engagement to match different patient segment engagement needs based upon proof of concept results	Completed	7) Develop plan for technology rollout and patient engagement to match different patient segment engagement needs based upon proof of concept results	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Milestone #5 Develop a data security and confidentiality plan.	Completed	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1) Create data security and confidentiality committee	Completed	1) Create data security and confidentiality committee	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2) Conduct assessment of data security and information controls using survey	Completed	2) Conduct assessment of data security and information controls using survey	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3) Document and validate plans and policies in	Completed	3) Document and validate plans and policies in line with all applicable regulations (e.g., Regulatory Issues Policies,	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
line with all applicable regulations (e.g., Regulatory Issues Policies, Consumer Privacy, Technical and Physical) at all existing PPS partners		Consumer Privacy, Technical and Physical) at all existing PPS partners							
Task 4) Document and validate the data breach reporting policy for each of the PPS partners; ensure alignment with all applicable regulations	Completed	4) Document and validate the data breach reporting policy for each of the PPS partners; ensure alignment with all applicable regulations	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 5) Identify Data Security contacts at each PPS partner and review data security and information control survey results and determine associated remediation plans	Completed	5) Identify Data Security contacts at each PPS partner and review data security and information control survey results and determine associated remediation plans	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 6) Establish an appropriate review process if a PPS partner determines that there is a data breach	Completed	6) Establish an appropriate review process if a PPS partner determines that there is a data breach	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 7) Establish an escalation path to the executive governance group for the PPS if a PPS partner determines that there is a data breach that must be resolved for the PPS as a whole	Completed	7) Establish an escalation path to the executive governance group for the PPS if a PPS partner determines that there is a data breach that must be resolved for the PPS as a whole	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 8) Develop plan for ongoing security testing and controls across network	Completed	8) Develop plan for ongoing security testing and controls across network	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a specific plan for engaging attributed members in Qualifying Entities	mccarrol	Documentation/Certification	3_DY2Q4_IT_MDL51_PRES4_DOC_R3_IT_M4_Board_Approval_Evidence_15855.pdf	DY2Q4 Remediation Response	06/21/2017 09:49 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	mccarrol	Documentation/Certification	3_DY2Q4_IT_MDL51_PRES4_DOC_IT_Milestone_4_10046.docx	Plan for engaging Qualifying Entities.	04/12/2017 03:04 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	
Develop an IT Change Management Strategy.	DY2Q4 M2 and related tasks 3, 5, and 6 have been moved to 6/30/2017 to reflect the ongoing nature of the work.
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	
Develop a specific plan for engaging attributed members in Qualifying Entities	DY2Q4 Remediation Response: Please see attached document: R3 IT M4 Board Approval Evidence The CBOs were actively engaged through outreach programs and the Fast Start Incentive program. If the CBO is HIPAA complaint, has a licensed provider on staff, the Alliance is financially supporting their connection to the RHIO. In addition to financing connectivity to the RHIO the Alliance is working with the RHIO to provide unilateral portal connectivity for organizations who meet Hixny requirements. In addition, the Alliance is standing up a population health analytic solution and intends to provide critical performance metrics and patient engagement metrics to CBOs engaged in DSRIP. The Alliance community health team is collecting critical metrics and coordinating with community based organizations in driving performance and patient activation. The community health workers are actively referring patients to community based organizations leveraging internal and external metrics. The plan development and monitoring lead is Kellin Rowlands, Alliance Technology Project Manager.
Develop a data security and confidentiality plan.	

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Milestone Review Status

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

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Timely and appropriate access to the appropriate data (e.g., claims, clinical data) through data latency or Vendors not using interoperability standards, which we will mitigate by working with global standards and the RHIO's existing connections, as well as leveraging existing claims data feeds from the State 2) Difficulty of actionable quality data at Point of Care which we will mitigate by leveraging existing Point of Care workflow tools or using solutions that have proven capabilities to work at the Point of Care 3) Patient churn/lack of visibility into patient's longer-term health, which we will resolve with our own Health Risk Assessment tools to collect detailed patient history 4)Reliance upon HIXNY/RHIO to provide interoperable IT platform which we will mitigate through working with HIXNY/RHIO to develop needed functionality 5) Provider confusion as all providers will be facing significant new initiatives in the community which include the IHANY ACO, Albany Medical Center PPS, and AFBHC PPS which we will mitigate through governance 6)Lack of technology adoption throughout the PPS which we will mitigate by investigating and providing technology solutions as needed to the PPS partners who have a need 7)Reliance upon NY state to provide sufficient patient consent and data compliance laws to enable sufficient combination, viewing, and usage of patient information 8)Reliance upon RHIO to provide interconnectivity and other iT functions in a timely manner which we will mitigate by involving the RHIO in our planning process

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.)

IT infrastructure is required for Clinical Integration, Practitioner Engagement, Performance Reporting, Population Health Management. IT Systems and Processes is dependent upon effective training, implementation, and PMO. Making sufficient investments in technology to support patient engagement and other program goals is dependent upon the PPS making the appropriate budget provided by meeting the overall DSRIP goals.

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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
Committee co-chair	Joe Gambino	Overall leadership
Committee co-chair	Jon Goldberg	Overall leadership
Analytics Lead	In Progress	Overall leadership for reporting, data aggregation, and dashboard design
Hometown Health representatives	Julie Greco/Eric Burton	Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization
St. Mary's Healthcare Amsterdam representatives	Michael Reynolds/Jim Degroff/Tina O'Hanlon	Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization
Capital Care representative	Charles Hagstrand	Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization
St. Peter's Health Partners representatives	Karen LeBlanc/Will Rauch	Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization
Whitney Young representative	Mary Connolly	Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization
Ellis representative	Dr. Bachwani	Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely at PPS member organization
Rensselaer County Department of Mental Health representative	Shephard	Ensure completion of current state analysis and roadmap to clinical data sharing, represent change management processes needed at , and validate ability to receive data securely specific to Rensselaer County mental health institutions

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Data security committee chair	Adam Dodge	Providing policies and support related to data compliance and security; data security and confidentiality plan

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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		
Tom McCarroll	VP of Performance Operations (Interim)	Overall IT decisions
Brenda Maynor	VP of Clinical Operations (Interim)	Clinical IT decisions
Olga Dazzo	Acting CEO	Ensuring IT decisions are in accordance with overall strategy
Dr. Kraev	Physician IT Committee	Provide IT requirements for DSRIP programs from a physician's perspective
Dr. Bachwani	Physician IT Committee	Provide IT requirements for DSRIP programs from a physician's perspective
PPS members' EMR representatives	Contributor	Roadmap for delivering interoperable IT platform, specific plan for engaging attributed members
Board of Managers	Approver	Roadmap for delivering interoperable IT platform, specific plan for engaging attributed members, IT Change Management Strategy
External Stakeholders		
HIXNY representative	Contributor	Roadmap for delivering interoperable IT platform, data security and confidentiality plan
Population health tool representatives	Contributor	Roadmap for delivering interoperable IT platform, specific plan for engaging attributed members, IT Change Management Strategy

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

The AFBHC PMO will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders. The AFBHC PMO will release the balance score card on a regular basis that is dictated by this implementation plan but no later than every quarter. For IT Systems and Processes, the balance score card will track metrics such as meaningful use of EHRs, adoption of certified PCMH standards, and patient engagement. Within the implementation period, the AFBHC PMO will track and report on progress related to tool implementation and configuration, the roadmap to achieving clinical data sharing and interoperable systems across PPS network, and the overall IT change management strategy. To assist the AFBHC, reporting will be done on two levels: the overall PPS and the individual PPS member to promote compliance. The individual PPS members will share information through their own current communication processes. External stakeholders will have appropriate access to the progress reporting as well.

IPQR Module 5.8 - IA Monitoring

Instructions :

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Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Completed	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	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Establish reporting structure for PPS wide-performance reporting and communication.	Completed	1. Establish reporting structure for PPS wide-performance reporting and communication.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Develop Rapid Cycle Evaluation team dedicated to the understanding, data interpretation, and dissemination of all milestones and metrics associated with Domains 2, 3, and 4 and its relationship to performance and revenue.	Completed	2. Develop Rapid Cycle Evaluation team dedicated to the understanding, data interpretation, and dissemination of all milestones and metrics associated with Domains 2, 3, and 4 and its relationship to performance and revenue.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Identify required Domains 2, 3, and 4 metrics defining Measure Steward, Data Sources, and timelines for reporting and performance.	Completed	3. Identify required Domains 2, 3, and 4 metrics defining Measure Steward, Data Sources, and timelines for reporting and performance.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Define clinical and financial performance key performance indicators with PPS-wide executive leadership beyond DSRIP.	Completed	4. Define clinical and financial performance key performance indicators with PPS-wide executive leadership beyond DSRIP.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Determine necessary functions and associated	Completed	5. Determine necessary functions and associated tools for combining state-supplied data with PPS-collected data.	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
tools for combining state-supplied data with PPS-collected data. Determine technology needed for reporting and management.		Determine technology needed for reporting and management.							
Task 6. Perform a current state assessment of existing reporting processes across the PPS and define target state outcomes.	Completed	6. Perform a current state assessment of existing reporting processes across the PPS and define target state outcomes.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Identify specific persons or positions in the network that will be responsible for submitting required data to the PPS for analytics and subsequent reporting for each metric, milestone, and project requirements.	Completed	7. Identify specific persons or positions in the network that will be responsible for submitting required data to the PPS for analytics and subsequent reporting for each metric, milestone, and project requirements.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Establish process for communicating state-provided data (accessed through the MAPP Tool) to providers through existing templates and Excel files as a short-term solution	Completed	8. Establish process for communicating state-provided data (accessed through the MAPP Tool) to providers through existing templates and Excel files as a short-term solution	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 9. Engage with finance to determine the fund flow and incentive payment implications of performance reporting	Completed	9. Engage with finance to determine the fund flow and incentive payment implications of performance reporting	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 10. Design first draft dashboards and reports so that they may be decentralized and rolled up at the project level, across projects, individual provider and group level, for PPS as a whole.	Completed	10. Design first draft dashboards and reports so that they may be decentralized and rolled up at the project level, across projects, individual provider and group level, for PPS as a whole.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 11. Develop performance reporting dashboards, with different levels of detail for reports to the Project Management Office (PMO), the Board, and the PPS providers.	Completed	11. Develop performance reporting dashboards, with different levels of detail for reports to the Project Management Office (PMO), the Board, and the PPS providers.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 12. Hold training sessions with providers to review performance reporting dashboards with different types of providers and provide providers ability to run reports themselves	Completed	12. Hold training sessions with providers to review performance reporting dashboards with different types of providers and provide providers ability to run reports themselves	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task	Completed	13. Hold town halls/rolling meetings with providers to review	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
13. Hold town halls/rolling meetings with providers to review initial DSRIP performance report reviews		initial DSRIP performance report reviews							
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.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	NO
Task 1. Identify role of provider types in projects, reporting, decision-making needs, revenue generation, and dashboards.	Completed	1. Identify role of provider types in projects, reporting, decision-making needs, revenue generation, and dashboards.	12/31/2015	09/30/2016	12/31/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 2. Identify appropriate curriculums tailored to each provider type with respective identified needs.	In Progress	2. Identify appropriate curriculums tailored to each provider type with respective identified needs.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task "3. Identify specific themes to be included in the training program: a. Success factors in a training program associated with the use of performance data b. The role played by function-specific and project-specific leadership c. The role of performance reporting in creating accountability "	In Progress	"3. Identify specific themes to be included in the training program: a. Success factors in a training program associated with the use of performance data b. The role played by function-specific and project-specific leadership c. The role of performance reporting in creating accountability "	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 4. Define performance reporting training program, including process for follow-up training and continuous quality improvement related to performance reporting	In Progress	4. Define performance reporting training program, including process for follow-up training and continuous quality improvement related to performance reporting	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 5. Develop training program that incorporates how the performance model incorporates into the value-based payment model and how performance can impact payment	In Progress	5. Develop training program that incorporates how the performance model incorporates into the value-based payment model and how performance can impact payment	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish reporting structure for PPS-wide performance reporting and communication.	mccarrol	Documentation/Certification	3_DY2Q4_PR_MDL61_PRES1_DOC_R4_Performance_Reporting_M1_Board_Approval_Evidence_15857.pdf	DY2Q4 Remediation Response	06/21/2017 09:53 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PR_MDL61_PRES1_DOC_R4_Performance_Reporting_M1_Data_Flow_Internal_15856.docx	DY2Q4 Remediation Response	06/21/2017 09:52 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PR_MDL61_PRES1_DOC_Performance_Reporting_Milestone_#1_10049.docx	PPS performance reporting structure document.	04/12/2017 03:08 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	DY2Q4 Remediation Response: Alliance identifies what information will be shared and with whom, and has a hierarchical performance reporting structure between the PPS lead and network providers. Utilizing multiple data sources, including partner 837 data, HixNY clinical data and DOH data feeds, the Alliance is working with vendors to generate multiple feeds to our partner providers. The feeds include targeted member lists, custom DSRIP performance dashboards based on weekly partner data feeds, risk stratification for high risk patients, chronic disease registries, and hot spot/geo mapping. Alliance works with our partners on implementation and workflow management to assure integration into practice. Alliance continues to explore the most efficient means for communicating clinical quality and performance reporting information. Currently Alliance has proposed the attached data flow for reporting data to all stakeholders (please see attached document: R4 Performance Reporting M1 Data Flow Internal). This flow is still in draft form until consent and data sharing policies are finalized. Until finalized, we have appropriately restricted the dissemination of information to our partners. Alliance is developing a rapid cycle evaluation tool to inform providers at the point of care. Working with administrative staff, Alliance is targeting integration of patient level data into providers existing scheduling/EHR platforms and supplement patient records with compiled analytics. Please see also attached document: R4 Performance Reporting M1 Board Approval Evidence

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	DY2Q4 Remediation Response: The goal of all of the Alliance's DSRIP initiatives is to transform the Medicaid payment and delivery system in an effort to achieve measurable improvements in quality of care and overall population health. The initiatives link funding for eligible providers to their progress toward meeting specific milestones and driving integrated delivery. To achieve an integrated delivery system, the PPS must collaborate as a network providing a coordinated continuum of services to ultimately achieve the goals of improving efficiency, quality and access to care. This project aims to increase the opportunity to align provider incentives through the use of population health management strategies and active collaboration. The goal of the project is to transition the health care delivery focus to value-based and evidence-based care by incorporating medical, behavioral health, post-acute and long-term needs.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass (with Exception) & Ongoing	The IA cannot consider this milestone complete. The PPS failed to submit evidence of board approval for the Performance Reporting structure. The PPS also failed to: 1. Provide policies, procedures, and detailed processes for reporting and communicating clinical quality and performance reporting 2. Identify approaches to detailed Rapid Cycle Evaluation 3. Document how it ensures data security through data use agreements.
Milestone #2	Pass & Ongoing	

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

1) Practitioner alienation if the performance reporting is not accurate, which we will mitigate through appropriate practitioner involvement and review of metrics and patient attribution.
2) IT Risks: Data Interoperability dependent upon working with multiple vendors that may not support existing standards; risk mitigation strategy is to engage vendors early and determine supplemental solutions where available.
3) There is risk that information reporting may not be uniform or available at the same time across the network therefore creating a division in the network. This risk will be mitigated by carefully selecting the rollout of reports.
4) There is a risk of selecting many more metrics for improvement than the network could possibly address in a given time period which could result in not achieving any of the stated metric goals. This risk will be mitigated by carefully selecting and prioritizing achievable metrics for improvement per given time periods

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.)

IT Systems and Processes: Completion of the milestones titled "Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network", "Develop a data security and confidentiality plan", and "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)";
Practitioner Engagement: Engaging the right set of practitioner leaders across the entire PPS is critical as reliability/believability within the Performance Reports is paramount for success;
Financial Sustainability: The establishment of financial flows and specific contracts to support VBP is a pre-requisite for establishing effective Performance Reporting as Performance Reporting must reflect all of the required metrics of a contract and effectively incentivize performance with practitioners;
Governance: The establishment of proper governance (e.g., physician leadership clusters, hubs) is critical for Performance Reporting as it establishes the categorizations for which performance reporting must adhere.

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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 & Data Committee	CIOs from Board of Manager entities, RHIO, and other providers	Oversight of reporting process from an IT perspective. Oversight of the development and implementation of technology plan to ensure the support for clinical workflows and timely and safe exchange of patient information.
Clinical Integration and Quality Committee and Project Steering Subcommittees	Clinical representatives from Board of Managers entities plus other community based organizations	Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network.
Compliance Officer	Colleen Susko	Ensure that reporting is accurate and complies with all laws and regulations
Rapid Cycle Evaluation Team	In Progress	Prompt evaluation of results and trend detection; timely communication to stakeholders
AFBHC Information Technology leader and technical staff	In Progress	Implementation of AFBHC Technology Plan; ensure operational performance
Initial Project Leads from Partner Entities	Joe Twardy, Pamela Rehak, Scott Friedlander, Brenda Maynor, Erin Simao, Dave Shippee, Patrick Carrese, Keith Brown, Kathy Ristau, Kevin Jobin-Davis, Rachel Handler, Millie Ferriter, Kathy Alonge-Coons, Amanda Mulhern	Shepherd projects through early phases of planning, development, and implementation
AFBHC Project lead for 2.b.iii, 2.b.iv, 3.g.i	Scott Friedlander (Interim)	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
AFBHC Project lead for 2.d.i	Erin Simao (Interim)	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
AFBHC Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i	In Progress	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
VP of Performance Operations	Tom McCarroll (Interim)/AFBHC Performance Office	Provide guidance and oversight for the Performance Operations of AFBHC
VP of Clinical Operations	Brenda Maynor (Interim)/AFBHC Clinical Office	Provide guidance and oversight for the Clinical Operations of AFBHC

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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		
Board of Managers	Collaborate with organizations for positive outcomes	Spearhead performance reporting metrics reports, dashboards, communication
IT Staff within individual provider organizations	Reporting and IT System maintenance	Monitor, tech support, upgrade of IT and reporting systems.
Providers	Organizations immediately responsible for delivering on the performance monitoring processes established across the PPS.	"Promote culture of excellence Employ standardized care practices to improve patient care outcomes."
Finance Committee	Oversee financial responsibilities	Determine the financial implications of performance reports
External Stakeholders		
Patient representative for performance reporting and their organizations	Provide patient feedback to support performance monitoring and performance improvement	Input into performance monitoring and continuous performance improvement processes
HIXNY	Data and information sharing	Monitor, tech support, upgrade of IT and reporting systems.

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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.

A shared IT infrastructure must be in place to provide the data to support accurate performance reporting across the entire PPS. Specific expectations include the need to connect across disparate systems, and capture data from the different modalities of care. Performance reporting will rely upon the IT stems to capture the right data at the right time across all PPS partners to ensure accurate and reliable reporting.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

The AFBHC Project Management Office (PMO) will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders. For Performance Reporting, the focus will be on the development and progress on the metrics included in the balance scorecard. To assist the AFBHC, reporting will be done on multiple levels to promote compliance including the project level, across projects, individual provider and group level, and the PPS as a whole.. The individual PPS members will share information through their own current communication processes and the PPS will establish a communication protocol appropriate for keeping all stakeholders and the workforce engaged. External stakeholders will have appropriate access to the progress reporting as well.

IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	Completed	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	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1. Establish Practitioner Engagement Task Force, subject to the committee and task force evaluation that is being conducted to ensure there is alignment with IHANY and that there is minimal duplication so that practitioners are not burdened. (Refer to Governance, Milestone: Finalize governance structure and sub-committee structure (4.a).	Completed	"a. Identify practitioner leaders/champions to co-chair the Practitioner Engagement Task Force b. Recruit practitioner members to Task Force c. Write expectations and goals of Task Force d. Ask co-chairs to participate and meet to review goals e. Identify facilitator "	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Develop practitioner communication and engagement plan	Completed	a. Identify role each provider type will play in projects b. Identify common communication needs for all providers c. Identify specific communication needs by provider type d. Develop PPS-wide professional groups e. Identify standard professional reports by provider types f. Identify timetable for needed communications, tailoring the communication by phase of project implementation g. Identify best methods of communication by provider types h. Develop implementation plan, including content	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		i. Present draft plan to relevant committees/groups							
Task 3. Begin implementation of communication and engagement plan	Completed	3. Begin implementation of communication and engagement plan	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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.	Completed	Practitioner training / education plan.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Begin to schedule visits with physician groups and other practitioners to teach about general themes, e.g., DSRIP and how DSRIP will help practitioners and Medicaid members, Project Requirements and Implementation overview, AFBHC population health management model, and other general topics to begin the engagement process.	Completed	1. Begin to schedule visits with physician groups and other practitioners to teach about general themes, e.g., DSRIP and how DSRIP will help practitioners and Medicaid members, Project Requirements and Implementation overview, AFBHC population health management model, and other general topics to begin the engagement process.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Develop practitioner training/education plan	Completed	"a. Develop curriculum with general and specific content for provider types to educate and incorporate assessment findings b. Include in the training program how each project impacts DSRIP Domains 2, 3, and 4 metrics and goals and in turn how each physician/practitioner impacts goals with subsequent potential earnings through funds flow policy. c. Identify frequency of training throughout the life of the DSRIP projects and beyond, target training content to the life cycle of each project d. Consider qualifying curriculum for continuing education credits e. Submit draft training/education plan to Workforce Committeee. Present training/education plan to other relevant committees/groups f. Develop survey of practitioners to assess their satisfaction with the type and amount of engagement from the PPS "	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task	Completed	3. Schedule training programs by provider types	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
3. Schedule training programs by provider types									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop Practitioners communication and engagement plan.	mccarrol	Documentation/Certification	3_DY2Q4_PRCENG_MDL71_PRES1_DOC_Practitioner_Eng_&_Trng_Plan_9752.xlsx	Practitioner Engagement and Training Plan	04/04/2017 04:28 PM
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.	mccarrol	Documentation/Certification	3_DY2Q4_PRCENG_MDL71_PRES2_DOC_Prac_Eng_Training_Schedule_Template_10053.xlsx	Practitioner Engagement Training Schedule Template	04/12/2017 03:16 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PRCENG_MDL71_PRES2_DOC_M1_Practitioner_Training_and_Education_Strategy_10051.xlsx	Practitioner Engagement Training and Education strategy.	04/12/2017 03:15 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.	

Milestone Review Status

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

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IPQR Module 7.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Due to the fast pace of DSRIP development, practitioners may not be fully aware of the intricacies of the projects and the positive effects they will have in spearheading the transformation of health care. Lack of awareness about DSRIP is a risk that will be mitigated through inclusion and communication with front line primary care physicians and other front-line practitioners. Other initiatives will be considered to mitigate this risk, such as inclusion of provider groups/types in the development of clinical best practices/protocols, development of annual goals, holding annual performance awards, sponsoring quality improvement summits within the PPS and holding collaborative sprints on subjects of professional groups' interest that tie to projects. Another risk to the successful engagement of all practitioners is the lack of integration of medical and behavioral health records throughout the alliance. Since this ties directly with the IT requirements, road maps for IT systems and processes with be followed to ensure interoperability, which will engage practitioners with simplified connectivity.

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.)

Given that this workstream is about communication, it impacts all organizational sections and project plans. Key aspects of each organizational section and project plans will be incorporated into the content of the communication and training programs. Communicating with 1,400 providers across six counties will be a challenge that will be carefully considered during the assessment and communication planning processes. Other workstreams will be leveraged to assist in provider engagement. For example IT benefits that will be offered practitioners, incentive programs, and workforce license innovations will be highlighted and used in the communication and training programs with practitioners.

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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
AFBHC Practitioner Engagement Task Force	"In Progress, will include the CMOs of the key partners of AFBHC: Capital Care (Lou Snitkof, M. D.), Community Care (Barbara Morris, M. D.), St. Mary's (Bill Mayer, M. D.), Ellis (Roger Barrowman, M. D.), St. Peter's (Dr. Cella, Dr. Silverman and Dr. T. Lawrence), Hometown Health (David Skory, M.D.), Whitney Young (Theodore Zeltner, M. D.) "	Be ambassadors for engagement. Guide the assessment, development of communication and engagement plan, training program development, and other practitioner engagement processes.
Medical Director	John Collins, MD	Promote practitioner engagement and ensure effective communication across PPS and network. Support the task force and receive guidance, develop the assessment, develop communication and engagement plan, direct development and implementation of training program and other practitioner engagement processes.
Leaders/champions/Task Force Co-chairs	Dr. Thomas Lawrence, Dr. Roger Barrowman	Provide leadership and cohesiveness across professional groups and provider types in network

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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		
Ellis Medicine	Paul Milton, Acting CEO, AFBHC LLC Manager	Leadership staff, strategic direction support
Samaritan Hospital	Jim Reed, M. D., President and CEO, AFBHC LLC Manager	Leadership staff, strategic direction support
St. Mary's Healthcare	Vic Giulianelli, CEO, AFBHC LLC Manager	Leadership staff, strategic direction support
Hometown Health Centers	Joe Gambino, CEO, AFBHC LLC Manager	Leadership staff, strategic direction support
Whitney M. Young, Jr. Health Center	Dave Shippee, CEO, AFBHC LLC Manager	Leadership staff, strategic direction support
Capital Care Medical Group, P.C.	Lou Snitkof, M. D., CMO, AFBHC LLC Manager	Leadership staff, strategic direction support
Community Care Physicians, P.C.	Richard Scanu, COO/CFO, AFBHC LLC Manager	Leadership staff, strategic direction support
External Stakeholders		
All providers in network	Provider	Achieve goals, receive incentives
PAC members	Advisory group	Guide the development of projects
Medical Society of the State of NY	Advisory and disseminate communication	Guide development of practitioner engagement
American Academy of Family Physicians	Advisory and disseminate communication	Guide development of practitioner engagement
New York State Psychiatric Association	Advisory and disseminate communication	Guide development of practitioner engagement
Mental Health Association in New York State	Advisory and disseminate communication	Guide development of practitioner engagement
American College of Physicians	Advisory and disseminate communication	Guide development of practitioner engagement
Adirondack Health Institute PPS	Coordination and disseminate communication	Coordination of practitioner engagement
Albany Medical Center PPS	Coordination and disseminate communication	Coordination of practitioner engagement
Leatherstocking Collaborative Health PPS	Coordination and disseminate communication	Coordination of practitioner engagement

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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.

AFBHC will leverage the following IT tools to engage the healthcare workforce on new and existing processes, coordinate patient care, recruit staff, and provide secure communication methods across the PPS: (1) Learning Management System, (2) Electronic Newsletters, (3) AFBHC website, and (4) HIXNY. A needs assessment will be conducted to determine scope of internet-based centralized delivery system of required and optional training courses across providers within AFBHC. This needs assessment will result in a plan for development of an AFBHC-wide Learning Management System (LMS.) In addition to providing training content and modalities, AFBHC will be able to track and report on workforce training initiatives. AFBHC will utilize IT-based communication tools to engage the workforce. In addition to the LMS, electronic newsletters will be used to communicate with employees within AFBHC. The AFBHC website will also have a workforce section outlining workforce efforts being undertaken, including an employment recruitment section to direct individuals to provider organization's job opportunities within AFBHC. Finally, providers will be connected to HIXNY, the Regional Health Information Exchange (RHIO) that serves as the hub to securely collect and deliver health information in real-time between authorized providers and their authorized employees. Providing real-time data empowers the appropriate health care workforce with meaningful information and secure communication modality across systems.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

The success of the practitioner engagement workstream will be measured by the degree that providers are engaged, metrics and milestones are being achieved, the number of providers participating in the incentive programs, the amount of incentive funds being earned by providers, Medicaid members access and satisfaction are positively reflected in their HEDIS and CAHPS measures as well as outcome measures. In addition practitioners' satisfaction with their degree of engagement is important for the adoption of projects and DSRIP transformation. Therefore, surveys of physicians determining their degree of satisfaction with engagement will be conducted at appropriate intervals.

IPQR Module 7.9 - IA Monitoring

Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	Completed	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Develop the AFBHC Population Health Management model that cares for people within a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, analytics, and actuarially-sound payment models from managed care organizations.	Completed	1. Develop the AFBHC Population Health Management model that cares for people within a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, analytics, and actuarially-sound payment models from managed care organizations.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 2. Finalize and formally adopt the Population Health Management model	Completed	"a. Present and discuss PHM model throughout the network to promote common shared understanding and ensure all network stakeholders move in the same strategic and operational direction	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		b. Formally adopt the PHM model at the Clinical Integration and Quality Committee and Subcommittees c. Formally adopt the PHM model at the Board of Managers. "							
Task 3. Using the AFBHC PHM model risk-stratify populations within the PCMH/behavioral/mental health foundation and target populations for specific interventions including health disparities.	Completed	3. Using the AFBHC PHM model risk-stratify populations within the PCMH/behavioral/mental health foundation and target populations for specific interventions including health disparities.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 4. With the assistance of the Rapid Cycle Evaluation team, identify any interventions that may not be working well and take remedial action communicating to appropriate stakeholders.	Completed	a. The Rapid Cycle Evaluation team will produce reports with sufficient frequency to detect early patterns of performance.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 5. Assess Population Health tools currently being used throughout the PPS (refer to IT Systems and Processes workstream plan, Milestone 1)	Completed	5. Assess Population Health tools currently being used throughout the PPS (refer to IT Systems and Processes workstream plan, Milestone 1)	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 6. IT Assessment and Issue Resolution Planning - Cross- PPS Partner capabilities assessment (Patient Engagement Tools, Patient Registries, Longitudinal Patient Record).	Completed	6. IT Assessment and Issue Resolution Planning - Cross-PPS Partner capabilities assessment (Patient Engagement Tools, Patient Registries, Longitudinal Patient Record).	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 7. Develop roadmap for population health management, including IT infrastructure, targeted populations and organizational integration (refer to IT Systems and Processes workstream plan, Milestone 1).	Completed	7. Develop roadmap for population health management, including IT infrastructure, targeted populations and organizational integration (refer to IT Systems and Processes workstream plan, Milestone 1).	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 8. Develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements.	Completed	8. Develop roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task "9. Establish a schedule for monitoring progress to achieving PCMH 2013 Level 3 certification "	Completed	"a. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for provider groups. b. Collect NCQA recognition documentation from practices	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		who are currently 2014 or 2011 Level 3 recognized (60% of PPS PCPs). d. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3. e. Asses the practices' needs for technical assistance and provide technical assistance. f. Establish a method to track and report progress on a regular basis. "							
Task 10. Where electronic functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems.	Completed	10. Where electronic functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 11. Review, revise and align policies, procedures and guidelines for using population tools across the PPS.	Completed	"a. Include review process for overseeing, coordinating, and managing projects to meet measurement and reporting deadlines b. Establish feedback systems to monitor effectiveness of population health tools and processes for rapid resolution of challenges "	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 12. Submit IT roadmap consistent with PHM model to PPS board for approval.	Completed	12. Submit IT roadmap consistent with PHM model to PPS board for approval.	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	12/31/2016	06/30/2017	12/31/2016	06/30/2017	06/30/2017	DY3 Q1	NO
Task "1. For facilities and facility capacities, including behavioral health units/facilities, there will be no reduction within the earlier years as area hospitals within the PPS have gone through consolidation via the Berger Commission in 2006, with many other hospitals following suit in ""right-sizing"" activities. Identifying bed utilization process and improving care pathways for inpatient admissions will be a component of	In Progress	"a. Develop plan to monitor PPS bed reduction needs at strategic intervals. Include reassessments of hospital and skilled nursing facility inpatient volumes, metrics, readmission trends after DSRIP projects implemented and functioning. Focus on outcomes for projects 2.b.iii, 2.b.iv, 2.b.viii and 3.g.i to determine if project specific metrics have impact on hospital volumes. a. Track bed utilization rates on annual basis for DSRIP years 4 and 5 requirements within projected population health	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
the PPS-wide bed reduction plan. Beds may be reduced by years 4 and 5 after determined by DSRIP success. This also holds true of long term care beds. For the DSRIP implement plan, the AFBHC will monitor bed status at designated intervals. "		roadmap b. Report findings of bed utilization reports to leadership of PPS after assessments completed "							
Task 2. Bed reduction/bed utilization status signed off by PPS board.	In Progress	2. Bed reduction/bed utilization status signed off by PPS board.	12/31/2016	06/30/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 8.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Population Health IT (PHIT) systems and tools are required to fulfill communication, patient care, patient tracking, and outcomes monitoring needs across the continuum. Because PHIT is foundational to most DSRIP project requirements, delayed PHIT implementation steps delay other project steps and puts the PPS at risk of not meeting project speed and scale requirements. The mitigation strategy includes accelerating implementation of PHIT interoperability and tools and using alternate methods where EHRs and PHIT tool functionality are not yet ready.

Other risks to the successful implementation of the Population Health Strategy is user readiness and lack of knowledge of Population Health IT. Historically, health care has been focused on care of the individual; the DSRIP initiative focuses on the health of populations. This paradigm change can be difficult for some. For those practices that are not yet PCMH recognized, they are likely unfamiliar with population health IT tools. Even if the practice has been using an EMR, population health IT tools add another level of expertise in computer use. For any practices that do not yet have an EMR, they face the dual challenge of converting to EMR and implementing population health tools. To mitigate this risk, this workstream will work closely with Workforce to offer training and change management support.

There is a lag with some providers and organizations, such as behavioral health outpatient settings in regards to EMR development and meeting meaningful use and reporting requirements. A comprehensive approach to EMR use will be part of the mitigation strategy to reduce this risk. Population Health strategies will work with IT implementation strategies to assess current state and assist in moving to future state to meet the needs of the providers

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.)

This project ties closely with the Cultural Competency Strategy in its aim to improve the health and health care of the target populations, track outcomes according to disparities, and promote community and patient engagement.

To implement the operational components of the Population Health Management implementation requires coordination with all functional workstreams, particularly the 1) IT Systems and Processes workstream; 2) Clinical Integration workstream; 3) Performance Reporting workstream; and 4) funds flow workstream. Population health management is integral to the care management coordination and alignment efforts described in Project 2.a.i. - Integrated Delivery System. All DSRIP projects contain various types of links to Population Health Management tools and PHIT systems.

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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
AFBHC Information Technology Lead	In Progress	Implementation and Oversight of population health IT strategy
Population Health Management Taskforce	In Progress	Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training. Monitors the impacts of DSRIP projects in terms of inpatient & community capacity; monitors assessment and needs for capacity change linked to improvements in population health management.
AFBHC and IHANY Clinical Integration and Quality Committees	In Progress	Implement and utilize population health tools in their practices
AFBHC Vice President of Clinical Operations	Brenda Maynor (Interim)	Oversee, coordinate and align care management across the PPS.
AFBHC Vice President of Performance Operations	Tom McCarroll (Interim)	Oversee, coordinate and align PPS operations to achieve measurable improvements in population health.

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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		
AFBHC PPS PMO	Oversight of DSRIP projects	Jointly responsible for Bed Reduction/Utilization Plan
Professional Peer Groups	Key role in the adoption of population health management practices amongst their members	Active engagement in the development of training & education materials
Practitioners	Use appropriate population tools in their practices	DSRIP metrics
Care Coordinators	Care management	For those projects requiring care management, achievement of project outcomes
External Stakeholders		
HIXNY 9-24-15 Scott Momrow	Support connectivity	Providers are able to share patient information across the PPS
Public Health representatives 9-24-15: We will be organizing the county mental health commissioners & public health officials to meet & collaborate with the Alliance. Names pending.	Population health experience	Coordination of community activities
Adirondack Health Institute PPS 9-24-15: Cathy Homkey, CEO	Neighboring DSRIP PPS	Coordination of population health management
Albany Medical Center PPS 9-24-15: George Clifford, Evan Brooksby, & Dr. Fredrick Venditti	Neighboring DSRIP PPS	Coordination of population health management
Leatherstocking Collaborative Health PPS 9-24-15: Sue van der Sommen, Executive Director	Neighboring DSRIP PPS	Coordination of population health management
All New York State PPSs 9-24-15: Currently, the CEO is establishing a network to collaborate with other PPS's in our region. To the extent there is a learning opportunity, cross fertilization efforts will be established to strengthen each others knowledge base.	State wide DOH DSRIP PPS	Coordination of PPS transformation
Patients & Families	Recipient of improved services	Feedback on outcomes

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
9-24-15: Individuals who represent patients or families will be identified as appropriate to serve on planning groups.		

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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 infrastructure is an essential component of population health management. IT infrastructure will be developed to support the following population health management processes: (1) financial and clinical risk stratification; (2) care delivery and coordination; (3) patient engagement; (4) monitoring outcomes; and (5) assessing impact of intervention(s) on overall cost of care. The primary pre-requisite for enabling these processes is acquisition and aggregation of data from across the AFBHC. This task is complicated by the many IT systems that are being used across the PPS. In order to better determine the role of HIXNY and other data aggregation platforms, a comprehensive data assessment will be conducted. In parallel to the data assessment, a functionality needs assessment will be conducted at the DSRIP program level to prioritize the IT capabilities needed to support the individual programs. The data assessment and the functionality needs assessment will drive decision-making about IT infrastructure and IT planning to support population health management program initiatives.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

The AFBHC PMO will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders.

IPQR Module 8.9 - IA Monitoring

Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	Completed	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1: Project leads/project teams will assess and map by provider type current state of integrated care and care transitions, behavioral health access, acute care, ambulatory care, discharge and readmission processes, palliative care, different patient populations including IDD patients, home health and population health issues through the lens of their respective projects. This work will be accomplished within the framework of the AFBHC Population Health Management Model.	Completed	1: Project leads/project teams will assess and map by provider type current state of integrated care and care transitions, behavioral health access, acute care, ambulatory care, discharge and readmission processes, palliative care, different patient populations including IDD patients, home health and population health issues through the lens of their respective projects. This work will be accomplished within the framework of the AFBHC Population Health Management Model.	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2: The AFBHC Workforce Committee (WC) is tasked with assessing the workforce needs across all projects and all organizational sections of the Implementation Plan. The Clinical	Completed	2: The AFBHC Workforce Committee (WC) is tasked with assessing the workforce needs across all projects and all organizational sections of the Implementation Plan. The Clinical Integration and Quality Committee will work with the WC to review and offer input towards helping refine the	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Integration and Quality Committee will work with the WC to review and offer input towards helping refine the workforce needs pertaining to Clinical Integration.		workforce needs pertaining to Clinical Integration.							
Task 3. Create a robust provider matrix that outlines provider requirements (e.g., DSRIP reporting requirements, PPS reporting requirements, DSRIP project functional requirements), current clinical (e.g., existing care transition programs and care coordination, including PCMH standardization) & IT state (e.g., solutions provided to support reporting and functional requirements) and project participation	Completed	3. Create a robust provider matrix that outlines provider requirements (e.g., DSRIP reporting requirements, PPS reporting requirements, DSRIP project functional requirements), current clinical (e.g., existing care transition programs and care coordination, including PCMH standardization) & IT state (e.g., solutions provided to support reporting and functional requirements) and project participation	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Outline associated data needs based upon the robust provider matrix (e.g., psycho-social information, clinical information, and claims) and connections by PPS partner (e.g., current data collected, analysis of data provided to and integrated from HIXNY, NY Department of Health, and other sources of data about the partners (e.g., Universal Assessment Tool) to inform the recommendations and plan for clinical integration needs	Completed	4. Outline associated data needs based upon the robust provider matrix (e.g., psycho-social information, clinical information, and claims) and connections by PPS partner (e.g., current data collected, analysis of data provided to and integrated from HIXNY, NY Department of Health, and other sources of data about the partners (e.g., Universal Assessment Tool) to inform the recommendations and plan for clinical integration needs	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Draft a clinical integration needs assessment in conjunction with IT, and present to finance and clinical quality committees with recommendations and financial implications; Director of Clinical Operations, IT and Operations Director to complete assessment with input from HIXNY	Completed	5. Draft a clinical integration needs assessment in conjunction with IT, and present to finance and clinical quality committees with recommendations and financial implications; Director of Clinical Operations, IT and Operations Director to complete assessment with input from HIXNY	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Consider any physical office changes required to promote integration of care considering technology alternatives to accomplish integration goals.	Completed	6. Consider any physical office changes required to promote integration of care considering technology alternatives to accomplish integration goals.	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 7. Submit final plan that to clinical quality committee for plan approval.	Completed	7. Submit final plan that to clinical quality committee for plan approval.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Develop a Clinical Integration strategy.	Completed	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1: Develop, appoint, and convene on a recurring schedule a Clinical Integration team that incorporates Clinical Quality, IT and key clinical project leads to monitor, evaluate and measure progress, risks and strategies toward milestones	Completed	1: Develop, appoint, and convene on a recurring schedule a Clinical Integration team that incorporates Clinical Quality, IT and key clinical project leads to monitor, evaluate and measure progress, risks and strategies toward milestones	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Utilize feedback from committees and board to develop a draft strategic plan, including the path towards a longitudinal patient record that incorporates clinical, claims, and psycho-social information for PPS partners use and systems for PPS partners to use them, specific strategies around Care Transitions and care coordination among primary care, mental health, IDD population and substance use providers and the path towards achieving it related to training, tools, communication, and the path towards managing sufficient compliance/member consent for sharing the data	Completed	2. Utilize feedback from committees and board to develop a draft strategic plan, including the path towards a longitudinal patient record that incorporates clinical, claims, and psycho-social information for PPS partners use and systems for PPS partners to use them, specific strategies around Care Transitions and care coordination among primary care, mental health, IDD population and substance use providers and the path towards achieving it related to training, tools, communication, and the path towards managing sufficient compliance/member consent for sharing the data	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Present the Clinical Integration Strategy to the	Completed	3. Present the Clinical Integration Strategy to the Clinical Integration and IT committees, including structural and IT	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Clinical Integration and IT committees, including structural and IT changes when necessary for ease of client and provider use for warm hand offs.		changes when necessary for ease of client and provider use for warm hand offs.							
Task 4. Submit for board approval of Clinical Integration Strategy.	Completed	4. Submit for board approval of Clinical Integration Strategy.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

The implementation of the clinical integration work stream takes into account the specific clinical projects and the work streams of practitioner engagement, workforce, cultural competency and all operational components of the DSRIP project. This complexity presents a risk to the successful improvement of clinical integration. To mitigate this risk, the AFBHC PPS will establish a robust Project Management Office (PMO) to oversee the clinical integration, coupled with IT work stream to assess current state, the transition to transformation of care within the provider groups, and the infusion of project requirements based on gaps identified during current state assessment. Practitioner engagement, workforce and governance will need to support the clinical transformation throughout the process change. Leads from the clinical integration work stream will need to develop dashboards, timelines and make decisions based on transformation of care. The workforce may need to be retrained, redeployed and reassigned dependent on community needs and the transition from acute care to health transformation. The Clinical Integration Quality component of this work stream will ensure quarterly metrics are tracked, work with IT and other work streams to report deficiencies, gaps, risks and mitigation strategies as they arise to ensure transition.

Another risk would be the timeline and rapid speed and scale of implementation of projects and plans. The AFBHC PPS has established a Steering Committee for planning and initiating the projects, established a PMO division, and will partner with IHANY and other established organizations to fulfill its obligations to the DSRIP timeline. Quality metrics will be shared with its members, RCA will be addressed to mitigate issues and determine process to improve integration in a timely manner and dashboards and data will be shared and used to demonstrate progress.

IT Risks: Data Interoperability dependent upon working with multiple vendors that may not support existing standards; risk mitigation strategy is to engage vendors early and determine supplemental solutions where available.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The Clinical Integration work stream is dependent on the workflow and work product of Workforce, Population Health Management, Performance Improvement and Practitioner engagement. Since all projects of the DSRIP program touch on the clinical aspect of transforming health, clinical integration can be considered the "seating chart" for the symphonic integration of the work streams. IT components may connect and drive metrics, dashboards and reports, but the clinical integration has to be placed in such a way that it touches the other work streams, and plays out harmoniously when workforce, engagement, process improvement and population health are transformed.

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IT Systems and Processes: Completion of the milestones titled "Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network", "Develop a data security and confidentiality plan", and "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).

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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 Integration and Quality Committee	In Progress	Provide guidance and sign off on clinical integration needs assessment and strategy. Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network.
Project Steering Committees	In Progress	Contribute to overall Clinical Integration Strategy for three project clusters: at-risk populations, behavioral health & primary care integration, and Integrated Delivery System & Project 11
Initial Project Leads from Partner Entities	Joe Twardy, Pamela Rehak, Scott Friedlander, Brenda Maynor, Erin Simao, Dave Shippee, Patrick Carrese, Keith Brown, Kathy Ristau, Kevin Jobin-Davis, Rachel Handler, Millie Ferriter, Kathy Alonge-Coons, Amanda Mulhern	Shepherd projects through early phases of planning, development, and implementation
AFBHC Project lead for 2.b.iii, 2.b.iv, 3.g.i	Scott Friedlander (Interim)	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
AFBHC Project lead for 2.d.i	Erin Simao (Interim)	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
AFBHC Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i	In Progress	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
VP of Performance Operations	Tom McCarroll (Interim)/AFBHC Performance Office	Provide guidance and oversight for the Performance Operations of AFBHC
VP of Clinical Operations	Brenda Maynor (Interim)/AFBHC Clinical Office	Provide guidance and oversight for the Clinical Operations of AFBHC
Operational IT & Data Committee Leads	In Progress	Provide IT support to the clinical integration process
Operational PCP Representative	John Collins, MD	Act as the liaison between primary care and the clinical integration process
Physician Representative	Thomas Lawrence, MD	Act as the liaison between physicians and the clinical integration process
Social/Community Worker Representative	In Progress	Act as the liaison between the community and the clinical integration process
Behavioral Health Representative	In Progress	Act as the liaison between behavioral health and the clinical integration process
Nursing Representative (care coordinators)	In Progress	Act as the liaison between care coordinators and the clinical integration process

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
MCO Liaison	In Progress	Act as the liaison between MCOs and the clinical integration process
PCMH project lead	In Progress	Act as liasion for PCMH certification and level of acheivement to meet DSRIP needs
Financial VBP representatives	Dan Rinaldi and John Gahan	Act as liasion for managed care to align future payments
PCP Office Staff representatives	Christine Shwajlyk	Act of liaison for provider office administration
Nursing Representative	In Progress	Act as the liaison between nursing and the clinical integration process

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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		
Board of Managers	Leadership	"Approve Clinical Integration strategy"
Practitioners	Support of DSRIP Project Implementation, including new pathways, lines of accountability, responsibility and communication	Engage in the process
Clinical staff	Support of DSRIP Project Implementation, including new pathways, lines of accountability, responsibility and communication	Engage in the process
External Stakeholders		
Patients	Care improved upon by the clinical integration of the PPS	Response to consultation on clinical integration strategy
Families	Communication with practitioners, particularly on behalf of children, the elderly, or those without mental capacity	Response to consultation on clinical integration strategy
CBOs	Supporting the development and implementation of the clinical integration strategy	Response to consultation on clinical integration strategy

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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.

IT workstreams will build the foundation for this workstream; the clinical integration will be developed and maintained simultaneously with the IT systems process. Specifically the delivery of a longitudinal patient record that incorporates clinical, claims, and psycho-social information for PPS partners use and systems for PPS partners to use them will be a critical dependency.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

The AFBHC PMO will utilize project management, population health, board management, and accounting software to manage the PPS infrastructure and projects. The project management tool will clearly define milestones, steps, and timing expectations, and be reported monthly utilizing a balanced score card approach for all committees. The balance score card approach will identify risks, performance and financial trends, and expectations by function and project to align with accountable PPS stakeholders. For Clinical Integration, the balance score card will track metrics related to IT Systems and Processes, but also performance of key clinical processes, such as Care Transitions and patient engagement. Within the implementation period, the AFBHC PMO will track and report on progress related to achieving data interoperability and implementing a uniform care transitions program. To assist the AFBHC, reporting will be done on two levels: the overall PPS and the individual PPS member to promote compliance. The individual PPS members will share information through their own current communication processes. External stakeholders will have appropriate access to the progress reporting as well.

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.

The Alliance for Better Health Care (AFBHC) is committed to a coordinated, synergistic approach to meeting 100% of project requirements to transform the health care delivery system for its population. Its approach to implementation is based on the AFBHC Population Health Management Model that cares for people in a PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based & social services. The model includes risk-stratification of populations with prevention & wellness interventions & effective transitions &care coordination processes. This is supported by robust technology, analytics, & actuarially-sound payment models.

Implementing the projects follows the accountabilities laid out in the AFBHC governance structure. The AFBHC Clinical Integration & Quality Committee will develop the foundation for the AFBHC Population Health Management Model & will align operating standards, best-practice clinical guidelines, & care pathways. The Steering Committee was instrumental in the development of the project plans & members have become leaders in the development of the plans along with staff, new volunteers, practitioners, & other stakeholders. They will continue to provide operational support through the actual implementation of the projects.

The AFBHC is established with administrative leadership & functions. The administrative functions are to establish the PPS operational structure, manage & oversee the projects implementation. The Project Management Office (PMO) reports to the AFBHC CEO & is responsible for building the processes & structures for coordination & alignment across project teams. The PMO includes clinical operations staffed with project leads for the duration. The PMO will implement & maintain the project management system to ensure milestones & metrics deadlines are met; coordinate projects with each other, other work streams & initiatives; identify & facilitate cross-team, collaborative planning (short term, ad hoc, long term) to promote alignment, provide user input, & eliminate duplication; sequence & stagger implementation according to project requirements, timeline & PPS capacities & capabilities; use feedback systems to monitor effectiveness of new tools & processes for rapid resolution of gaps or barriers; & engage leadership to resolve system barriers.

The PMO is responsible for linking project teams with the Workforce Work streams to: coordinate hiring, redeployment & training needs across projects; prepare workforce for project implementation; & ramp up staff numbers & ensure staff preparation for project implementation. Teams will follow a project process which includes: select & engage PPS project partners; define team roles & responsibilities; follow project requirements, milestones & metrics; assess partner capabilities & identify new partners to fill gaps; identify partners' current strengths; use evidence-based clinical, organizational &population health practices; use a holistic approach to services; &coordinate with other DSRIP project teams & work streams.

The PPS has identified specific roles that each provider type will play in executing project requirements. Each project has identified the role that each of the committed providers & community based organizations will play in accomplishing 100% of the project goals. Not all committed providers will be responsible for 100% of the project requirements, but rather, 100% of the project requirements will be met by the committed providers playing their respective roles in each project. For example, in the withdrawal management project (3aiv) not all PCP's that are committed to the project will seek approval for outpatient medication management, but 100% of those PCPs will be educated & linked to those that will be working in the detox centers.

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

Instructions :

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

The AFBHC has integrated planning for like projects to leverage synergies, incorporate dependencies, minimize unnecessary duplication, promote efficiency and leverage limited time of participants. Planning and implementation for Projects 2.a.i. and 2.d.i are grouped as the Integrated Delivery System projects; 2.b.iii., 2.b.iv., 2.b.viii, 3.d.ii, 3.g.i, and 4.b.i are grouped as the At-Risk Populations projects; 3.a.i., 3.a.iv., and 4.a.iii. are grouped as the Behavioral Health and Primary Care integration projects. The project team chairs lead their respective project teams and work together to coordinate the projects within their group.

Based on project selection, projects and work streams are naturally synergistic. The cultural competency and health literacy work stream provides support for the standard for culturally and linguistically appropriate services for the PPS projects, including PCMH; care management services and patient registries within the population health work stream provide the model, policies and procedures and tools to meet the care management, outreach and transitions of care requirements for the PCMH; behavioral health and primary care integration serve both primary care and the behavioral health projects.

The PMO is also responsible for providing and coordinating technical support for the project teams including: 1) team facilitation support and improvement tools; 2) data and analytic support; and 3) criteria and standards for dashboards and project evaluation. The PMO is responsible for linking project teams with the IT work stream (refer to Part 1 IT Systems and Processes work streams) to provide user input, establish timelines, and to facilitate transitional manual processes until electronic systems are functional.

The Patient Centered Medical Home provides the platform for implementing the role of primary care providers in the projects. The AFBHC will leverage the overlapping requirements of the DSRIP projects and the NCQA PCMH requirements. The integrated role of the PCP is managed through the combined efforts of the AFBHC Clinical Integration and Quality Committee and the IHANY (ACO) Clinical Integration and Quality Committee to ensure alignment and reduce duplication.

Select PPS functions supporting DSRIP project implementation will be housed in the PMO: communication planning; care management alignment, integration, and oversight; staff development and patient/family education; population health analytics, decision-support, reporting and outreach tools; and culturally competence / health literacy / community engagement assessment development, alignment, and oversight. The PPS will coordinate and align with other projects : coordinates DSRIP projects with each other, other work streams and initiatives; facilitates cross-team, collaborative planning and alignment; sequences and staggers implementation according to project requirements, PPS capabilities, and care site capacities; uses feedback systems to monitor effectiveness and activate rapid response process; and engages PPS leaders to resolve barriers.

In addition to their role in the overall operations of the AFBHC, the Cultural Competency / Health Literacy, IT systems, Population Management, and Workforce workstreams (explained in more detail in the workstream sections of the implementation plan) all have linkages to the projects and will work closely with the Project Managers and Project teams to facilitate the respective infrastructures are in place for successful project implementation according to defined timelines.

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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
Oversight	Board of Managers	Governance
Providers	Ellis Medicine	Implement project requirements as indicated
Providers	St Peter's Health Partners	Implement project requirements as indicated
Providers	St. Mary's Healthcare Amsterdam	Implement project requirements as indicated
Providers	Whitney M Young Jr Health Center	Implement project requirements as indicated
Providers	Hometown Health	Implement project requirements as indicated
Providers	Community Care Physicians	Implement project requirements as indicated
Providers	Capital Care Medical Group	Implement project requirements as indicated
The Innovative Health Alliance of New York LLC (IHANY) is an Accountable Care Organization (ACO) participating in the Medicare Shared Savings Program (MSSP). IHANY has the same service area and many of the same partners and providers as AFBHC, so the two entities expect to share appropriate functions to maximize efficiency and effectiveness.	IHANY	Collaborators for clinical integration and EBM
Initial Project Leads from Partner Entities	Joe Twardy, Pamela Rehak, Scott Friedlander, Brenda Maynor, Erin Simao, Dave Shippee, Patrick Carrese, Keith Brown, Kathy Ristau, Kevin Jobin-Davis, Rachel Handler, Millie Ferriter, Kathy Alonge-Coons, Amanda Mulhern	Sheperd projects through early phases of planning, development, and implementation
AFBHC Project lead for 2.b.iii, 2.b.iv, 3.g.i	Scott Friedlander (Interim)	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
AFBHC Project lead for 2.d.i	Erin Simao (Interim)	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
AFBHC Project Leads for 2.a.i, 2.b.viii, 3.a.i, 3.a.iv, 3.d.ii, 4.a.iii, 4.b.i	In Progress	Implement AFBHC projects throught the central AFBHC Clinical Operations office in close collaboration with partner entities
VP of Performance Operations	Tom McCarroll (Interim)/AFBHC Performance Office	Provide guidance and oversight for the Performance Operations of AFBHC
VP of Clinical Operations	Brenda Maynor (Interim)/AFBHC Clinical Office	Provide guidance and oversight for the Clinical Operations of AFBHC

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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		
Board of Managers	Leadership of AFBHC	"Oversight of strategic direction, performance and achievement per Implementation Plan. Oversight of PPS Chief Executive Officer, strategic direction, Implementation Plan execution including milestones and metrics, short and long-term financial performance and health of the PPS and key providers, staffing, workforce development and engagement. Development of Operating Agreement, policies, provider agreements, fund distributions. "
Compliance Officer and Audit and Compliance Committee members	Ensure Compliance	Compliance with federal and state laws and other regulations. Ensuring privacy protection and development and oversight of related policies.
Finance Committee	Oversee finances	Oversee the financial sustainability and health of the AFBHC and practitioners ensuring the short and long term viability of the organization.
IT & Data Committee	Oversee technology	Technology support, making population health and clinical communication possible. Oversee the development and implementation of technology plan to ensure the support for clinical workflows and timely and safe exchange of patient information.
Clinical Integration and Quality Committee	Oversee clinical integration	Adoption of evidence based practices and protocols consistent across all projects and intended to be used uniformly by specific provider types across the network.
Workforce Committee	Oversee workforce	Responsible for the AFBHC overall workforce strategy. Oversees the Workforce Implementation Plan and the approval of required Milestones within the plan. Responsible for overseeing the collection of data required for workforce quarterly reporting. Coordinates workforce activities with Project Leads.
Practitioner Engagement Taskforce	Spearhead practitioner engagement	Be ambassadors for engagement. Guide the assessment, development of communication and engagement plan, training program development, and other practitioner engagement processes.

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Cultural Competency Taskforce	Spearhead cultural competency initiatives	Develop, coordinate, oversee and align PPS cultural competency, health literacy and community engagement strategy and training
Project Steering Committees	Oversee Projects	Provide strategic direction for three project clusters: at-risk populations, behavioral health & primary care integration, and Integrated Delivery System & Project 11
External Stakeholders		
HIXNY	IT Connection	IT system connectivity partner
Hope House, Inc.	Recovery program	Residential recovery program
Belvedere Health Services	Home Care	Home care services
Schenectady County Office of Community Services	Government Office	Ensure comprehensive array of services across disability groups
Healthy Capital District Initiative (Contact: Kevin Jobin-Davis)	Care access coordinators	Facilitate health care access
Albany County Department of Mental Health (Contact: Stephen Giordano PhD.)	Behavioral Health	Local Government Unit; and provider of outpatient treatment services for persons with Mental Illness and Substance Abuse
Community Health Center Homecare	Home Care	in-home healthcare services
Rensselaer County Department of Mental Health (Contact: Katherine G. Alonge-Coons LCSWR)	Behavioral Health	Local government unit and safety net provider of mental hygiene services: Medicaid Service Coordination, Outpatient MH services for children, adolescents, adults and Forensic– including satellites in primary care practices; Health Home Care Coordination; community outreach for MICA population.
Catholic Charities of Albany (Contact: Keith Brown)	Assist in project 3.a.iv, etc.	expertise in SUD and ambulatory detox
Mohawk Opportunities	CBO	NFP helping individuals living with mental illness, HIV/AIDS/homeless achieve stable community living
Asthma Coalition of the Capital Region	Assist in project 3.d.ii	Convene stakeholders working to decrease asthma mortality and morbidity in low income areas
Community Hospice (Contact: Laurie Mante)	CBO	community hospice services
Equinox Inc.	Assist in project 3.a.iv, etc.	SUD treatment services
Rensselaer County Department of Health (Contact: Mary Fran Wachunas)	Government Office	Model for population health programming
Unity House of Troy (Contact: Christopher Burke)	CBO	Provides a full array of housing for adults with mental illness; provides services to assist those who are living in poverty, adults living with HIV/AIDS, victims of domestic violence, and children with developmental delays
NYS Office of Mental Health Hudson River Field Office (Contact: May Lum)	Behavioral Health	Regulatory oversight of MH continuum of care in some counties of the PPS. Standards of care for behavioral health inpatient and outpatient programs, emergency, community support, residential

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		and family care programming
NYS Office of Alcoholism and Substance Abuse Services (Contact: Tim Donovan)	Assist in project 3.a.iv, etc.	Regulatory oversight for the Substance Abuse continuum of care
Fulton County Department of Public Health	Government Office	Provide resources for projects touching Fulton County residents
Montgomery County Department of Public Health	Government Office	Provide resources for projects touching Montgomery County residents
Northern Rivers Family Services	CBO	business and managerial support to its affiliate agencies, Northeast Parent & Child Society and Parsons Child and Family Center.
Senior Hope Counseling	CBO	non-intensive outpatient mental health services for the elderly
Schenectady Community Action Program	CBO	helping persons in poverty achieve self-sufficiency
U.S. Committee for Refugees	CBO	protect the rights and address the needs of persons in forced or voluntary migration worldwide by advancing fair and humane public policy, facilitating and providing direct professional services, and promoting the full participation of migrants in community life.
Trinity Alliance	CBO	provide services to the community that will support and promote healthy families, adults and children
University of Albany	Education	prepares graduate level social workers to work in primary care settings managing chronic disease
Hudson-Mohawk Recovery Center (Contact: Tom Bendon)	Assist in project 3.a.iv, etc.	operates five NYS Office of Alcoholism and Substance Abuse Services licensed treatment facilities for addiction throughout Rensselaer County, New York
Conifer Park	Assist in project 3.a.iv, etc.	treatment for chemical dependency
Albany College of Pharmacy	Education	places residents under faculty members for training in primary care settings to maximize patient engagement and medication adherence
Empire State College	Education	educates and prepares nurses for practice
Schenectady Community College	Education	educates and prepares community navigators, cultural competency and health literacy courses
IHANY	ACO	collaborate on clinical integration and EBM
Schenectady Bridges Out of Poverty	CBO	training

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IPQR Module 10.5 - IT Requirements

Instructions :

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

The IT committee reporting to the governing body provides oversight for the overall IT vision of providing the right information to the right person at the right time and in the right place. The AFBHC IT committee and it's representatives are responsible for implementing the IT operational plan that will establish connectivity, communication, and data sharing throughout the PPS. The IT Workstream team is designing the operational work plan that will: establish priorities, align disparate systems; facilitate information sharing across organizations; meet PCMH meaningful use requirements; and align IT capacity with the needs of population health management tools (refer to the IT Systems and Processes Workstream and the Population Health workstream). IT infrastructure development to support the successful implementation of DSRIP projects includes: 1) establishing processes and structures to implement the DSRIP Data-Sharing and Confidentiality requirements; 2) incorporating developing /acquiring the capabilities and infrastructure into the Population Health IT work plan to meet reporting requirements and support evidence-based practices; 3) prioritizing the steps/actions, hardware, and other resources required to achieve transition medical records and access the HIE; 4) facilitating communication between PPS IT Committee and project teams to align IT and clinical workflows; 5) putting into place population health management analytic capabilities including, but not limited to: outcomes measurement; performance dashboards; quality improvement; patient risk stratification; service utilization; complex care management; patient outreach; and care transitions (refer to Population Health workstream); 6) establishing EHR registries targeted for specific patient populations with capabilities to support reporting to monitor and track adherence with standards of care, and identify care gaps; 7) identifying alternate methods where EHR/RHIO functionality is not ready and transitioning to electronic as it becomes available.

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

The DSRIP projects provide the vehicle to establish PPS-wide expectations, metrics and reporting structure to inform provider and partner incentives for clinical and population performance. The AFBHC's PMO will oversee data acquisition and analytics. The PMO provides data analysis and dashboard development support to the DSRIP project teams and for ongoing DSRIP operations after the projects are fully implemented. The PMO will work closely with the partner Information Technology leaders PPS to confirm the metrics required for each project and to align metric requirements with IT capabilities. This PPS function will build upon and coordinate with existing resources in the PPS partner organizations to align tools and methods.
The PMO will work with the Population Health Management team, Performance Reporting workstreams, and the Project Managers to assess the capabilities throughout the PPS for reporting the specific metrics required by the DSRIP project; develop and acquire capabilities and infrastructure to meet project reporting requirements. The Project Managers will work with the PMO and the Project Teams to: establish the reporting plan to gather data, ensure data integrity, create and distribute project dashboards and other reports; establish the process to review, evaluate, prioritize and initiate the rapid improvement process to address gaps, determine data needs to inform project planning and assist teams with aggregating,

analyzing and interpreting data. The PPS Workforce workstream will assist in providing education and training to project teams and as needed about data analysis, management, reporting and interpretation.

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IPQR Module 10.7 - Community Engagement

Instructions :

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

The AFBHC plan for community engagement recognizes that engagement occurs at multiple levels including policy, PPS, organizational, programmatic, and individual. This plan, as well as the PPS selection of Project 2.d.i., reflects the understanding of these levels and the interactions between them.
Representatives from community based agencies and stakeholders comprise the AFBHC PAC. Town hall meetings, website and email correspondence provide the opportunity for two-way communication between the AFBHC PPS and PAC members to provide input to project direction, invite project team participation, and generate support for project implementation. Patient scenarios are being used to describe how services will change with DSRIP implementation for populations in need. An AFBHC DSRIP newsletter has been distributed and will continue as a means of updating the community on PPS progress. The AFBHC PPS will build upon past successes in community involvement. For example, a community coalition consisting of over 70 organizations was established for the UMatter Schenectady initiative and plans to reunite and repurpose the coalition for the PPS support are underway. Established relationships with Bridges out of Poverty allow the PPS to benefit from their expertise and help teach providers, care givers and other staff to understand the burden of poverty as part of the PPS cultural competency plan. The Healthy Capital District Initiative (HCDI) R5 project brings together a wide range of physicians, community-based service providers, payers, businesses, and hospitals from the Capital District to identify interventions that will reduce use of emergency services for primary care treatable conditions. To achieve this goal, the project will determine the root causes of sub-optimal emergency room utilization, where health system gaps exist, best practice models in the region/country, and develop initiatives to improve utilization.

The PPS will leverage existing groups, such as neighborhood associations were they exist. Plans for community advisor groups that represent geographic communities and population-specific advisory groups for marginalized groups LGBTQ, people with disabilities, Veterans, formerly incarcerated individuals, etc. are underway. Community Health Workers who reflect the characteristics of the community they serve are an important component of the engagement strategy.

Responsibilities for community engagement will be housed in the DSRIP office to leverage planning, alignment, implementation and oversight across the PPS geographic region. The community engagement work stream will: 1) inventory current patient/advisory activities from PPS partners across the system; 2) identify key success factors, best practices, and effective tools; 3) define a structure and process used for community engagement, such as organizational or agency councils; project team advisors; program advisors; office practice advisors; committee advisors; 1:1 advisors, as in the peer to peer programs; 4) using the AHRQ Working with Patients and Families as Advisors: Implementation Handbook adopt and adapt these guidelines as needed to meet the needs of the characteristics of PPS population defined in the Community Needs Assessment; 5) develop expectations and provide training for patient engagement at the front line provider and care giver level: 6) establish processes to promote alignment and coordinate across site; provide flexibility for sites to adapt as needed based on the setting, beneficiary population and purpose; 7) Include engagement metrics on project dashboards (ex. Participating advisors; and, 8) coordinate with the Cultural Competency and Health Literacy Work stream plans.

Community Based Agencies are key to the success of transforming health care in the AFBHC. The PPS governing body will approve contractual

guidelines and the AFBHC CEO will be responsible for making contractual arrangements with participating CBOs.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending (Baseline)

Instructions :

Please include details on expected workforce spending on a semi-annual basis. Funds may be shifted from one funding type category to another within the workforce strategy spending table, as long as the PPS adheres to their overall spend commitments. However, the PPS may apply a 25% discount factor to the DY1 Workforce Strategy Spend target. If the PPS applies this discount in DY1, the PPS will be expected to reallocate those funds appropriately in DY2-4 to fully meet their DY1-4 total commitment.

Funding Type	Year/Quarter										
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)	DY3(Q1/Q2)($)	DY3(Q3/Q4)($)	DY4(Q1/Q2)($)	DY4(Q3/Q4)($)	DY5(Q1/Q2)($)	DY5(Q3/Q4($)	Total Spending($)
Retraining	25,000.00	25,000.00	234,375.00	228,375.00	159,500.00	159,500.00	131,000.00	131,000.00	65,000.00	35,000.00	1,193,750.00
Redeployment	5,000.00	5,000.00	0.00	6,000.00	6,500.00	6,500.00	6,000.00	6,000.00	0.00	0.00	41,000.00
New Hires	250,000.00	250,000.00	7,500.00	9,000.00	10,000.00	8,000.00	8,000.00	8,000.00	0.00	0.00	550,500.00
Other	0.00	0.00	69,875.00	69,875.00	125,000.00	75,000.00	85,000.00	75,000.00	100,000.00	50,000.00	649,750.00
Total Expenditures	**280,000.00**	**280,000.00**	**311,750.00**	**313,250.00**	**301,000.00**	**249,000.00**	**230,000.00**	**220,000.00**	**165,000.00**	**85,000.00**	**2,435,000.00**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	NO
Task 1. Establish the AFBHC Workforce Committee (WC) which will be responsible for managing the workforce related Milestones and Action Steps in the Implementation Plan.	Completed	1. Establish the AFBHC Workforce Committee (WC) which will be responsible for managing the workforce related Milestones and Action Steps in the Implementation Plan.	09/30/2015	09/30/2015	09/30/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. The WC will review and assess workforce commitments made in the PPS's Organizational and Project applications in relation to defining the target workforce state.	Completed	2. The WC will review and assess workforce commitments made in the PPS's Organizational and Project applications in relation to defining the target workforce state.	09/30/2015	09/30/2015	09/30/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. The WC will assess and determine the job roles that will be impacted by each project.	In Progress	3. The WC will assess and determine the job roles that will be impacted by each project.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 4. The WC will match the anticipated job role impacts with the provider organizations within the PPS.	In Progress	4. The WC will match the anticipated job role impacts with the provider organizations within the PPS.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 5. The WC will utilize data collected to help define a preliminary target workforce state.	In Progress	5. The WC will utilize data collected to help define a preliminary target workforce state.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 6. The WC shall utilize the Project Advisory Committee (PAC) to provide input to the preliminary target workforce state.	In Progress	6. The WC shall utilize the Project Advisory Committee (PAC) to provide input to the preliminary target workforce state.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 7. The WC shall consider PAC suggestions and recommendations into further defining the target	In Progress	7. The WC shall consider PAC suggestions and recommendations into further defining the target workforce state.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
workforce state.									
Task 8. Using the data and information gathered, the WC will define the target workforce state and present to the Board of Managers for approval.	In Progress	8. Using the data and information gathered, the WC will define the target workforce state and present to the Board of Managers for approval.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	NO
Task 1. Concurrent with developing the transition roadmap, the AFBHC Workforce Committee (WC) will determine immediate training, recruiting, and redeployment needs required in DY1.	In Progress	1. Concurrent with developing the transition roadmap, the AFBHC Workforce Committee (WC) will determine immediate training, recruiting, and redeployment needs required in DY1.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 2. The WC will develop workforce governance policies that define how decisions are made and approved regarding workforce resource allocations, hiring, training, and redeployments.	In Progress	2. The WC will develop workforce governance policies that define how decisions are made and approved regarding workforce resource allocations, hiring, training, and redeployments.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 3. The WC will develop the Master Workforce Matrix by defining the target workforce state and performing the workforce gap analysis to assist with creating a workforce transition roadmap.	In Progress	3. The WC will develop the Master Workforce Matrix by defining the target workforce state and performing the workforce gap analysis to assist with creating a workforce transition roadmap.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 4. The WC will add a timeline to the Master Workforce Matrix outlining when workforce trainings, hirings, and redeployments are expected to take place.	In Progress	4. The WC will add a timeline to the Master Workforce Matrix outlining when workforce trainings, hirings, and redeployments are expected to take place.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 5. The WC will establish a schedule of Workforce Outcomes, by DSRIP year, against which workforce transitions progress can be measured on a regular basis.	In Progress	5. The WC will establish a schedule of Workforce Outcomes, by DSRIP year, against which workforce transitions progress can be measured on a regular basis.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 6. The WC shall consider PAC suggestions and recommendations into further developing the workforce transition roadmap.	In Progress	6. The WC shall consider PAC suggestions and recommendations into further developing the workforce transition roadmap.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 7. The WC shall present the workforce transition roadmap to the Board of Managers for approval.	In Progress	7. The WC shall present the workforce transition roadmap to the Board of Managers for approval.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	NO
Task 1. The AFBHC Workforce Committee (WC) will develop the methodology to collect workforce census information from its committed providers. Information to include position counts, position vacancies, etc.	In Progress	1. The AFBHC Workforce Committee (WC) will develop the methodology to collect workforce census information from its committed providers. Information to include position counts, position vacancies, etc.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 2. The WC will collect and report quarterly all required workforce information throughout the duration of the DSRIP project.	In Progress	2. The WC will collect and report quarterly all required workforce information throughout the duration of the DSRIP project.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 3. The WC will summarize into a Master Workforce Matrix, all workforce items as specified and required by DOH for Domain 1, including Domain 1 project requirements; implementation plan workforce requirements; data collections from the target workforce state; and the workforce commitments made by the PPS in their organizational and project applications.	In Progress	3. The WC will summarize into a Master Workforce Matrix, all workforce items as specified and required by DOH for Domain 1, including Domain 1 project requirements; implementation plan workforce requirements; data collections from the target workforce state; and the workforce commitments made by the PPS in their organizational and project applications.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 4. The WC will utilize the Master Workforce Matrix to identify gaps and determine what steps will need to be taken for each provider to meet their respective workforce needs.	In Progress	4. The WC will utilize the Master Workforce Matrix to identify gaps and determine what steps will need to be taken for each provider to meet their respective workforce needs.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 5. The WC shall consider PAC suggestions and recommendations in the gap analysis.	In Progress	5. The WC shall consider PAC suggestions and recommendations in the gap analysis.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 6. The WC will provide a final updated and required Workforce Strategy Budget, Workforce	In Progress	6. The WC will provide a final updated and required Workforce Strategy Budget, Workforce Impact Analysis, and New Hire Employment Analysis for the DY1, Q4 quarterly	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Impact Analysis, and New Hire Employment Analysis for the DY1, Q4 quarterly report.		report.							
Task 7. The WC will define the detailed gap analysis between the current and future state of the PPS workforce and present to the AFBHC Board for approval.	In Progress	7. The WC will define the detailed gap analysis between the current and future state of the PPS workforce and present to the AFBHC Board for approval.	12/31/2016	03/31/2017	03/31/2017	06/30/2017	06/30/2017	DY3 Q1	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Completed	Compensation and benefit analysis report, signed off by PPS workforce governance body.	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task 1. The AFBHC Workforce Committee (WC) will develop the methodology to regularly collect salary and benefit information from its committed providers, with consideration given to utilizing an independent third party to collect and report on the data.	Completed	1. The AFBHC Workforce Committee (WC) will develop the methodology to regularly collect salary and benefit information from its committed providers, with consideration given to utilizing an independent third party to collect and report on the data.	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Utilize an independent third party to collect baseline compensation and benefits information from providers for job roles previously identified in the Master Workforce Matrix.	Completed	2. Utilize an independent third party to collect baseline compensation and benefits information from providers for job roles previously identified in the Master Workforce Matrix.	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. The WC will determine the need and make recommendations to collect/not collect compensation and benefits information for job roles determined as having a low impact for training, hiring, or redeployment.	Completed	3. The WC will determine the need and make recommendations to collect/not collect compensation and benefits information for job roles determined as having a low impact for training, hiring, or redeployment.	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. The WC will utilize the collected data to prepare a compensation and benefits analysis of the workforce expected to be impacted by training, hiring, or redeployment and present to the Board of Managers for approval.	Completed	4. The WC will utilize the collected data to prepare a compensation and benefits analysis of the workforce expected to be impacted by training, hiring, or redeployment and present to the Board of Managers for approval.	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5	Completed	Finalized training strategy, signed off by PPS workforce	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop training strategy.		governance body.							
Task 1. The AFBHC Workforce Committee (WC) will review and assess workforce commitments made in the PPS's Organizational and Project applications to help develop the PPS training strategy.	Completed	1. The AFBHC Workforce Committee (WC) will review and assess workforce commitments made in the PPS's Organizational and Project applications to help develop the PPS training strategy.	12/31/2015	12/31/2015	12/31/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Concurrent with developing the training strategy, determine training priorities and needs required in DY1.	Completed	2. Concurrent with developing the training strategy, determine training priorities and needs required in DY1.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 3. Create a Training Sub-Committee (TSC) comprised of provider staff educators, and other education professionals, that will assist the WC in assessing training priorities, developing the training strategy, identifying timelines, training schedules, and implementation of the training plan.	Completed	3. Create a Training Sub-Committee (TSC) comprised of provider staff educators, and other education professionals, that will assist the WC in assessing training priorities, developing the training strategy, identifying timelines, training schedules, and implementation of the training plan.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 4. The WC and TSC will utilize the Master Workforce Matrix as a guide to assess the needs of the job roles previously identified as requiring training/retraining.	Completed	4. The WC and TSC will utilize the Master Workforce Matrix as a guide to assess the needs of the job roles previously identified as requiring training/retraining.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 5. The WC and TSC will utilize the Master Workforce Matrix to match training needs with training providers and their associated costs.	Completed	5. The WC and TSC will utilize the Master Workforce Matrix to match training needs with training providers and their associated costs.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 6. The WC and TSC will incorporate training timelines into the Master Workforce Matrix.	Completed	6. The WC and TSC will incorporate training timelines into the Master Workforce Matrix.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 7. The WC and TSC will define and present a training strategy plan to the Board of Managers for their approval.	Completed	7. The WC and TSC will define and present a training strategy plan to the Board of Managers for their approval.	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop training strategy.	mccarrol	Documentation/Certification	3_DY2Q4_WF_MDL112_PRES5_DOC_R6_Evidence_of_Governance_Body_Approval_Wkfrc_Trng_Strtg_15858.docx	DY2Q4 Remediation Response	06/21/2017 09:58 AM
	mccarrol	Documentation/Certification	3_DY2Q4_WF_MDL112_PRES5_DOC_M5_Alliance_Workforce_Training_Strategy_10057.docx	Workforce Training strategy approved by workforce committee	04/12/2017 03:29 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	M1 and associated tasks 3-8 are moved to 6/30/2017 to reflect the ongoing nature of the work.
Create a workforce transition roadmap for achieving defined target workforce state.	M2 and associated tasks 1-7 are moved to 6/30/2017 to reflect the ongoing nature of the work.
Perform detailed gap analysis between current state assessment of workforce and projected future state.	M3 and associated tasks 1-7 are moved to reflect the ongoing nature of the work.
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	
Develop training strategy.	DY2Q4 Remediation Response: Please see attached document reflecting minutes from Workforce Committee meeting approving workforce training strategy: R6 Evidence of Governance Body Approval Wkfrc Trng Strtg

Milestone Review Status

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

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Milestone Review Status

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

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

1) A key challenge for AFBHC will be recruiting for health professionals in shortage occupations to meet the needs and requirements of each project. The AFBHC Workforce Committee will consider establishing a centralized recruitment function that addresses key positions needed.
2) Engaging 1,400 providers in a shared workforce training strategy will be a key challenge. Balancing the many training priorities that AFBHC will be required to fulfill with the workforce priorities of individual providers could be problematic to AFBHC reaching its milestones and metrics. As the AFBHC Workforce Committee develops the overall PPS training strategy, it will address how required trainings will be handled across providers. The use of internet-based communication tools will assist with keeping providers engaged and informed in the workforce training strategy of AFBHC.
3) As providers begin to work together there is a potential threat of the unlawful sharing of compensation and benefits information in violation of federal and state antitrust laws. The AFBHC Workforce Committee will review these laws, in consultation with legal counsel, and develop a policy (or additions to the antitrust policy) for providers to guard against this threat. Further, antitrust protections are afforded AFBHC and its providers if an independent third party collects and reports compensation and benefits data according to antitrust laws.
4) The required reporting of participant-level training data, including outcomes, across all AFBHC providers will be a key challenge. The AFBHC Workforce Committee will consider establishing a Rapid Cycle Team to assist with coordinating workforce reporting functions. Also under consideration will be the use of an internet-based Learning Management System (LMS) to help deliver training content and produce training outcomes reports.
5) An outside threat that could impact most providers within AFBHC is the expected implementation of the ICD-10 medical records coding system in October 2015. Provider priorities may temporarily shift to ICD-10 as payments to providers hinge on accurate coding. AFBHC will consider establishing a multi-provider committee to assess and monitor ICD-10 provider readiness and its potential impact to implementation of AFBHC projects. AFBHC will develop contingency plans in the event provider focus shifts to ICD-10 implementation.

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

The overall PPS Workforce Strategy is clearly dependent on other workstreams in the implementation plan. The Governance section requires a finalized workforce communication and engagement plan. The Cultural Competency/Health Literacy section requires developing a training strategy focused on addressing the drivers of health disparities, requiring training plans for clinicians and other segments of the workforce. The IT Systems and Processes section requires developing an IT change management strategy with an education and training plan. The Performance Reporting section requires developing a training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting. The Practitioner Engagement section requires the development of a training/education plan targeting physicians and other

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professional groups, designed to educate them about DSRIP and the PPS-specific quality improvement agenda. The Clinical Integration section requires developing a clinical integration strategy, providing training for providers across care settings and training for operations staff. Each project also has project-specific workforce deliverables that will need to be incorporated into the workforce plan. Developing and implementing the PPS workforce plan will be heavily dependent on provider human resource and staff education departments. The quarterly workforce reporting and required documentation will also be dependent on the participation from provider human resource and staff education departments. Workforce reporting and documentation will be enhanced through information technology that can centrally record participant-level data for training, hiring, and redeployments. Given the significant costs associated with the PPS workforce, it is critical that the Workforce Strategy is developed in conjunction with the Financial Sustainability workstream.

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Workforce Committee (WC)	Committee Members listed below	Responsible for the AFBHC overall workforce strategy. Oversees the Workforce Implementation Plan and the approval of required Milestones within the plan. Responsible for overseeing the collection of data required for workforce quarterly reporting. Coordinates workforce activities with Project Leads. Oversees activities of the Training Sub-Committee (TSC).
Workforce Committee Chair	Dave Shippee, President and CEO, Whitney M. Young, Jr. Health Center	Accountable for overseeing and managing the activities of the Workforce Committee (WC) and Training Sub Committee (TSC)
Workforce Committee Member	Andrea Thomas, Director of Human Resources, Capital Care	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Andrew Rodrigue, Director of Human Resources, Community Care	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Joe Giansante, Vice President of Human Resources, Ellis Medicine	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Kathy Messore, Chief Human Resources Officer, Hometown Health	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Al Turo, Interim Vice President Chief Human Resources Officer, St. Mary's Healthcare Amsterdam	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Barbara McCandless, Vice President Human Resources, St. Peter's Health Partners	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Matthew Petrin, Vice President Human Resources, Whitney M. Young, Jr. Health Center	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	BobVanZetta, Executive Director, Family & Child Service Schenectady	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Susan Cipolla, Director of Human Resources, Catholic Charities of the Diocese of Albany	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	TBD, Regulatory Specialist, New York State Nurses Association (NYSNA)	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	TBD, Education Specialist, Higher Education Representative	Responsibilities listed above for the Workforce Committee (WC).
Workforce Committee Member	Maureen Tomlinson, Organizer, SEIU 1199	Responsibilities listed above for the Workforce Committee (WC).
Training Sub-Committee (TSC)	Staff Educator representation from Ellis Medicine, St. Peter's Health Partners, St. Mary's Healthcare (Amsterdam), Whitney M. Young Jr. Health Center, Hometown Health Center, Community Care Physicians, and Capital Care Medical Group, and other	Working with the WC, responsible for the development and implementation of the AFBHC training plan. Responsible for coordinating employee training to include focus on employees working with specific poplulations such as developmentally

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	provider organizations as determined by the WC.	disabled, homeless, and uninsured.

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IPQR Module 11.7 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Ellis Hospital School of Nursing	Educator	Nursing certifications and training.
Samaritan Hospital School of Nursing	Educator	Nursing certifications and training.
Memorial Hospital School of Nursing	Educator	Nursing certifications and training.
External Stakeholders		
Iroquois Healthcare Association	Workforce Consultant	Compensation and benefits data collection and reporting, training partnerships, workforce strategy.
Hudson Mohawk AHEC	Workforce Consultant	Local administrator of health care training.
SEIU 1199	Labor Union	Input regarding job impacts resulting from DSRIP projects.
CSEA	Labor Union	Input regarding job impacts resulting from DSRIP projects.
NYSNA	Labor Union	Input regarding job impacts resulting from DSRIP projects.
University at Albany	Educator	Public Health Education, Health Disparities Certificate program
Albany College of Pharmacy	Educator	Degree programs and continuing education provider
Empire State College	Educator	RN to BSN in Nursing, non-degree nursing education, offers online and part-time programs for existing workers
Maria College	Educator	Licensed Practical Nurse (LPN) training, BSN degree program, Health and Occupational Science program, Psychology program
Schenectady County Community College	Educator	Chemical Dependency Counseling (A.A.S. and Certificate), Health Studies Certificate, Nursing A.S. Program in cooperation with Ellis Medicine.
School of Health Sciences at The Sage Colleges	Educator	Nursing degree programs, Continuing Education for Nurses, Psychology advanced degree programs.
Hudson Valley Community College	Educator	Dental Hygiene (A.A.S.), Dental Assisting Certificate, Emergency Medical Technician (A.A.S. & Certificate), Sonography Certificate, Nursing (A.A.S.), Health & Wellness Institute
HealthStream	Online Education and Workforce Reporting Services	Online training and Learning Management System (LMS) provider. Education areas include, but are not limited to, Cultural Competency, Health Literacy, Team-Based Transitional & Collaborative Care, Behavorial Health, Population Health

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		Management, and Leadership Development.

IPQR Module 11.8 - IT Expectations

Instructions :

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

1. AFBHC is well positioned to use an existing and continuously developing IT infrastructure that the health care workforce will utilize to coordinate patient care. Most AFBHC partner organizations are already connected together within the Health Information Exchange of New York (HIXNY). HIXNY is the Regional Health Information Organization (RHIO) that serves as the hub to securely collect and deliver health information in real-time between authorized providers and their authorized employees. Providing real-time data empowers the appropriate health care workforce with meaningful information that can be used to improve population health and meet individual needs one patient at a time. 2. AFBHC will utilize IT-based communication tools to engage the workforce. It is expected that electronic newsletters will be used to communicate with employees within AFBHC. The AFBHC website will also have a workforce section outlining workforce efforts being undertaken, including an employment recruitment section to direct individuals to provider organization's job opportunities within AFBHC. 3. A shared IT infrastructure will also support an internet-based centralized delivery system of required and optional training courses across providers within AFBHC. Known as a Learning Management System (LMS), the LMS is also an important tool in recording and reporting on workforce related outcomes at the individual employee level.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

The success of the AFBHC workforce strategy will predominantly be measured in DY1/DY2 against milestones, actions steps, target dates, and Domain 1 required workforce metrics. In succeeding years, emphasis will increasingly move from pay-for-reporting to pay-for-performance. Ultimately, the success of the workforce strategy will be measured against AFBHC meeting its outcome metrics for each DSRIP project. AFBHC must be able to regularly measure if the investments made in its workforce strategy are having a positive impact on the ability of AFBHC to meet its stated goals and project outcomes. AFBHC will consider establishing a centralized workforce reporting function to assist with reporting new hire activity, workforce impacts, and workforce budget spending. An internet-based Learning Management System (LMS) will be an important tool in being able to centrally collect, record, and report on workforce outcomes. Through an LMS, online training courses can be assigned to employees across multiple providers within the PPS. The LMS automatically records training progress and completions for each employee. Most courses have pass/fail thresholds that must be met in order for a course to be considered complete. Where thresholds are not being met, the LMS can be used to identify employees requiring remediation activities. In addition, the LMS has the capability to enter and record training outcomes that are provided in other settings such as classroom training. The LMS has full reporting capabilities to produce detail and summary reports for selected time periods to assist with preparing quarterly reports. The LMS reports can also be used by the Workforce Committee (WC) and the Training Sub-Committee (TSC) to monitor training progress at provider organizations within the PPS. Many providers within AFBHC have experience using

online Learning Management Systems and it is expected that administrative staff from these providers will assist with managing the LMS processes and producing the necessary reporting for the WC use.

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IPQR Module 11.10 - Staff Impact

Instructions :

Please upload the Workforce Staffing Impact (Projections) and the Workforce Staffing Impact (Actuals) tables provided for quarterly reporting.

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
mccarrol	Documentation/Certification	3_DY2Q4_WF_MDL1110_DOC_Staffing_Impact_Quarterly_DY2_Q3_Q4_ACTUALS_11551.xlsx	DY2Q4 Workforce Actuals	04/24/2017 10:22 AM
mccarrol	Documentation/Certification	3_DY2Q4_WF_MDL1110_DOC_DY2Q4_Workforce_Projections_11.10_11550.docx	Module 11.10 Projections	04/24/2017 10:21 AM

Narrative Text :

DY2Q4 Remediation Response:

The staff impact analysis is cumulative. DOH guidance specifically was: "For organizations that reported data previously, activity should be reported for the most recent 6 month period. Organizations that have not reported before are permitted to report back to the beginning of DSRIP to 4/1/15. When we conducted the first staffing impact analysis in September 2016, we asked providers to report actuals from April 1, 2015 to September 30, 2016. Those numbers in the DY2Q2 reports include DY1 numbers. Even when we did the most recent impact analysis for DY2Q4, we asked providers in our instructions to report actuals back to April 1, 2015 if they had not participated in the first impact analysis.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 11.11 - Workforce Strategy Spending (Quarterly):

Instructions :

Please include details on workforce spending for DY2. The workforce spending actuals should reflect only what was spent during the relevant quarters and is not cumulative across semi-annual periods. The PPS can shift funding across categories; e.g., from Retraining to New Hires. Please note that the "Cumulative Percent of Commitments Expended through Current DSRIP Year (DY2)" section is calculated based on the total yearly commitments.

Benchmarks	
Year	**Amount($)**
Total Cumulative Spending Commitment through Current DSRIP Year(DY2)	1,185,000.00

Funding Type	Workforce Spending Actuals		Cumulative Spending to Date (DY1-DY5)($)	Cumulative Percent of Commitments Expended through Current DSRIP Year (DY2)
	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)		
Retraining	18,858.09	91,783.00	511,616.09	99.78%
Redeployment	0.00	0.00	0.00	0.00%
New Hires	0.00	0.00	25,000.00	4.84%
Other	45,806.80	551,933.27	748,368.82	535.51%
Total Expenditures	**64,664.89**	**643,716.27**	**1,284,984.91**	**108.44%**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 11.12 - 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.

The AFBHC plan has aimed to provide the broad array of services to address the needs identified in the CNA and has not yet addressed the specific demands on the partners and stakeholders for implementing the selected projects and if the current drill down of the PPS can match the demand in services created by the selected DSRIP projects. A major risk to the successful completion of Project 2.a.i. is that the aggressive speed and scale targets for provider and patient engagement may outpace the PPS's capacity to meet those targets within the designated timelines. To mitigate this strategy, the AFBHC will conduct capacity assessments and gap analysis. The risk mitigation strategy is to establish an ongoing method for monitoring capacity with demand for services. A dashboard report documenting current capacity compared, projected capacity based on the patient and provider engagement timelines, identified gaps, the nature of those gaps, and what has been / being done to reduce gaps. This dashboard will be reported to the governing board on a quarterly basis for review, evaluation, and action.
The second risk to the successful completion of Project 2.a.i. is that the time limitations for completing the DSRIP CNA, the DSRIP organizational and project applications and the implementation plan has resulted in the lack of knowledge and widespread participation of physician providers in the DSRIP initiative to date. Physician participation and engagement are the foundations of successful system transition. To mitigate this risk, the AFBHC has taken active steps toward provider participation:
1) Dr. Thomas Lawrence, CMO at St. Peter's Health Partners Medical Associates is now an active member of the steering committee.
2) Physician leaders will be added to the AFBHC governing board.
3) The AFBHC and IHANY (the newly established regional ACO) have initiated collaboration between their respective Clinical Integration and Quality Committees to promote alignment, avoid duplication and streamline provider time requirements for participation in administrative activities associated with both organizations.
4) The AFBHC will invite provider participation on the practitioner engagement implementation plan team.
5) The AFBHC will map specific provider roles for each project so these expectations may be included in their operating agreements
6) The AFBHC will plan a comprehensive educational effort using a variety of methods and leveraging physician champions.
7) The AFBHC will establish financial incentives to reward achievement of quality targets.
8) The AFBHC will offer change support, tools, and training from the PPS administrative offices to primary care practices. The success of the mitigation efforts will be documented by the signed operating agreements and distribution of incentives.

Another risk to the successful completion of this project is that the PPS does not achieve NCQA recognition for its primary care practices by DY3, Q4. To mitigate this risk, the PPS will dedicate at least one project manager to focus on PCMH certification and keep on target for the timeline. Current state of the practices will be assessed, technical assistance needs identified and technical assistance will be provided from the PPS central project management office.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
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	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task 1. Complete full provider list of all AFBHC participants, including medical, behavioral, post-acute and long term care providers		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Assess and catalogue the PPS partners and stakeholder organizations clinical providers: physicians, physician's assistants, nurse practitioners, behavioral health providers, clinical psychologists, clinical social workers, Community based service providers, social services and other MEB disorders care professionals. Include: provider name, type, NPI, specialty, solo or group practice, practice size, number of open slots for new patients; PCMH status, presence and role of care coordination.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Coordinate clinical assessments with assessment of IT capabilities (refer to Part I IT Systems and Processes and Population Health Management) to identify IT strengths and gaps.		Project		In Progress	04/01/2015	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task 4. Building upon the description of the list of stakeholders and community engagement organizations presented in the DSRIP Project Plan application, conduct a drill-down assessment of the		Project		In Progress	04/01/2015	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
specific services provided by each stakeholder organization and how many clients/patients may be added to the their current case load with existing resources.										
Task 5. Assess the Medicaid MCOs in the PPS service area, including CDPHP, MVP and Fidelis to engage in discussions regarding project-related issues and VBP. Evaluate MCO's Medicaid provider networks and compare and contrast to AFBHC network. Determine any follow up strategies depending on findings		Project		In Progress	04/01/2015	03/31/2017	01/01/2017	09/30/2017	09/30/2017	DY3 Q2
Task 6. Project teams, Workforce leaders, and PPS administrative office staff will collaborate to conduct a network gap analysis and develop subsequent plan to fill gaps. Report findings to appropriate stakeholders including the Clinical Integration and Quality Committee		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Project future capacity needs per DSRIP project based on the patient and provider engagement timelines identify gaps or oversupply of the network.		Project		In Progress	07/01/2016	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task 8. Develop a plan with timelines to meet those gaps based on the patient and provider engagement timelines		Project		In Progress	04/01/2015	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task 9. Develop a dashboard of current capacity compared to projected capacity based on the patient and provider engagement timelines and distribute to pertinent internal stakeholders.		Project		In Progress	04/01/2015	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task 10. Determine list of elements that need to be included in the provider agreements/contract and distribute and negotiate with providers.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 11. Finalize participation agreements/contracts		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 12. Create a process to track all executed provider agreements/contracts		Project		In Progress	04/01/2015	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task 13. Create process and dashboard platform to track provider contracts, requirements, terms and corrective actions		Project		In Progress	04/01/2015	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task 14. Report dashboards to the Governing Board on a quarterly		Project		In Progress	04/01/2015	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4

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basis for review, evaluation and action.										
Task 15. Establish process for the periodic review of provider network lists to fill in the timely clinical and operational service gaps		Project		In Progress	04/01/2015	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish a planning process and re-occurring meetings with the AFBHC three partner Health Homes (Samaritan Hospital DBA Capital Region Health Connection; St Mary's HealthCare, Amsterdam, Visiting Nurse Service of Schenectady County, Inc. DBA Visiting Nurse Service of Northeastern New York) and IHANY ACO to develop a strategy that develops into an Integrated Delivery System.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Conduct inventory of the population health management strategies and capabilities that have been adopted by the three partner Health Homes, the IHANY ACO, and compare capabilities to DSRIP requirements.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Develop an ideal population health management model that leverages best practices from each entity.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. As part of the Part I IT Systems and Processes plan, assess the population health management IT tools and systems used by the three Health Homes, seven key partners, IHANY and other partners throughout the PPS (refer to Part 1 IT Systems and Processes). Include: gaps in care Identification capabilities, risk stratification capability, patient outreach & engagement capability, patient care and tracking capability, patient to provider attribution		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
capabilities.										
Task 5. Coordinate strategy for Population Health IT tools and software with IHANY, Health Homes, and community providers (refer to Part I Clinical Integration).		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Create the AFBHC centralized Clinical Integration and Quality Department to coordinate and align care management across the PPS.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Identify and document care management best practices from the Medicaid Health Homes, the Comprehensive Primary Care Initiative (CPCI) participants, and NCQA recognized PCMHs		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Incorporating best practices, document with a flow diagram the care management workflow / patient flow among the PPS partners and CBOs.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Select the care transitions model(s) that will be endorsed by the PPS and define the transitions workflow / patient flow among the PPS partners and CBOs, including discharges from SNFs.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. Formally adopt and operationalize the AFBHC Population Health Management Model that cares for people within a		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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PCMH/behavioral/mental health foundation surrounded by a comprehensive integrated network inclusive of medical specialists, acute, post-acute, community based and social services. The model is inclusive of risk-stratification of populations with attendant prevention and wellness interventions with effective transitions and care coordination processes. The model is supported by robust technology, timely actionable analytics, and actuarially-sound payment models from managed care organizations. Conduct subsequent steps within the context of this model.										
Task 6. Incorporating identified best practices, revise care management job descriptions to demonstrate the interrelated care management roles of the Health Homes, Home Care, downstream providers, acute inpatient care management, primary care, outpatient behavioral care, social services, public health organizations, state mental health agencies and care transitions programs		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Incorporate and implement revised care management roles in Projects 2.b.iii., 3.a.i., 3.a.iv., 3.d.ii., 3.g.i. and 4.a.iii.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Implement selected care transitions model in Projects 2.b.iv. and 2.b.viii		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 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.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Hospital	In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY		Provider	Safety Net Mental Health	In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirements.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Nursing Home	In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 1. Survey participating providers to understand current infrastructure and connectivity to HIXNY		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Determine requirements for HIXNY connectivity among partners. Assess current systems capability against these requirements.		Project		In Progress	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions.		Project		Completed	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Develop a roll-out plan for systems to achieve sharing health information among clinical partners, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Establish a process for monitoring project milestones and performance		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Align Project implementation timelines with respective IT timeline to ensure IT requirements are in place for project implementation.		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9. Coordinate with IT Systems and Processes for the roadmap to achieving clinical data sharing and interoperable systems across PPS network		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 10. Collaborate with hospital systems and IT to assess and edit		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
current policies and protocols around 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										
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.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Survey participating providers to understand their use of EHR's and PCMH status and level		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Determine requirements for meeting Meaningful Use and PCMH level 3 standards. Assess current systems capability against these requirements.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 3. Create a gap analysis based on the current state analysis to determine incremental needs and associated budget		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Develop a roll-out plan for systems to achieve Meaningful Use and PCMH level 3 certification, including a training plan to support the successful implementation of new platforms and processes.		Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 5. Establish a project management process and tool for monitoring project milestones and performance		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 7. Track progress toward PCMH Level 3 recognition, including progress toward meaning use.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Define populations for which registries are needed based on current data available through portals such as Salient		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Survey Participating partners to determine requirements for population health strategy and requirements		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Develop a roll-out plan for systems and IT platforms including patient registries among clinical partners, including a training plan to support the successful implementation of new platforms and processes		Project		In Progress	04/01/2015	03/31/2017	01/01/2017	09/30/2017	09/30/2017	DY3 Q2
Task 5. Establish a process for monitoring project milestones and performance metrics		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPs		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 7. Where EHR functionality is not yet ready, implement alternate in the interim. Track conversion to electronic systems.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8. Coordinate strategy for Population Health IT tools and software with IHANY (refer to Part I Clinical Integration) and the IT Roadmap (refer to Part I IT Systems and Processes).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all eligible participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All eligible practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Designate a PPS level PCMH project lead		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Establish PCMH project team		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Finalize strategy for achieving PCMH Level 3 certification for contracted providers		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. Based on analysis of pros/cons of corporate vs individual practice NCQA PCMH recognition, select approach(es) for provider groups		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Determine level of support with financial implications for AFBHC		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 9. Collect NCQA recognition documentation from practices that are currently 2014 or 2011 Level 3 recognized		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Task 10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 11. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 12. Identify practices participating in projects whose implementation success depends on them achieving 2014 recognition and target them to achieve recognition first. (2.b.iii, 2.b.iii, 3.a.i.)		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13. Establish goals and timelines to achieve 2014 Level 3 NCQA recognition by the end of DY3, starting with practices currently in progress.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 14. Asses the practices' needs for technical assistance and provide technical assistance.		Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 15. Track providers progress on quarterly basis for meeting requirements within projected roadmap and take corrective action and or celebrate depending on results		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish the structure and process to meet regularly with MCOs to review and evaluate costs, quality, and utilization		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Define participants: MCOs, PPS / IHANY clinical integration committee, PPS finance committee, and other stakeholders as indicated		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Define monthly meeting schedule.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Define data series of utilization and performance measures to track and Develop data reports		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Task 5. Establish a process to provide feedback to selected governance or operational bodies on a regular basis to review data; resolve performance gaps; and report back progress		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Include the following issues identified in the projects: Including but not limited to: 2.a.i, 2.b.iv, 2.d.i, 3.a.iv, 3.d.2, 3.g.i, and 4.b.i		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Build infrastructure for collecting, reporting and ensuring the quality of provider performance data is available for performance tracking and subsequent incentive payments.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 2. Establish a process to identify and resolve documentation gaps that may affect performance reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Establish incentive compensation to patient outcomes consistent with DSRIP goals considering the budget and funds flow framework.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 4. Develop VBP Educational Program explaining the content and implications of Level 1, 2, and 3 Value Based Payments as it refers to: all care for total population, integrated primary care, acute and chronic bundles, and total care subpopulations: New York State Roadmap for Medicaid Payment Reform (June 2015).		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 5. Establish communication schedule to present the VBP Educational Program		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6. Model agreed-upon value-based payment arrangements that align incentives with outcomes, are actuarially sound, and are acceptable to the network and share findings with appropriate stakeholders, Finance Committee, and the Board		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Task 7. Develop a plan that demonstrates how the incentive based payment model would evolve into value based payment model and obtain Board approval.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 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.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Using input from IHANY, results from the community needs assessment, the AFBHC PPS will establish communication methods for providers, community health workers, clients, peers and community organizations outlining short term and long term goals of DSRIP.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 2. Based on Community Needs Assessment, identify chronic diseases that will have outreach programs offered (chronic disease in general, diabetes, end stage renal disease, chronic pain, cancer survivors).		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Determine strategy for apprising community assessment information, including determination of repeating assessment within the DSRIP calendar timeframe		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. In conjunction with the workforce committee, determine training curriculum for community health workers, including train the trainer methods, learning management system modules, and other educational platforms		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 5. Include Cultural Competency / Health Literacy committee to decide where and how advisors will be used throughout the PPS. Using the AHRQ Working With Patient and Families as Advisors Implementation Handbook as a guide (http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf) develop a training program for advisor roles in the PPS.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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6. Engage Medicaid members to participate as ad hoc advisors in the planning and development of programs, processes, and tools to transform healthcare delivery and address health disparities across cultures										
Task 7. Using marketing avenues, brand developed strategies to drive toward goal of Triple Aim.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8. Develop strategy, including policy / procedures, expectations, and guidelines for what, when, where, who and how outreach and navigation activities will be carried out.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 9. Implement outreach steps per strategy developed by PPS IDS		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 10. Identify PPS partners for project and ensure those experienced with navigation, community health workers, and peer support is included.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 11. Create an inventory of community partners providing outreach and navigation activities (type, volume, role expectations, characteristics of individual and patient population served)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12. Match characteristics of individual and patient population served with offered of services (ex. community-based organization, PCMH, clinical program).		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 13. Community Health Workers (CHW). Using NY benchmarks as guide (http://nyshealthfoundation.org/uploads/resources/making-the-connection-community-health-workers-sept-2012.pdf), establish roles expectations, selection process, standards, and onboarding curriculum to prepare Community Health Workers for positions in their own communities. Redeploy internal workers as possible. Include developed protocols for engagement.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 14. Establish a Self-Management Education Program (ex. Standard Self-Management Model) that is administered from the PPS level to increase capacity and flexibility of offerings. Choose a model that has been adapted to different cultures and may be taught in multiple languages. (Stanford Chronic Disease Self-		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Management model or similar program).										
Task 15. Coordinate activities with patient activation measures in various projects across the PPS, with emphasis on 2di project alignment		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 16. Based on the Community Needs Assessment, identify other populations that could benefit from the program in their native language using language interpretation platforms.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 17. Establish methods to stratify outcomes to quantify disparities, identify target areas and evaluate interventions.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES2_DOC_20170331_2.a.i_R2Metric_2.3_CIQ_Meeting_Minutes_2-6-17_11180.docx	Metric 2.3 CIQ Meeting Minutes	04/20/2017 10:51 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES2_DOC_20170331_2.a.i_R2Metric_2.3_CIQ_DSRIP_PROJECT_UPDATES_11179.DOCX	Metric 2.3 CIQ DSRIP Project Updates	04/20/2017 10:50 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES2_DOC_20170331_2.a.i_R2Metric_2.3_CIQ_Agenda_3-6-17_11178.docx	Metric 2.3 CIQ Agenda	04/20/2017 10:50 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES2_DOC_20170331_2.a.i_R2Metric_2.3_ACO_Integration_Summary_11177.docx	Metric 2.3 ACO Integration Summary	04/20/2017 10:49 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES2_DOC_20170331_2.a.i_R2Metric_2.2B_Health_Homes_Lessons_Learned_v6.16.15_11176.pdf	Metric 2.2B Health Homes Lessons Learned	04/20/2017 10:48 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES2_DOC_20170331_2.a.i_R2Metric_2.2A_Health_Homes_Lessons_Learned_Summary_11175.docx	Metric 2.2 Health Homes Lessons Learned Summary	04/20/2017 10:47 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES2_DOC_20170331__2.a.i_R2Metric_2.1_Health_Home_List_11174.xlsx	Metric 2.1 Health Home List	04/20/2017 10:46 PM
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES3_DOC_20170331_2.a.i_R3Metric_3.3_Screenprints_of_discharge_plan_in_PCP_Record..._11427.docx	Metric 3.3 Screen prints of discharge plan in PCP Record	04/23/2017 11:39 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
health services.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES3_DOC_20170331_2.a.i_R3Metric_3.4_IDS_Trainings_11186.xlsx	Metric 3.4 IDS Trainings	04/20/2017 11:00 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES3_DOC_20170331_2.a.i_R3Metric_3.3_Discharge_Summary_in_the_PCP_EHR_11184.DOCX	Metric 3.3 Discharge Summary in the PCP EHR	04/20/2017 10:57 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES3_DOC_20170331_2.a.i_R3Metric_3.2_IHANY_Alliance_Complex_Care_Management_Workf..__11183.pdf	Metric 3.2 IHANY Alliance Complex Care Management Workflow	04/20/2017 10:56 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES3_DOC_20170331_2.a.i_R3Metric_3.1_HIE_11182.DOCX	Metric 3.1 HIE	04/20/2017 10:55 PM
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2ai_MDL2ai2_PRES9_DOC_20170331_2.a.i_R9_MCO_Meeting_Process_11187.docx	MCO Meeting Process	04/20/2017 11:10 PM

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.	Task 5 has been moved to 9/30/2017 to reflect the ongoing nature of the work.
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.	DY2Q4 Remediation Response: No. All practices are not connected. But we're close: 91.4% of Alliance participating providers are connected to the local RHIO/QE (HIXNY). We will have all connected by 12/2017. We are working with HIXNY and our partners' EHR vendors to accelerate this process.
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	Task 4 has been moved to 9/30/2017 to reflect the ongoing nature of the work.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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 eligible participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	
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.	Tasks 1,3, 4 have been moved to 9/30/2017 to reflect the ongoing nature of the work
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.	Tasks 4 and 5 have been moved to 6/30/2017 to reflect the ongoing nature of the work

Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 2.a.i Mid-Point Assessment project narrative	Completed	2.a.i Mid-Point Assessment project narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
2.a.i Mid-Point Assessment project narrative	

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

Instructions :

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

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

Instructions :

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

One risk that threatens the success of this project is that the number of new patients referred to Primary Care Physicians (PCP) from the ED exceeds the PPS' primary care capacity to absorb new patients. To mitigate this risk, one of the first steps is to identify PCPs that are accepting new patients and ensure that processes are in place for ED navigators to refer patients to these targeted PCPs. To ensure primary care placement opportunities for patients, the PPS will track supply & demand for primary care throughout the PPS to identify gaps, assess geographic areas of need & recruit & place physicians in PCP shortage areas. Open access scheduling capabilities will also be assessed with current state PCP practices & a recommendation for future state participating practices. Demand for primary care from this project will be coordinated with Project 2.d.i. as industry experience has shown that as the number of insured increase, the need for primary care increases. Due to PCP shortages in the area and nationally, the PPS is also evaluating the need for primary care Nurse Practitioners and exploring with the Workforce Committee the retraining & redeployment of currently employed licensed nurses to pursue advanced practice credentials in primary care.

Another risk is that patients may not want to be redirected to PCPs. To mitigate this risk, the project will develop a patient education campaign, including patient focus groups, Medicaid beneficiaries & community representatives to include preventive health importance and continuity of care benefits.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of the DSRIP program with their existing commitments. The PPS will work closely with the RHIO. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. As PHIT roll-out depends on sufficient capital funding from NY state, delay in the capital release will delay the rollout. The PPS will accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

A risk to the PPS is that the successful implementation of this project will have negative impacts on the hospitals' finances. Since ED visits & inpatient admissions via the ED are sources of revenue for the hospitals, as patients become more engaged in appropriate outpatient venues, volume for the EDs & revenues for the hospitals will also decline. The mitigation strategy is to monitor hospital admissions/readmissions, revenues/sources of revenue; document the amount, timing & duration of the impact; & allocate funding in the budget & funds flow to offset revenue losses due to reduced hospital utilization.

Resistance to change is a risk common to DSRIP project interventions. For this project, the PPS has already been piloting navigators in the ED & has a project manager in place. Resistance will be mitigated by integrating requirements of the 2.b.iii. with the current navigator role & to closely oversee the project with a dedicated project director responsible for implementation in the 6 emergency departments. Project 2.b.iii will work closely with the workforce strategy of AFBHC & the PPS, & assess the effectiveness of the navigator role based on patient & provider engagement

speed and milestone achievement of the DSRIP timeline.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	15,287

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	1,898	6,327	7,988	11,865
	Quarterly Update	610	1,201	1,396	1,639
	Percent(%) of Commitment	32.14%	18.98%	17.48%	13.81%
IA Approved	Quarterly Update	0	1,200	0	1,635
	Percent(%) of Commitment	0.00%	18.97%	0.00%	13.78%

Warning: PPS Reported - Please note that your patients engaged to date (1,639) does not meet your committed amount (11,865) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ2biii_MDL2biii2_PES_ROST_project_2biii_201703_submission_12884.xlsx	2.b.iii DY2Q4 Patient Engagement Roster	04/26/2017 01:30 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for DY2,Q4.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Stand up program based on project requirements		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify project lead at PPS level		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. The following six Emergency Departments (EDs) will participate in the project: St Mary's Hospital, Amsterdam; Ellis Hospital; St Peter's Hospital ; Samaritan Hospital, St Mary's Hospital, Troy; and Albany Memorial Hospital. Incremental establishment of the ED Navigator roll out plan will be devised with ED leadership. • Hospital – ED and Behavioral Health leadership teams are formulating an urgent care business plan to redirect non-emergent behavioral health & medical (60/40) ED visits to a secondary Ellis site location. This will allow ESI Levels 4 & 5 to be treated and released with follow up and lessen high volumes and throughput congestion of main ED campus.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Identify and invite key stakeholders to project teams, such as EMS, law enforcement, transportation, housing, community services and public organizations and practitioners.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4. Pilot program at St Mary's Hospital ED for initial roll out of project and stage implementation of other EDs		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Form project implementation teams at each site, including ED administrative and front line staff and PPS providers		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6. Conduct monthly meetings with project lead and teams from sites, define roles and responsibility and track progress toward objectives of program. Include additional stakeholder meetings to address workforce and recruitment efforts to meet associated		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
staffing needs of the project.										
Task 7. Identify process metrics, institute tracking mechanism to collect data, manually then progression to IT platform		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8. Define future state for ED patient navigator model to include a social triage of At-Risk define populations to assess for: PCP needs or connectivity, transportation barriers/needs, medication attainment, health home care management services, home care services, community meals, DME equipment needs, etc. Assessment and attainment of services will assist member to follow up in the most cost effective setting and be provided with the help they need to maintain their health and wellbeing.		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 9. Define target, at-risk patient population. PPS will consider ED visits with an ESI triage level of 4 or 5, as well as, At-Risk populations identified in our Community Needs Assessment.		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 10. Identify and communicate with project teams baseline metrics and potentially preventable ED visit salient data results		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 11. Add PCMH staff to project teams to coordinate open access scheduling and other PCMH requirements of project		Project		In Progress	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12. Track and evaluate programs at each site using rapid cycle team evaluation techniques		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 13. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task All eligible practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs		Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Work with PPS project team to identify Contract/MOUs with PCP practices		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. Classify providers according to criteria required to meet Meaningful Use Stage 2 requirements.		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards.		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Establish communication means for encounter notification systems through various avenues, including direct communication, IT solutions and other notification systems for PCPs		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Establish communication means for encounter notification systems (ENS) through various avenues, including direct communication, IT solutions and other notification systems for Health Home care managers		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6. Track progress toward completion of fully functioning ENS in PCP offices and Health Home lead agencies.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 7. Track providers progress on quarterly basis for meeting requirements within projected roadmap		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		Completed	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
8. Finalize strategy for achieving PCMH Level 3 certification for contracted providers										
Task 9. Assess level of administrative and financial support that MCO's in the region are currently providing or planning to provide primary care practices to help them achieve PCMH Level 2014 standards to ensure there is coordination and no duplication of effort.		Project		Completed	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10. PCMH project team to finalize roadmap for achieving Meaningful Use with providers		Project		Completed	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 11. Identify PCMH practices that have flexible scheduling/open access scheduling currently in place		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12. On a quarterly basis, update master census of PCMH providers and level achieved that is distribute to patient navigators at rolled out sites. See Milestone #5		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Assess current state ED triage flow for target, at-risk populations as defined in Requirement #1, step #8		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Consider scope of roles and responsibilities of patient navigator, such as: • Evaluate (in person or follow up next day) of all ED Visits by		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Medicaid Members meeting level 4 or 5 • Assess with member to arrange for a post ED follow up PCP visit or re-connectively to their exiting PCP. • Assess transportation needs/barriers. Connect member with Medicaid Answering Services for covered health care appointments • Assess medication attainment barriers. If no means of transportation, assess for scheduled home delivery of medications or contract with local transportation companies to assist members with Pharmacy trip to fill scripts. • Assess additional needs to be referred to Health Home Care Managed Service, or if already involved, message Health Home CM with ED alert notice of their member • Assess for additional community needs such as meals on wheels, DME equipment needs, home health services, etc and referral to community based organization as indicated										
Task 3. Design patient navigator workflow with key stakeholders that will need support staff to sustain project requirements (Hospital Directors of Care Management Departments, ED Management, Health Home Management)		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Develop process and protocols for navigator interactions for ESI level 4 and 5 triaged patients		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Determine per ED location/volume hours of navigator operation to meet project requirements		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6. Select, hire, retrain, redeploy navigators per site implementation		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 7. Identify method to flag target patient population to patient navigator		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8. Design scripting to be used by navigator staff when interfacing with target population		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 9. Maintain current listing of all community support resources that will be used to connect target patients to appropriate services		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task		Project		Completed	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
10. Develop process for patient navigator to hand off pertinent information to PCP/care manager/health home care manager, care transitions coach and other CBO services currently involved										
Task 11. Develop scripting guidance for patient preference on scheduling appointment, locations, barriers to keeping appointment, transportation		Project		Completed	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 12. Include methods to address age appropriate literacy level and adapt methods accordingly		Project		In Progress	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 13. When process for Project 2di implemented, train patient navigators in PAM tool to use for capture special patient population		Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 14. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 15. Inform PCPs, behavioral health providers and CBOs, including but not limited to EMS and law enforcement organizations implementation of patient navigator program and track education sessions		Project		In Progress	11/01/2015	03/31/2017	11/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 16. Within the requirements of EMTALA and other regulatory policies, explore the possibilities to use EMS as the remote arms and eyes for ED providers to guide interventions in the field and to minimize ED over-utilization of non-emergent episodes		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 17. Invite local transportation units and EMS to submit plans for pilot programs for innovative system change, implement if appropriate		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 18. Explore transportation options to increase adherence to medication attainment after discharge from ED to prevent recidivism. Engage pharmacological associations to develop innovated strategies to reduce barriers in attainment, medication reconciliation, poly-pharmacy and adherence to prescribed treatment regimen.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Established protocols allowing ED and first responders - under	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2020	03/01/2017	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).		Provider	Safety Net Hospital	Completed	04/01/2015	03/31/2020	03/01/2017	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Ellis Hospital										
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for ED Triage project		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Working with the project committee document current and future state work flow of ED Triage project in addition to capturing manual solutions in place at this time.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Identify prioritization of systems to build, metrics, or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7. Develop a roll-out plan for systems to achieve clinical data sharing and associated metrics, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish a process for monitoring project milestones and performance.		Project		Completed	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems.		Project		Completed	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biii_MDL2biii3_PRES4_DOC_R9_2.b.iii_M4_15859.docx	DY2Q4 Remediation Response	06/21/2017 10:31 AM
Use EHRs and other technical platforms to track all patients engaged in the project.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biii_MDL2biii3_PRES5_DOC_20170331_2biii_R5_SPHP_PtEngageSampleReport_10411.xlsx	2biii Pt Engagement Sample Report (St. Peter's Health Partners)	04/17/2017 10:13 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biii_MDL2biii3_PRES5_DOC_20170331_2biii_R5_SMH_PtEngagementEDNavigatorDocumentation_10405.pdf	2biii Patient Engagement ED Navigator Documentation (St. Mary's Amsterdam)	04/17/2017 09:49 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biii_MDL2biii3_PRES5_DOC_20170331_2biii_R5_SMH_PtEngagementCaptureScreenshot_10404.pdf	2biii Patient Engagement Capture Screenshot (St. Mary's Amsterdam)	04/17/2017 09:48 AM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Task 15 has been moved to 06/30/2017 to reflect the ongoing nature of the work.
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	DY2Q4 Remediation Response: This is an optional Milestone. Our previous guidance from the IA in instances where Alliance does not plan on completing a Milestone has been to change the status to on-hold and push the due date to DY5Q4. However, since the IA wants Alliance to note our intention in a narrative, change the due date to the current quarter and mark the Milestone as complete, we have done so.
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass (with Exception) & Complete	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #5	Pass & Complete	

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Mid-Point Assessment	Completed	project 2.b.iii narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Mid-Point Assessment	

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

Instructions :

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

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

Instructions :

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

A risk to the success of this project is that care transition activities aren't currently reimbursed by Medicare/Medicaid, although some MCOs provide some level of reimbursement for care transitions plans, which vary between plans & providers. Physician practices that aren't PCMH certified are reluctant to participate. The AFBHC mitigation strategy involves using regular meetings with Medicaid MCOs to advocate for reimbursement of interventions key to the project success. The PPS is developing process improvement initiatives for providers to obtain PCMH certification, as well as agreements to incentivize providers to participate in projects & achieve desired outcomes.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of the DSRIP program with their existing commitments. The PPS will work closely with the RHIO. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. As PHIT roll-out depends on sufficient capital funding from NY state, delay in the capital release will delay the rollout. The PPS will accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

Inconsistent approach to transitions of care across the PPS & providers' lack of resources, knowledge & time risks success. The PPS is developing a standardized approach to engage patients & families in these services.

Another risk is lack of knowledge of the full extent of causes of readmission in the PPS. Hospitals currently rely on internal methods to monitor 30-day readmissions. Access to Medicaid claims data now provides the ability to track the movement of attributed members across sites of care internal & external to the PPS. Preliminary data reveals that hospital-based tracking methods tend to underestimate member readmissions as they only measure readmissions to the site of discharge. This measurement dynamic is a risk to the PPS as it creates disconnect between the PPS' understanding of their target performance compared with NY's measurement of their performance to target- this unfavorable gap can negatively impact incentive payments & the PPS budget. To mitigate this, the PPS is using salient data to further understand patient movement, coordinating readmission analyses across hospitals & tracking readmissions according to source (LTC, SNF, home health & home) to identify facilities, agencies & patients at higher risk of readmission than others. This data will provide a comprehensive readmission rate of the attributed population, identify care gaps & target improvements at the system root cause. The PPS will also collaborate with other PPSs in the area to ensure that strategies are in place to reduce gaps/redundancies so reduction in 30 day readmissions is attainable.

Like Project 2.b.iii, a risk to the PPS is that the successful implementation of this project will have negative impacts on the hospitals' bottom line. In the fee for service reimbursement environment, hospital admissions are associated with revenue. As avoidable admissions decline, hospital revenues will also decline. To mitigate this risk, the PPS will monitor hospital admissions/readmissions, revenues/revenue sources, document the amount, timing & duration of the impact & allocate monies in the budget & funds flow to offset revenue losses.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	26,978

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	2,451	8,169	11,845	20,421
	Quarterly Update	1,438	2,752	3,964	7,005
	Percent(%) of Commitment	58.67%	33.69%	33.47%	34.30%
IA Approved	Quarterly Update	0	2,752	0	7,001
	Percent(%) of Commitment	0.00%	33.69%	0.00%	34.28%

Warning: PPS Reported - Please note that your patients engaged to date (7,005) does not meet your committed amount (20,421) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ2biv_MDL2biv2_PES_ROST_project_2biv_201703_submission_12912.xlsx	2.b.iv DY2Q4 Patient Engagement Roster	04/26/2017 01:34 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for DY2,Q4.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. PPS Clinical Operations team will conduct inventory of which PPS hospital providers and CBO's are currently providing care transitions services		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Identify the current role that MCO's and Health Homes play in care transitions and the current protocols being used by these entities in the region.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Review each providers current approach/policy to care transitions services		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. The PPS will adopt a 30-day, Coleman-like model of care transitions services that includes: inpatient hospital visit from the care transitions coach, home visit post-acute discharge, medication and diagnosis review and education, symptom identification, create personal health record, secure post hospitalization PCP visit, and perform a series of follow up calls/visits after significant events during the high-risk readmission period.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Develop a post-acute network for the PPS community, including level of engagement		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Develop a standardized protocol for integrated clinical teams to manage population health strategies of Care Transitions services from inpatient to discharge		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7. Utilize, develop and standardize education and training materials that are sensitive to cognitive competency, and culturally and linguistically tailored to the populations we serve (for example Easy To Read [ETR] materials)		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8. Establish a best practice model of service utilizing a Coleman-like model of care transitions with participating providers and CBO's		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 9. Complete an assessment of participating providers, LTC and CBO's of targeted high risk diagnosis (Core Measure, developmentally disabled, physical rehabilitation, & Behavioral Health/SUD), social barriers (Homeless, underinsured) and hot spotting		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 10. Collaborate with the Workforce Committee to create a PPS-wide strategy to redeploy/recruit the necessary professionals to support care transitions services and from the assessment of the vulnerable populations in # 4 to expand capacity and competence to include "intensive care transitions coaches"		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 11. Present standardized protocols to appropriate Clinical Integration subcommittees and Clinical Integration and Quality Committee for formal adoption.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 12. Clinical Operations team will establish a process and structure to conduct a root cause analysis (RCA) on future failed discharges leading to readmissions within 30 days and develop process improvement plans based on data		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15: Remediation Response 13. PPS will measure outcomes of the program and follow up services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. While the AFBHC Transitions of Care Protocol is being drafted, the AFBHC CFO and project designee will meet with health plans to align discussion of projects and include health homes discussion in the region to identify consistency of practice, alignment of eligibility criteria for health homes program, and services covered.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. Determine payment for services that are lacking, for example, transitions of care services, and define methods of coverage and payment.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Discuss with MCO's the cost/benefit of expanding eligibility criteria for health homes in achieving DSRIP goals and determine potential coverage options.		Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4. Establish AFBHC policy and procedure that defines how care transitions communications and processes will occur among entities and the role that the health plans, health homes, hospitals, and PPS will play.		Project		In Progress	09/01/2015	12/31/2017	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 5. Clearly identify in the policy and procedure how members will be linked to services as required under the Affordable Care Act.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6. Present policy to the Finance and Clinical Integration Subcommittee and Committee.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 7. Establish process metrics to ensure agreed-upon procedures are working and achieving Domains 2 goals.		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure required social services participate in the project.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Required network social services, including medically tailored home food services, are provided in care transitions.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Engage with network of trusted social service agencies, housing, CBOs, transportation, pharmacy associations and advocacy agencies (association for blind, deaf, etc.) in the PPS region to develop strategies to connect targeted populations to appropriate resources. Submit strategies to project team and AFBHC leadership to review and for approval.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. Conduct an assessment of the ability of PPS's local Meals on Wheels (MOW), regional food banks and food delivery companies to provide medically tailored meals to members identified through the care transitions planning process.		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Clinical Operations team will assess the availability of a congregational health networks within the PPS to expand our bandwidth of providers to improve the health of our most vulnerable		Project		Completed	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Identify with trusted social service agencies identified in #2 and PPS stakeholders to add or enhance services that are absent or deficient by linking with project roadmap		Project		Completed	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
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.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Practitioner - Primary Care Provider (PCP)	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Snitkoff Louis Md										
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Practitioner - Non-Primary Care Provider (PCP)	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion:										

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Naveh Marcia Spiegel Md										
Task Policies and procedures are in place for early notification of planned discharges.		Provider	Hospital	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Ellis Hospital										
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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Clinical Operations and Project Implementation teams will map transitions process starting from patient admission to the hospital through discharge and develop standardized systems approach for early notification of planned discharges		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. Clinical Integrated Teams (acute case mangers/discharge planners, social workers) will perform a risk assessment upon admission to trigger alerts to the care transitions coaches (See #1, Step 4)		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Clinical Integrated Teams will collaborate with the care transitions coach to coordinate identified high-risk needs post-acute hospitalization		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Care transitions coach will develop post-acute plan utilizing identified network providers, internal ancillary support personnel (Pharmacy, PT, OT), CBO/social service liaisons, and family members to support patient and provide safe hand-off after 30-day period.		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Initiate steps identified in # 1, Step 7 utilizing teach back and/or return demonstration technique		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6. Clinical Operations and Project Implementation team will establish a unified referral process to allow Clinically Integrated Teams to capture high risk patients through the facilities daily census report.		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7. Clinical Operations and Project Implementation teams will		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
engage respective IT departments to review and modify any patient access limitations to ensure Clinically Integrated Teams have access to necessary data and the ability alert care transitions service teams to contact patients and families to offer/provide care transitions services.										
Task 8. Clinical Operations Team will coordinate care transitions services with other PPS projects (2.b.iii and 2.b.viii) to fully capture the high risk patient population.		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. The PPS will complete an assessment of current hospital IT policies and protocols around existing automated systems to alert post-acute providers and PCPs of transitional plans		Project		Completed	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. Establish alternative methods of communication (secure email, fax, phone calls, physician portal) until EHR platform is operational for all transitional hand offs and PCP notification.		Project		Completed	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. The Clinical Operations & Project Implementation team will survey participating providers to extract additional ideas surrounding timely notification of post-acute discharge dispositions		Project		Completed	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Clinical Operations team will adopt a standardize process/tool to exchange information at each warm hand-off (ie: Interact Like Tool) that includes significant information such as MOLST, patient care plan, medications, additional support services		Project		Completed	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Ensure that a 30-day transition of care period is established.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1. Eligible patients enrolled in a high risk readmission process for 30-days transitions period will be assigned a care transitions coach		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. The care transitions coach will establish a rapport with the patient and family by initiating contact about the Coleman-like Care Transitions Program through an initial hospital visit		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. The care transitions coach will follow patient from hospitalization to discharge and set up a home visit within 3 business days of discharge.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. The care transitions coach will perform the following interventions during the home visit with the patient/family: medication reconciliation of discharge meds, develop personal health record and create questions to be discussed at post-acute PCP visit, provide, utilizing the teach –back method, disease and medication education, provide GREEN-YELLOW-RED symptom/self-management guide sheets, establish 3 additional follow up calls/visits that surround significant health care events to provide support and establish any additional community support needs for the patient to avoid unnecessary ED visit or hospital readmission.		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Track , measure and evaluate care transition programs effectiveness through data, feedback and outcomes, report through Clinical Integration and Quality committee		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement for Care Transitions project		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. Working with the project committee, document current and future state work flow of Care Transitions project in addition to capturing manual solutions in place at this time.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification and treatment plan creation		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementation new EHR systems vs RHIO connectivity based on the DSRIP project needs and associated provider's needs.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish a process for monitoring project milestones and performance		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Where electronic functionality is not yet ready, implement alternative in the interim and track conversion to electronic systems		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_SPHP_MAXseriesOverview_12978.pdf	St. Peters Health Partners, SPHPMA Primary Care Care Management, Health Home, Alliance PPS, IHANY ACO Collaboration with Medicaid Accelerated Exchange Series (MAX Series)	04/26/2017 02:08 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_SPHP_CBO_Partnership-_Respite_Program_for_Homeless_11430.pdf	St Peters Health Partners Partnership CBO - DSRIP Respite Program for Homeless	04/23/2017 12:33 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_SPHP_Acute_Care_Discharge_Planning Policy_11429.docx	St. Peters Health Partners Transitions of Care Acute Care Discharge Planning Policy	04/23/2017 12:32 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_Ellis_CBOcollaborationTransportPharmacy_10998.docx	Ellis Medicine- CBO Collaboration (Transportation Services and Pharmacy)	04/20/2017 09:22 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_ELLIS_TransitionsOfCarePolicy_10997.doc	Ellis Medicine Transitions of Care Policy	04/20/2017 09:22 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_TheEddyCOACHWorkflow_10996.pdf	The Eddy -Coach Workflow	04/20/2017 09:21 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_SPHPAcuteDCWorkflow_10995.pdf	St. Peters Health Partners Transitions of Care Acute d/c Workflow	04/20/2017 09:19 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_CHCandPalmersPharmacyPartnership_10994.pdf	Community Collaboration - Home Care Agency and local Pharmacy (medrec)	04/20/2017 09:17 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_SMH_CTC_Program_Descriptions_(inpt_PC_CHC)_10993.pdf	St. Mary's Amsterdam Care Transitions Coach Program Descriptions (Inpatient, Behavioral Health, Primary Care Coach)	04/20/2017 09:16 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES1_DOC_20170331_2biv_R1_SMH_CT_workflow_10992.pdf	St. Mary's Amsterdam Care Transitions Workflow	04/20/2017 09:15 AM
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.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_R10_2biv_M4_SPHP_Acute_Discharge_Planning_15862.pdf	DY2Q4 Remediation Response	06/21/2017 10:42 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_R10_2biv_M4_The_Eddy_COACH_workflow_15861.pdf	DY2Q4 Remediation Response	06/21/2017 10:41 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_R10_2biv_M4_SMH_CT_workflow_15860.pdf	DY2Q4 Remediation Response	06/21/2017 10:40 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_Engaged_Hospitals_13913.xlsx	Provider Commitments - Hospitals	04/27/2017 02:26 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_Engaged_Non-PCP_for_MAPP_v_13903.xlsx	Provider Commitments - Practitioner - Non-PCPs	04/27/2017 02:19 PM
	ba628534	Documentation/Certificati	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_Engag	Provider Commitments - Practitioner - PCPs	04/27/2017 02:18 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
		on	ed_PCP_for_MAPP_v_13902.xlsx		
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_20170331_SMH_R4_CHC_Hospital_Liason_Job_Description_11010.pdf	Community Health Center (Homecare Agency) -St. Mary's Hospital Liaison Job Description	04/20/2017 09:50 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_20170331_SMH_R4_CHC_HIXNYalertsEarlyNotificationDC_11009.pdf	St. Mary's Amsterdam - Community Health Center utilizing HIXNY alerts- early notification DC)	04/20/2017 09:48 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_20170331_2biv_R4_SMH_ProcessDemonstratingOnsiteCareManagers_11007.pdf	St. Mary's Amsterdam - Process demonstrating onsite hospital liaison care transitions coaches from Community Health Center (Homecare Agency)	04/20/2017 09:44 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES4_DOC_20170331_2biv_R4_SPHP_CollabCoachPCP_11001.pdf	SPHP- Coach and Primary Care Collaboration and Communication prior to patient hospital discharge (screeners onsite at hospital)	04/20/2017 09:36 AM
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES5_DOC_R11_2biv_M5_SMH_Sample_Discharge_Summary_Included_in_PCP_Medical_Record_15864.docx	DY2Q4 Remediation Response	06/21/2017 10:55 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES5_DOC_R11_2biv_M5_SMH_15863.pdf	DY2Q4 Remediation Response	06/21/2017 10:54 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES5_DOC_20170331_2biv_R5_SMH__Primary_Care_CTC_documentation_11431.pdf	St. Mary's Healthcare- Primary Care -Care Transitions Coach documentation	04/23/2017 12:49 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES5_DOC_20170331_2biv_R5_Ellis_DeptartmentalCareTransitionsPolicy_11106.doc	Ellis Medicine Departmental Care Transitions Policy demonstrating communication protocols	04/20/2017 02:30 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES5_DOC_20170331_2biv_R5_SMH_CareTransitionsPolicy_DocumentationPatientMedicalRecord_11102.pdf	St. Mary's Healthcare Care Transitions Policy with screenshot tracking Care Transitions patients in EHR.	04/20/2017 02:27 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES5_DOC_20170331_2biv_R5_SPHP_PCMHEHRCommunication_11101.pdf	SPHP and Primary Care EHR protocols	04/20/2017 02:25 PM
Ensure that a 30-day transition of care period is established.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_R12_M6_Highlighted_SPHP_Acute_Care_Discharge_Planning_15866.pdf	DY2Q4 Remediation Response	06/21/2017 10:58 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_R12_2biv_M6_Highlighted_Eddy_Visiting_Nurse_Association_SOP_15865.docx	DY2Q4 Remediation Response	06/21/2017 10:57 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_20170331_2biv_R6_SPHP_AcuteCareDischargePlanningPolicy_11434.docx	St. Peters Health Partners - Discharge Planning Policy	04/23/2017 12:55 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_20170331_2biv_R6_SPHP_SOPCareTransitionsCoach_11433.docx	St Peters Health Partners - Standard Operating Procedure - Care Transitions Coach Program	04/23/2017 12:54 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_20170331_2biv_R6_SMH_CT_workflow_11432.pdf	St. Mary's Healthcare - Care Transitions Workflow	04/23/2017 12:53 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_20170331_2biv_R6_SMH_CTC_policy_11115.pdf	St. Mary's Healthcare Care Transitions Coach Policy	04/20/2017 02:50 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_20170331_2biv_R6_ELLIS_CareTransitionsProgramPolicy_11114.docx	Ellis Care Transitions Program Policy	04/20/2017 02:50 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES6_DOC_20170331_2biv_R6_ELLIS_TransitionCoachProcess_11113.pdf	Ellis Medicine Transitions Coach Process	04/20/2017 02:49 PM
Use EHRs and other technical platforms to track all patients engaged in the project.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES7_DOC_R13_2biv_M7_SMH_15869.pdf	DY2Q4 Remediation Response	06/21/2017 11:01 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES7_DOC_R13_2biv_M7_SPHP_PCMHEHRCommunication_15868.pdf	DY2Q4 Remediation Response	06/21/2017 11:00 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES7_DOC_R13_2biv_M7_15867.docx	DY2Q4 Remediation Response	06/21/2017 11:00 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES7_DOC_20170331_2biv_R7_SMH_ScreenshotTrackingDSRIPCareTransitionsPts_11438.pdf	St. Mary's Healthcare - Screenshot EHR Tracking DSRIP Patients	04/23/2017 01:01 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES7_DOC_20170331_2biv_R7_SMH_CareTransitionsTrackingPatients_11437.pdf	St. Mary's Healthcare - DSRIP Tracking Patient Engagement Report	04/23/2017 12:59 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES7_DOC_20170331_2biv_R7_Ellis_SampleDSRIPTrackingReport_11436.xls	Ellis - DSRIP Tracking Report	04/23/2017 12:59 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2biv_MDL2biv3_PRES7_DOC_20170331_2biv_R7_SPHP_SampleDSRIPTrackingReport_11435.xls	St Peters Health Partners Sample Tracking DSRIP Patients Report	04/23/2017 12:58 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	Tasks 1, 2, 3 have been moved to 03/31/2018 to reflect the ongoing nature of the work.
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.	DY2Q4 Remediation Response: The previously submitted documentation meets the requirement. The onsite hospital presence of coach screeners addresses the need for early identification of patient needs: Able to collaboratively identify at-risk patients upon hospital admission with hospital staff via risk stratification and multi-disciplinary rounding. 30-day care plan and medical follow up appointments are established with patient prior to discharge through case conferencing with patient and hospital staff. The agreed upon process among the PPS is that the patient is identified and seen prior to discharge and followed through a 30-day period post discharge. Please see attached care transitions policies and workflows previously provided that demonstrate the presence of onsite screeners: R10 2biv M4 SMH_CT workflow R10 2biv M4 The Eddy COACH workflow R10 2biv M4 SPHP Acute Discharge Planning
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	DY2Q4 Remediation Response: Please see the attached documents to support the project requirement for SMH: R11 2biv M5 SMH R11 2biv M5 SMH Sample Discharge Summary Included in PCP Medical Record
Ensure that a 30-day transition of care period is established.	DY2Q4 Remediation Response: The attached policies/procedures from St. Peter's Health Partners as well as Eddy Visiting Nurse Association have been updated to reflect the period of performance for the transition of care program of 30 days. We have highlighted the language in both documents. Please see attached documents: R12 2biv M6 Highlighted Eddy Visiting Nurse Association SOP R12 M6 Highlighted SPHP Acute Care Discharge Planning
Use EHRs and other technical platforms to track all patients engaged in	DY2Q4 Remediation Response:

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
the project.	The attached policies/procedures from St. Peter's Health Partners as well as Eddy Visiting Nurse Association have been updated to reflect the period of performance for the transition of care program of 30 days. We have highlighted the language in both documents. Please see attached documents: R13 2biv M7 R13 2biv M7 SPHP_PCMHEHRCommunication R13 2biv M7 SMH

Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 2.b.iv Care Transitions Mid-Point Assessment narrative	Completed	2.b.iv Care Transitions Mid-Point Assessment narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
2.b.iv Care Transitions Mid-Point Assessment narrative	

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

Instructions :

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

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

Instructions :

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

This project's success may risk hospitals' bottom line. As avoidable admissions decline, hospital revenues may decline. To mitigate the risk, the PPS will monitor hospital admissions/readmissions, revenues/revenue sources, document the impact & allocate monies in the budget & funds flow to offset losses.
As the project effects patient volume, hospitals may experience overstaffing. The PPS will monitor volume/productivity closely & coordinate with the Workforce Committee to retrain/redeploy workers within the PPS if necessary.
There are many IT Risks, such as data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of DSRIP with existing commitments. As Population Health IT (PHIT) systems & tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. PHIT rollout depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.
Another risk success is limited availability to the full extent of readmissions in the PPS. Hospitals have relied on internal methods to monitor readmissions. Access to Medicaid claims data now allows tracking attributed member movement across care sites in & out of the PPS. Preliminary data reveals that hospital tracking methods underestimate readmissions as they measure readmissions to the site of discharge. This dynamic is a risk as it creates disconnect between the PPS' understanding of their target performance compared with NY's measurement- this gap can negatively impact incentive payments & the PPS budget. For mitigation, the PPS is using data to understand patient movement, coordinating & tracking readmissions according to source (LTC, SNF, home health & home) to identify facilities, agencies & patients at higher risk of readmission. This will provide a comprehensive readmission rate of the attributed population, identify care gaps & target improvements at the system root cause
The home-health process will include protocols to identify worsening patient status early, evaluate condition & direct patients to appropriate care. Collaboration with other project strategies will help achieve speed & scale. The actively engaged patient in this project is the number of participating patients who avoided homecare to hospital transfer due to INTERACT-like principles. As submitted in the original application, the PPS actively engaged target is based on estimated members receiving homecare as of 12/2014. We assume that 50% of patients managed in the prior year continue to be engaged in active management of their chronic conditions. DSRIP success in other areas (25% Asthma and 33% Care Transitions) will drive growth of members with homecare above historical levels.
Due to varying documentation methods among the participating home health agencies, care processes are at risk from miscommunication & missing info. To mitigate the risk, this project will work with the IT committee to use consistent electronic tools across agencies. The PPS will assess the current use of the INTERACT program & implement standardized INTERACT tools. Project leads will assess current state readiness & willingness to participate & coordinate strategies with the PPS if roadblocks to change are found. Project goals will be evaluated quarterly to ensure milestones are on track for success.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	12,404

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	2,158	7,195	7,435	7,994
	Quarterly Update	0	405	453	389
	Percent(%) of Commitment	0.00%	5.63%	6.09%	4.87%
IA Approved	Quarterly Update	0	405	0	388
	Percent(%) of Commitment	0.00%	5.63%	0.00%	4.85%

Warning: PPS Reported - Please note that your patients engaged to date (389) does not meet your committed amount (7,994) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ2bviii_MDL2bviii2_PES_ROST_project_2bviii_201703_submission_12930.xlsx	2bviii DY2Q4 Patient Engagement Roster	04/26/2017 01:44 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for DY2,Q4.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify project lead at PPS level		Project		Completed	04/01/2015	11/30/2015	04/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task 2. Form project implementation teams at each site, including case management and home care administrative and front line staff and PPS providers		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. St Mary's Hospital, Amsterdam; Ellis Hospital; St Peter's Hospital; Samaritan Hospital, St Mary's Hospital, Troy; and Albany Memorial Hospital partner hospitals will participate in development of early discharge identification process for home care service integration with Community Health Center, The Eddy and Visiting Nurse Service of Schenectady. (*Expedited Discharge Team [EDT] in lieu of Rapid Response Team name)		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Include existing Coleman trained care transitions coaches (CTC) to assist in development of discharge teams		Project		Completed	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Complete a current state baseline of discharge processes, home care integration, palliative care and hospice involvement.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Define future state for the hospital to home-care collaboration programs with INTERACT-like techniques • Include collaboration during hospital visit to include home care		Project		Completed	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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liaison for greater acceptance of services being offered										
Task 7. Integrate behavioral health concerns into process, including screening tools and appropriate referrals		Project		Completed	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8. Present recommendations and periodic updates to the Clinical Integration and Quality committee of the PPS on project methodology		Project		Completed	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Implement clinical guidelines for hospital discharges to home care services.		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 10. Establish two way communication with hospital and home care that services have been initiated when patient discharged. • Home care will also report back to the hospital regarding patients referred but not admitted to home health because the patient cancelled once they got home or they were not home/not found, etc..		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management		Provider	Home Care Facilities	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Com Hlth Ctr Of Smh & Nlh Inc										
Task Evidence-based guidelines for chronic-condition management implemented.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Asses current tools and educational offering utilized by home care staff for identification of changes in condition, chronic disease management, etc		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Identify and obtain INTERACT-like tools that are needed to be used to educate home care		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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3. Determine resources needed for training, such as modules, train the trainer methods or direct education										
Task 4. Develop education plan and timeline for home care staff		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Secure resources needed for training sessions, using INTERACT-like tools to supplement gaps in education needs		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Train staff on chosen care model, focus on changes in patient condition, evidence based preventive medicine care coordination and chronic disease management		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Document, track and aggregate evaluations of all training sessions using a learning management software (LMS) tool provided by the PPS.		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Revise education methods as necessary to meet the needs of the participants		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.		Provider	Safety Net Hospital	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Ellis Hospital										
Task 1. Using INTERACT-like tools develop care pathways for home care to monitor chronically-ill patients		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Through provider agreements, include guidance on when to notify primary care physician of change in condition		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Focus on care pathways with INTERACT-like tools on at home		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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care level of recognition • Acute mental status change • Changes in vital signs • Change in behavior • Observed change in fluid intake and output • Fever or change in temperature • Nausea, vomiting, diarrhea • Symptoms of lower respiratory illness • Symptoms of CHF • Symptoms of UTI										
Task 4. Work with IT resources through the PPS to help track readmissions		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Establish quality review methodology for review of care pathways, adapt to improve outcomes		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Link to interventions developed with other projects, such as care transition project, integration of behavioral health & palliative care		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Pilot EHR programs and software solutions to home care teams, work with IT consultants to assess feasibility of piloting programs		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Train staff on guidelines		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.		Provider	Home Care Facilities	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Snitkoff Louis Md										
Task 1. Develop training programs for home care staff based on		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
INTERACT-like tools. Provide education to PCP and their staff on the use of home care services and pathways utilized to prevent hospitalization and avoiding readmission										
Task 2. Develop learning programs for home care staff, including early warning tools and communication tools		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Include education for home care staff on needs of special populations, including intellectually and developmentally disabled members		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Conduct initial and annual training sessions for home care staff		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Collaborate with Workforce Committee of the PPS to develop training programs for new hires, retrained and/or re-deployed staff.		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Maintain list of trainings, participants, evaluations and curriculum revisions through PPS based Learning Management System (LMS) tool		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop plan with cultural competency and health literacy taskforce education specific to cultural differences and end of life care		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Evaluate, review and update training materials as needed and/or as recommended by Clinical Integration and Quality committee		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify Advance Care planning tools including communication guide, tracking tool, comfort order set, and educational materials for patient and families. Provide education to staff on advance care planning, MOLST, and palliative care. Include subject		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
matter experts such as Hospice Teams to assist in educational sessions										
Task 2. Assess current state tools that are available to patients and families		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Adopt Advance Care planning tools to supplement existing tools for patients and families.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Use INTERACT-like principals to address options for palliative and end of life care if appropriate.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Script discussions with patients and families regarding accessibility to forms		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Explore innovative ways to identify tools, ie: magnetize, ID alerts, software apps		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Coordinate with Cultural Competency and Health Literacy task force of the PPS inclusion of age appropriate, culturally sensitive care planning tools		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Track, trend and benchmark defined measures related to INTERACT-like advance care planning tools.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Identify areas for improvement if necessary and report through the Clinical Integration and Quality Committee care improvement activities		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Create coaching program to facilitate and support implementation.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.		Provider	Home Care Facilities	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Snitkoff Louis Md										
Task 1. Identify INTERACT-like coaching program for the home care and expedited discharge teams		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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2. Identify champion(s) for the program at sites to motivate and assist in coordination of the program.										
Task 3. Identify coaching tools on INTERACT-like to guide implementation Use communication tools that support engagement with hospitals and home care agencies		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Schedule and conduct strategic meetings with hospitals and home care agencies to evaluate development, implementation and outcomes of programs		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Integrate coaching program with overlapping projects of the PPS, including Care Transitions project (2.b.iv) and ED Care Triage project (2.b.iii).		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Integrate technology platforms and solutions recommended by the PPS IT committee to support program implementation.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Implement quality improvement cycle to evaluate outcomes through metrics		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Use quality improvement tools to coach home care education and care process improvements.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT-like principles.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Collaborate with education vendors to purchase patient and family focused education		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Assess what is currently being used by health care workers in the home environment		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Include patient and family education components with INTERACT-like solutions. Identify, develop patient/family education tools that address health literacy/cultural sensitivity & utilize technology such as videos, tablets to address principles of adult education		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Task 4. Patient and family education sections to include education for family members to recognize change in condition and communication avenues regarding change.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Include discussions with patient and families risks and benefits of hospitalization using INTERACT-like advance care planning tools.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Establish a patient and family-oriented teach back program for early identification of adverse effects of medication		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Establish a patient and family-oriented teach back program for understanding of early comfort measures		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish quality review methods through the Clinical Integration and Quality committee of the PPS to evaluate patient hospital readmission for those who have received the aforementioned training, and use root cause analysis to revise methodology as necessary to enhance participation.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. As sites are phased in, track and evaluate programs at each site using rapid cycle team evaluation techniques		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 11. Communicate with hospitals and home care agencies level of success of program quarterly		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify INTERACT-like processes that include medication management for hospital to home care collaboration.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 2. Explore pharmacy support for homecare when evaluating care		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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models										
Task 3. Assess providers and entities that use INTERACT-like interventions in practices, including primary care, PCMH, hospitals, mental health providers, home health organizations, Health home, pharmacies, community based organizations, etc.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 4. Include members of all provider types on project teams		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 5. Develop future state care coordination and medication management model		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6. Use home care tools, including advance care planning, monitored medication dispensers, medication reconciliation worksheets, early change in condition tools, SBAR communication tools that reflect all relevant services		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7. Work with project managers/directors, leads and champions of other projects within the PPS, and PPS leadership to establish, strengthen and enhance integration of projects to include INTERACT-like tools for home health care.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 8. Extend educational sessions to providers and entities on care and medication model		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 10. Track and evaluate programs at each site using rapid cycle team evaluation techniques		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 11. Consider pilot program on medication reconciliation with community resources and pharmacies for disposal, removal, and poly-pharmacy reconciliation		Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1. Determine requirements and needs assessment for technology assisted services (telehealth/ telemedicine) program within the PPS		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 2. Assess current telehealth/telemedicine use and other technical platforms in the PPS to evaluate opportunities.		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 3. Update existing telehealth systems for more desired state of the art technology and expand best practices to enhance the use and unitization of telehealth for high risk patients		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 4. Determine incremental IT needs and associated financial implications, including short-term solutions		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 5. Establish a process for monitoring telehealth/telemedicine milestones and performance.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7. Consider piloting a telemedicine program for a specific high risk diagnosis and care pathway as identified in our Community Needs Assessment. Utilizing existing model / data from results of RCA's for readmissions.		Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 8. Data analysis will be shared with partners and Managed Care Organizations.		Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Determine requirements for clinical interoperability system		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 2. Assess current EHR and other technical platforms in the PPS against these requirements		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3. Determine method to identify the best source for medication reconciliation										
Task 4. Determine incremental IT needs and associated budget, including short-term solutions		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 5. Establish a process for monitoring project milestones and performance.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 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		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Service and quality outcome measures are reported to all stakeholders.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify members of Clinical Integration and Quality committee, including project lead and teams from hospital and home care		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. Incorporate existing quality improvement process from existing home care agencies		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Project committee benchmark, track and trend defined measures		Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 4. Develop process for rapid cycle improvement methodologies focusing on root cause analysis (RCA) of hospital transfer Use		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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INTERACT like tools, such as acute care transfer logs, to track and trend transfers										
Task 5. Project lead/champions and other home health key stakeholders to aggregate data to summarize finding and trends from individual hospital transfers into quality improvement tool on monthly basis		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6. Quality improvement committee members to recommend outcome improvement efforts based on trending data and action plans related to applicable metrics		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7. Track and evaluate programs at each site using rapid cycle team evaluation techniques and report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Monitor partnering sites that are unable to meet metrics and goals and develop process improving plan with AFBHC leadership team to gain full attainment of partner contract requirements		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
short-term manual solutions										
Task 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish a process for monitoring project milestones and performance		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Develop a process for determining how success will be measured that incorporates feedback from providers and other key users of IT, including financial and patient engagement impact and risks.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_Engaged_Home_Care_13869.xlsx	Provider Commitments - Home Care Facilities	04/27/2017 01:39 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_20170331_2bviii_R2.2_CHC_TelemonitoringPolicy_13195.pdf	Metric 2.2- Community Health Center- Tele-monitoring Policy	04/26/2017 04:26 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_20170331_2bviii_R2.2_CHC_At_Every_Visit_Guidelines_13193.pdf	Metric 2.2- Community Health Center- "At Every Visit Guidelines"	04/26/2017 04:25 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_20170331_2bviii_R2.2_EddyVNA_policy_evidence_based_education_13192.docx	Metric 2.2- Eddy Visiting Nurse Association- Evidence based education policy	04/26/2017 04:24 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_20170331_2bviii_2.2_EddyVNA_Care_Transitions_Policy_13190.pdf	Metric 2.2 Eddy Visiting Nurse Association Care Transitions Policy	04/26/2017 04:23 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_20170331_2bviii_R2.2_ELLIS_VNS_Care_Central_CareTransitionsProgramPolicy_13189.pdf	Metric 2.2 Ellis, Visiting Nurse Service, Care Central Health Home, Care Transitions Program Policy	04/26/2017 04:22 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_20170331_2bviii_R2.1_Alliance_PPS_wide_INTERACT_training_13188.pdf	Metric 2.1- Alliance INTERACT Train-the-trainer 2-day program	04/26/2017 04:20 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES2_DOC_20170331_2bviii_R2.1_PPS_InventoryOfTrainings_13183.xlsx	Metric 2.1 PPS Inventory of Trainings	04/26/2017 04:18 PM
Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_20170331_2bviii_R3.2_CHC_Workflow_14121.pdf	Metric 3.1 3.2 Community Health Center- monitoring chronically ill patients workflow	04/28/2017 09:57 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_Engaged_SN-Hospitals_13872.xlsx	Provider Commitment - Safety Net Hospitals	04/27/2017 01:52 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_20170331_2bviii_R3_Metric_1_and_2_Ellis__Rapid_Response_Plan_High_Risk_Tool_13871.docx	Metric 3.1 and 3.2- Ellis - Rapid Response Plan and High Risk Tool used	04/27/2017 01:51 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_20170331_2bviii_R3.1_and_2_CHC_ReadmissionProcessFlow_13835.pdf	Metric 3.1 and 3.2 -Community Health Center- Readmission Process Flow	04/27/2017 01:03 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_30270331_2bviii_R3.1_CHC_care_pathways_and_clinical_tools_implemented_part2_13832.pdf	Metric 3.1 - Community Health Center - Asthma self management program methodology and tools	04/27/2017 12:55 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_20170331_2bviii_R3.2_CHC_SMHcollaborationAndReadmissionReviewProcess_11461.pdf	Metric 3.2 - Hospital / Home Care Collaboration - Readmission Review Process	04/23/2017 02:24 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_20170331_2bviii_R3.2_CHC_Physician_Verbal_OrdersPolicy_11459.pdf	Metric 3.2 -Community Health Center- Physician Verbal Orders Policy	04/23/2017 02:23 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_20170331_2bviii_R3.2_CHC_MonitoringPtsWorkflow_11458.pdf	Metric 3.2 Community Health Center - Monitoring patients workflow	04/23/2017 02:22 PM
	ba628534	Communication Documentation	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_COMM_20170331_2bviii_R3.2_EddyVNA_Plan_to_monitor_chronic_patients_11457.pdf	Metric 3.2 Eddy Visiting Nurse Association- Strategic plan for monitoring critically ill patients	04/23/2017 02:20 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES3_DOC_20170331_2bviii_R3.1_CHC_Carepathways_and_clinical_to	Metric 3.1 Community Health Center - Care Pathways and clinical tools implemented part 3	04/23/2017 02:14 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			ols_implmentedpart3_11452.pdf		
Educate all staff on care pathways and INTERACT-like principles.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES4_DOC_Engaged_Home_Care_13873.xlsx	Provider Commitment - Home Care Facilities	04/27/2017 01:55 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES4_DOC_20170331_2bviii_R4_PPS_InventoryOfTrainings_13851.xlsx	PPS -Inventory of Trainings to include INTERACT	04/27/2017 01:14 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES4_DOC_20103131_2bviii_R4_CHC_INTERACTtrainingDocumentation_11464.pdf	Community Health Center - Partner "train the trainer" INTERACT training documentation	04/23/2017 02:30 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES4_DOC_20170331_2bviii_R4_Alliance_PPS_wide_INTERACT_training_11463.pdf	Alliance PPS-wide Train-the-trainer Program	04/23/2017 02:29 PM
Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES5_DOC_20170331_2bviii_R5_EddyVNA_AdvanceCarePlanningToolkit_11467.pdf	Eddy Visiting Nurse Association - Advance Care Planning Toolkit	04/23/2017 02:37 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES5_DOC_20170331_2bviii_R5_CHC_AdvanceCarePlanningToolkit_11466.pdf	Community Health Center Advance Care Planning Toolkit	04/23/2017 02:36 PM
Create coaching program to facilitate and support implementation.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES6_DOC_Engaged_Home_Care_13880.xlsx	Provider Commitment - Home Care Facilities	04/27/2017 01:59 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES6_DOC_20170331_2bviii_R6_Alliance_PPS_wide_INTERACT_training_13860.pdf	Alliance PPS wide INTERACT Training	04/27/2017 01:22 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES6_DOC_20170331_2bviii_R6_PPS_InventoryOfTrainings_13859.xlsx	PPS Inventory of Trainings	04/27/2017 01:21 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES6_DOC_20170331_2bviii_R6_CHC_ColemanTraining_11469.pdf	Community Health Center - Coleman Training	04/23/2017 02:42 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES6_DOC_20170331Â-_2bviii_R6_EddyVNA_CoachesTrainingInventory2biv2bviii_11468.docx	Eddy Visiting Nurse Association - Coach Training Inventory 2biv 2bviii	04/23/2017 02:41 PM
Educate patient and family/caretakers, to facilitate participation in planning of care.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES7_DOC_20170331_2bviii_R7_EddyVNA_Patient_Educational_Material__11477.docx	Eddy Visiting Nurse Association Patient Education Material	04/23/2017 03:38 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES7_DOC_20170331_2bviii_R7_Ellis_UseOfZoneSheets_11476.docx	Schenectady Visiting Nurse Services - Use of Zone Sheets and Methodology	04/23/2017 03:36 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES7_DOC_20170331_2bviii_R7_CHC_CaregiverToolkitEvent_11473.pdf	Community Health Center - Caregiver Education Event	04/23/2017 03:30 PM
Use EHRs and other technical platforms to track all patients engaged in the project.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES12_DOC_R14_2bviii_M7_SMHA_image_15871.jpg	DY2Q4 Remediation Response	06/21/2017 11:10 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES12_DOC_R14_2bviii_M7_SMHA_15870.pdf	DY2Q4 Remediation Response	06/21/2017 11:09 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES12_DOC_20170331_2bviii_CHC_Healthwyse_TrackingDSRIPPatients_11480.JPG	Community Health Center - Tracking DSRIP Patients - Healthwyse	04/23/2017 03:51 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES12_DOC_20170331_2bviii_TheEddy_TrackingDSRIPpatients_report_11479.pdf	Eddy Visiting Nurse Association - Tracking DSRIP Patients Report	04/23/2017 03:48 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2bviii_MDL2bviii3_PRES12_DOC_20170331_2bviii_EddyVNA_SampleTrackingReport_11478.xlsx	Eddy Visiting Nurse Association- Sample Tracking Report	04/23/2017 03:47 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	
Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	N/A
Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	N/A
Educate all staff on care pathways and INTERACT-like principles.	N/A
Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	
Create coaching program to facilitate and support implementation.	N/A
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	
Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	
Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	
Use EHRs and other technical platforms to track all patients engaged in the project.	DY2Q4 Remediation Response: Please see attached documents: R14 2bviii M7 SMHA R14 2bviii M7 SMHA image

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Complete	
Milestone #3	Fail	The PPS did not meet the provider level commitment for this milestone.
Milestone #4	Pass & Complete	
Milestone #5	Pass & Complete	
Milestone #6	Pass & Complete	
Milestone #7	Pass & Complete	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Complete	

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 2.b.viii Hospital to Home Mid-Point Assessment narrative	Completed	2.b.viii Hospital to Home Mid-Point Assessment narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
2.b.viii Hospital to Home Mid-Point Assessment narrative	

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

Instructions :

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

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

Instructions :

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

As patient engagement in the health system grows, utilization of services will increase. The PPS must have the primary care capacity to absorb the targeted population. To mitigate this risk, the Workforce committee will track supply & demand for PCP to identify gaps, assess geographic need & recruit/place physicians in shortage areas. Demand for PCP will be coordinated with Project 2.b.iii. The PPS will recruit primary care NPs & explore retraining RNs to pursue advanced practice credentials in primary care. Successful mitigation will be reflected in supply to demand match.
There are many IT Risks, such as data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO (the expected interoperable clinical platform) has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing DSRIP needs with existing commitments. Population Health IT (PHIT) systems & tools are required & delay to PHIT implementation delays the projects & risks not meeting speed/scale requirements. PHIT depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.
Due to the transient nature of the target population, one risk is initiating activation activities on people who are lost to follow-up. Patient dropouts before the end of the performance period will negatively impact target implementation. To mitigate this risk, the PPS will develop specific client plans depending on engagement level. The PPS will address identified socio-economic barriers by linking to appropriate CBOs to meet basic needs (housing resources, food banks, transportation). Protocols for recovering dropouts will be created to document initial engagement. There are high rates of chronic disease, PQI & PPV in the PPS. A portion of unmet needs among the low income population is related to lack of engagement in disease management. The project will establish a PPS-administered chronic disease management program to extend the reach of self-management educational opportunities in times, places & languages that meet the population's needs. With the Cultural Competency Task Force, the project will train Community Health Workers (CHW) & make efforts to establish them within neighborhoods where they live. Outreach workers will have cultural competency/health literacy training to ensure cultural & linguistically appropriate interactions with the population. Successful mitigation will be reflected in number of persons engaged, a shift in the cohort to higher levels of engagement over time & low dropout rates.
Another risk is the ability to accurately track progress in patient engagement levels for the population at various levels & achieve project milestones' time/scale. The transience of the target population risks engagement in self-management care & measuring engagement outcomes if patients don't adopt self-management recommendations. Strategies to reduce this risk are intertwined with other projects. The IT component will incorporate methods to record initial engagement with the population, either electronically or manually until PHIT is available in the PPS. The PPS will explore ways to engage CBOs & find IT solutions that make access to this population more efficient. Integrating IT into community health work will allow for annual alerts for patients who need reassessment. Compliance will be tracked annually & dashboards will be created to determine which patients have engaged with self-management vs. inability to track patients for follow-up.

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Alliance for Better Health Care, LLC (PPS ID:3)

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY3,Q4	6,622

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	426	1,421	2,729	5,781
	Quarterly Update	796	1,289	2,030	3,655
	Percent(%) of Commitment	186.85%	90.71%	74.39%	63.22%
IA Approved	Quarterly Update	0	1,289	0	3,604
	Percent(%) of Commitment	0.00%	90.71%	0.00%	62.34%

Warning: PPS Reported - Please note that your patients engaged to date (3,655) does not meet your committed amount (5,781) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ2di_MDL2di2_PES_ROST_project_2di_201703_submission_12934.xlsx	2di DY2Q4 Patient Engagement Roster	04/26/2017 01:47 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its Actively Engaged commitments for DY2,Q4.

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Alliance for Better Health Care, LLC (PPS ID:3)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 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		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. PPS will develop MOUs, contracts and letters of agreement to work in concert to identify and engage uninsured, low utilizers, under-utilizers of healthcare. Identified partners and CBO's will be located utilizing data from the DSRIP Community Needs Assessment and other organizations already working with the targeted population		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. PPS will contract with Insignia Healthcare where PAM tool data will be stored for PPS tracking and reporting		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. PPS Clinical Operations Team will provide CBOs and partners quarterly reports on PAM tool implementation and statistics		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. PPS will create and distribute "hot spot" poster maps to contracted partners and CBO's in this project by utilizing data from our DSRIP Community Needs Assessment and information provided by other community organizations such as HCDI (Healthy Capital District Initiative). PPS will abstract additional information based on the organization's current involvement in serving the population of interest.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. The PPS will work in concert with additional regional PPS' (Adirondack Health Institute and Albany Medical Center) where county cross over occurs to collaborate on a coordinated		Project		Completed	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
approach to launch Project 11 efforts										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patient Activation Measure(R) (PAM(R)) training team established.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. PPS will contract with Insignia to provide PAM training on engaging target populations		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. PPS will elicit volunteers from partners and CBO's to assign PAM "train the trainer" champions		Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Volunteer Champions will attend coordinated educational planning session with Insignia on July 16, 2015.		Project		Completed	06/01/2015	07/31/2015	06/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task 4. Volunteer Champions will continue to attend additional training and webinars provided by Insignia to ensure consistent education on patient activation techniques and documentation requirements		Project		Completed	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. PPS Project 11 Manager will develop and organize additional educational sessions across the PPS utilizing the train the trainer champions and track attendance		Project		Completed	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. PPS Project 11 Manager will track individuals who attend Insignia PAM training and additional training sessions provided by Insignia		Project		Completed	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. PPS Project 11 Manager will collaborate with additional PPS's, CBO's and partners to develop strategy to capture attributed populations that corresponds		Project		Completed	06/01/2015	03/31/2016	06/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
1. Create and distribute "hot spot" poster maps developed using data from our DSRIP Community Needs Assessment and other community organizations (HCDI-Healthy Capital District Initiative) based on their current involvement in serving the population of interest.										
Task 2. Based on the above data, PPS will identify and partner with CBOs that are located in the "hot spot" areas.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. PPS will develop contracts with identified partners and CBOs to perform outreach and engagement efforts		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Collaborate with hospital partners (St. Mary's Healthcare, St. Peter's Health Partners and Ellis Hospital) and partner CBOs (Community Health Center, Living Resources, Schenectady Visiting Nurses) that provide Charity Care to identify additional members for patient activation.		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. PPS will arrange for Project 11 retreat to assemble key stakeholders and Workforce Committee to review current hot spot data and determine if there are outlying gaps in the PPS region such as sub-cultures (Amish, Burmese, and Guyanese) that the PPS would need develop additional cultural sensitive plans on how to employ additional community outreach workers to assist in engagement activities.		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Collaborate with Government Officials to acknowledge and decipher legal aspects of health care reform and assistance for illegal immigrants and populations/cultures that are not networked into mainstream society.		Project		Completed	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community engagement forums and other information-gathering mechanisms established and performed.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Explore and assess a variety of venues and opportunities to survey the targeted population (e.g. health fairs, community events and forums, shelters, senior centers & church gatherings).		Project		Completed	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
2. Contract with community assessment experts in developing a survey/questionnaire for participation. Ensure survey is developed based on the DSRIP Community Needs Assessment that is culturally, intellectually and linguistically suitable for participants to complete.										
Task 3. Investigate the potential to contract with professional facilitators to hold community engagement forums to attain first hand attitudes and knowledge regarding one's ability to access and participate in healthcare/self-management		Project		Completed	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 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.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Project Manager and Workforce Committee will develop educational tracking mechanisms to track all providers who receive training for reporting		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. The PPS Cultural Competency Taskforce will collaborate with Iroquois Healthcare Alliance to develop curriculum and training programs that will address patient activation techniques.		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. The PPS will offer a variety of venues (webinars, in-person, online) courses to enhance the availability of providers to receive training. Continue to utilize volunteer PAM train the trainers to provide onsite training at provider sites.		Project		Completed	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 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	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	03/01/2017	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 1. Engage with the 3 Lead Health Homes in the PPS (St. Mary's Healthcare, Care Central-Ellis & Samaritan) to determine if DEAA/BAA feasibility for the review of Health Home Assignment files that denotes an attributed member with their last 5 healthcare encounters. This would allow community outreach workers to reconnect members to their PCP, administer PAM activations tool and assist members with referrals to Health Home Care Management services and other entitlement needs		Project		On Hold	04/01/2015	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 2. Evaluate how each MCO determines PCP selection or assignment for their members		Project		Completed	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Coordinate & contract with the three leading Health Homes and downstream care coordination agencies, within our PPS, to assist with proactive outreach activities and administration of the PAM assessment tool.		Project		On Hold	01/01/2016	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 4. The PPS in concert with the MCO and partnering PCPs, will develop systematic protocol for access and read only rights to assess those designated as NU and LU of healthcare services to appropriate redirect care back to the designated/chosen provider of choice.		Project		On Hold	04/01/2016	03/31/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task For each PAM(R) activation level, baseline and set intervals		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
toward improvement determined at the beginning of each performance period (defined by the state).										
Task 1. Coordinate with the state on obtaining the method for establishing a baseline for each beneficiary based on network assessment		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Leverage data gained from PAM tool and working with PCP's to establish baselines and intervals toward improvement for each performance period.		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Develop plans to validate patient population and identify method to improvement engagement		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Include beneficiaries in development team to promote preventive care.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Investigate the potential to contract with professional facilitators to hold community engagement forums. This will allow the PPS to collectively gain personal insight, beliefs and bias that beneficiaries may have that prevents them from accessing needed healthcare		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Collaborate with Cultural Broker Program developed through the Cultural Competency Taskforce		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Utilize the AHRQ Working With Patient and Families as Advisers Implementation Handbook as a guide to develop a training program for adviser roles in the PPS		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Utilize information from the PAM admin tool to collect required information and training logs to report against required metrics.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Establish protocols and procedures for the community navigators to screen, assess, and administer the PAM® tool with eligible populations.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. Project 11 Team will develop pathways for community navigators to utilize when additional support is needed to assist the member through the various stages of the PAM assessment determination		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Collaborate with Insignia to create and deliver reporting data. Provide feedback to PCPs and MCOs regarding level of engagement, reassessment and overall participation statistics		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Develop tool to be used by community navigators to assess cultural, linguistic and other needs that will enable placement with the most appropriate provider.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Volume of non-emergent visits for UI, NU, and LU populations increased.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. The PPS Project Manager will work in conjunction with 2 b iii Project Lead to conduct a gap analysis and ongoing assessment of our PCMH partners to determine capacity and service specialty.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Utilize the PPS website and provide a 'quick link' for community outreach workers to obtain current PCMH capacity and service information (ie: hours operation, accepting of new pts, etc)		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Identify providers with open scheduling and capacity to accept returning patients, new patients or who need specialized service such as dentistry.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Develop a referral process for community navigators to assess needs and link members to additional service providers.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #11	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Provider	PAM(R) Providers	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Healthy Capital District Initiative										
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	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Healthy Capital District Initiative										
Task 1. Collaborate with AFBHC leadership and CBOs who provide navigation services to develop contracts for outreach and engagement activities.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Engage Workforce Committee to perform a gap analysis to determine workforce resources and training needs.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 3. Working with our community partners to develop strategies to identify or engage potential navigators who represent the populations served.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation response 4. Develop a broad approach to train navigators to administer the PAM tool.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 5. Identify the appropriate number and locations of navigators needed to utilize the PAM tool to meet the engagement commitments. Evaluate effectiveness of approach and address opportunities for improvement for work performed by the patient navigators.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4

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DSRIP Implementation Plan Project

Alliance for Better Health Care, LLC (PPS ID:3)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
6. Develop a training strategy for established navigators that incorporates a periodic review of PAM administration techniques. Offer opportunities to leverage the experience of the successful navigators to partner with lower performing navigators.(i.e.: the rate of patients who decline opportunity to complete the PAM once the process is initiated).										
Task 9-24-15 Remediation Response 7. Based on CNA and workforce analysis, develop a methodology for piloting the PAM tool rollout, placement of trained navigators and expectations of engagement numbers a targeted locations.		Project		Completed	09/24/2015	03/31/2016	09/24/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9-24-15 Remediation Response 8. Develop process to identify areas for roll out of PAM tool and placement of trained navigators.		Project		Completed	09/24/2015	03/31/2016	09/24/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9-24-15 Remediation Response 9. Once the pilot rollout is achieved and redefined, if needed for improved outcomes, contrinue to roll out PAM engagements sessions to achieve desired quotient of patient engagment.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 10. Evaluate success of the program using workforce feedback, aggregation of engagment data and process improvements based on outcomes.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 11. Develop quarterly outcome dashboards and report to project teams, Clinical Integration and Quality Committee and Goverance committees to track and adjust program success when required.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures for customer service complaints and appeals developed.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. The Alliance for Better Health Care has established an anonymous compliance hotline. Anyone may call the hotline or		Project		Completed	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4

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enter a concern on the web. The hotline is managed by an independent third party, Navex Global. Once a concern is received by the third party, a report is immediately sent to the Alliance's compliance officer. The compliance officer follows up on all concerns. A log is maintained of all concerns and the respective follow up actions. Hotline calls will be shared with the Audit and Compliance Committee quarterly.										
Task 2. Calls made directly to the Corporate Compliance Officer will establish an internal investigation and respond in an agreed-upon manner with the member.		Project		Completed	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15: Remediation Response 3. Policy and procedures for customer service complaints and appeals will be established & will, at a minimum, address the following key components: a. Members will have the availability to call the PPS, leave any questions/concerns/complaints regarding the NYS DOH DSRIP program on the 24 hour hotline or may submit a written complaint to the Corporate Compliance Officer for the Alliance for Better Health Care to 14 Columbia Circle , Albany NY 12203. Themes for complaint resolution would include: Resolve issues where all information is available within the first call, if health is at risk within 48 hours of all information being available, otherwise within 7 days and not longer than 60.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response: The compliance committee will track, aggregate & report complaints & resolutions & outcomes to the Project lead (s) and Clinical Integration and Quality Committee to ensure optimal awareness and quality improvement. Quarterly outcome dashboards will be developed & reported to project teams, CQIC & governance committees to track & adjust program success, if required.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task List of community navigators formally trained in the PAM(R).		Provider	PAM(R) Providers	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Providers Associated with Completion: Healthy Capital District Initiative										
Task 1. Community navigators embedded in "hot spots" will receive PAM® training through the PPS-wide training team (see requirement #2)		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Mechanism for tracking training of community navigators will be developed with our IT consultants		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.		Provider	PAM(R) Providers	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Providers Associated with Completion: Healthy Capital District Initiative										
Task 1. Based on the "hot spot" data, AFBHC will identify and partner with CBOs and ensure a presence at community events in these areas		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Assess feasibility of co-locating community navigators at established Navigator Agency sites that provide facilitated insurance enrollment		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Create a directory (map) of sites where community navigators are located across the 6-county region		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 4. Develop a PPS-level strategy to screen person status (UI, NU, & LU) & collect contact information when they visit the PPS designated facility or "hot spot" area for health services or other social services.		Project		Completed	09/24/2015	09/30/2016	09/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9-24-15 Remediation Response 5. Develop outreach plan based on determined "hot spot" data to		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4

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schedule & coordinate events for optimal interactions with beneficiaries and navigators. Project leads will measure outcomes of the program as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing a continuous process improvement method. Quarterly outcome dashboards will be develop and reported to project teams, CIQC & governance committees to track and adjust program success, if required. Project lead will establish & maintain lines of communication and collaboration with neighboring PPS, leveraging resources to ensure best methodology to engage targeted populations.										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Navigators educated about insurance options and healthcare resources available to populations in this project.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Explore streamlining of resource directories into an existing platform(s), such as 2-1-1, to be used by community navigators		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Educate navigators on the use of tools that will contain information on insurance options and healthcare resources		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Timely access for navigator when connecting members to services.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify PCP practices in the referring area that are in process of PCMH certification or have achieved NCQA 2014 Level 3 PCMH status and who have open access scheduling availability		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Identify process for connectivity to PCPs and PCMH providers through various avenues, including but not limited to direct conversation, IT solutions and other notification methods		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. : Work with PCMH Project Manager from PPS organization structure to maintain current, accurate database for use by		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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navigators, including practice census and appointment availability.										
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.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program. Assess current EHR and other technical platforms in the PPS against these requirements		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Create a gap analysis based on the current state analysis to determine incremental IT needs and associated budget, including short-term manual solutions.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Establish a process for monitoring project milestones and performance		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES1_DOC_20170331_2.d.i_R1M1_PAM_partnership_inventory_10574.xlsx	PAM partnership inventory	04/18/2017 10:09 AM
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES2_DOC_20170331_2.d.i_R2M1_PAM_training_inventory_10577.xlsx	PAM Training inventory	04/18/2017 10:11 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES3_DOC_R17_2.d.i_M3_Percent_of_population_uninsured_by_neighborhoods_15874.docx	DY2Q4 Remediation Response	06/21/2017 11:26 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES3_DOC_R17_2.d.i_M3_Excel_data_for_Map_Non-_and_Low_Utilizer_15873.xlsx	DY2Q4 Remediation Response	06/21/2017 11:25 AM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES3_DOC_R17_2.d.i_M1_Hot_Spot_Map_for_Alliance_Attributed_Non-_and_Low_Utilizers_Map_15872.pdf	DY2Q4 Remediation Response	06/21/2017 11:24 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES3_DOC_20170331_2.d.i_R3M1a_Excel_data_for_Map_Non-_and_Low_Utilizer_10581.xlsx	Excel data non- and low utilizers	04/18/2017 10:14 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES3_DOC_20170331_2.d.i_R3M1_Hot_Spot_Map_for_Alliance_Attributed_Non-_and_Low_Utilizers_Map_10580.pdf	Hot Spot Map for Alliance Attributed Non-and Low Utilizers	04/18/2017 10:13 AM
Survey the targeted population about healthcare needs in the PPS' region.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES4_DOC_20170331_2.d.i_R4M1_AFBHC_Survey_language_on_page_1_Request_for_Partners_Conducting_Community_based_Listening_Sessions_2016_2017_10583.pdf	Alliance Survey language on page 1 Request for Partners Conducting Community based Listening Sessions	04/18/2017 10:16 AM
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES5_DOC_20170331_2.d.i_R5M1_List_of_Providers_trained_in_PAM_10584.xlsx	List of Providers trained in PAM	04/18/2017 10:18 AM
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	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES6_DOC_R20_2di_M6_15879.docx	DY2Q4 Remediation Response	06/21/2017 02:10 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES7_DOC_20170331_2.d.i_R7M1_Sample_PAM_Cohort_report_10585.pdf	Sample PAM Cohort report	04/18/2017 10:24 AM
Include beneficiaries in development team to promote preventive care.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES8_DOC_20170331_2.d.i_R8M1a_SCAP_Listening_Session_Report_Sample_of_feedback_received_10590.pdf	SCAP Listening Session Report Sample of feedback received	04/18/2017 10:28 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES8_DOC_20170331_2.d.i_R8M1_Listening_session_attendance_roster_10587.xlsx	Listening session attendance roster	04/18/2017 10:27 AM
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES9_DOC_20170331_2.d.i_R9M1_Sample_Performance_Measure_Report_10594.pdf	Sample Performance Measure Report	04/18/2017 10:31 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.					
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES10_DOC_20170331_2di_R10M1_Sample_Baseline_Non-emergent_Volume_report_10595.pdf	Sample Baseline Non-emergent Volume report	04/18/2017 10:33 AM
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.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES11_DOC_R25_R28_2di_M11_M14_15875.xlsx	DY2Q4 Remediation Response	06/21/2017 01:11 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES11_DOC_20170331_2.d.i_R11M2_PAM_Navigator_Training_Dates_10602.xlsx	PAM Navigator Training Dates	04/18/2017 10:38 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES11_DOC_20170331_2.d.i_R11M1_PAM_Navigator_Training_inventory_10598.xlsx	PAM Navigator Training inventory	04/18/2017 10:34 AM
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES12_DOC_20170331_2.d.i_R12M1b_Web_Browser_Compliance_information_part_2_10604.JPG	Web Browser Compliance information part 2	04/18/2017 10:41 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES12_DOC_20170331_2.d.i_R12M1a_Web_Browser_Compliance_information_part_1_10601.JPG	Web Browser Compliance information part 1	04/18/2017 10:37 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES12_DOC_20170331_2.d.i_R12M1_Compliance_Program_Policy_10600.pdf	Compliance Program Policy	04/18/2017 10:37 AM
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES13_DOC_R27_2.d.i._M13_Trained_Community_Navigators_15876.xlsx	DY2Q4 Remediation Response	06/21/2017 01:19 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES13_DOC_20170331_2.d.i_R13M1b_Sample_Agenda_Patient_Activation_protocol_HCDI_10613.pdf	Sample Agenda Patient Activation protocol HCDI	04/18/2017 10:45 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES13_DOC_20170331_2.d.i_R13M1a_Agenda_and_Process_for_PAM_and_Coaching_Training_10612.docx	Agenda and Process for PAM and Coaching Training	04/18/2017 10:44 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES13_DOC_20170331_2.d.i_R13M1_Navigators_Trained_in_PAM_inventory_10609.xlsx	Navigators Trained in PAM inventory	04/18/2017 10:43 AM
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs,	mccarrol	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES14_DOC_R25_R28_2di_M11_M14_15878.xlsx	DY2Q4 Remediation Response	06/21/2017 01:59 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES14_DOC_20170331_2.d.i_R14M1_Navigators_in_hot_spot_areas_10617.xlsx	Navigators in hot spot areas	04/18/2017 10:48 AM
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES15_DOC_20170331_2.d.i_R15M1_List_of_PPS_Trainers_10621.xlsx	List of PPS Trainers	04/18/2017 10:50 AM
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES16_DOC_20170331_2.d.i_R16M1_Sample_Process_for_intake_of_navigator_calls_St._Peters_Health_Partners_10622.pdf	Sample Process for intake navigator calls St. Peters Health Partners	04/18/2017 10:52 AM
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.	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES17_DOC_20170331_2.d.i_R17M1a_Flourish_2_0_Admin_Tool_-_Coach_Manual_10624.pdf	Flourish 2.0 Admin Tool - Coach Manual	04/18/2017 10:55 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ2di_MDL2di3_PRES17_DOC_20170331_2.d.i_R17M1_Flourish_Survey_Administration_Quick_Guide_for_Coach_10623.pdf	Flourish Survey Administration Quick Guide for Coach	04/18/2017 10:54 AM

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.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 1 there is no provider level commitment and as such there is no provider level reporting required.
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 2 there is no provider level commitment and as such there is no provider level reporting required.
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.	DY2Q4 Remediation Response: Additionally, each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 3 there is no provider level commitment and as such there is no provider level reporting required.
Survey the targeted population about healthcare needs in the PPS' region.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 4 there is no provider level commitment and as such there is no provider level reporting required.
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 5 there is no provider level commitment and as such there is no provider level reporting required.
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).	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
• 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.	provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 6 there is no provider level commitment and as such there is no provider level reporting required. In light of changes the department made associated with PPS MCO contracting expectations, Alliance put this milestone on-hold and changed the completion date to DY5Q4. Our guidance from the IA has been, that when a Milestone does not make sense and we will not be completing it, we should note the Milestone as on-hold and change the due date to DY5Q4. However, pursuant to the direction of the IA now, we will change the status to completed. Please note that we can say that we continue our efforts to establish a working relationship with the MOCs in our region. Data sharing limitations and MCO reluctance to engage has created a challenge in obtaining a list of PCP's assigned to NU and LU enrollees from MCOs. Regardless, the effort to engage NU and LU is occurring with MCOs contracting directly with community based organizations. An example of this relationship is CDPHP, Commission of Economic Opportunity (CEO) and Catholic Charities. CDPHP and CEO, located in Troy, entered into an agreement that CEO would receive payment for outreach efforts. CDPHP provides a list of MCO members that CEO is then tasked with locating. The list contains members that have outdated PCP assignments and/or members that were flagged as no utilizer/low utilizer by CDPHP. CEO then conducts outreach, first by phone. If they are unable to reach the member, they then will travel to the last known address on file for the member. The CDPHP care coordinator stays in contact with the outreach team. If the member is contacted, CEO then conducts a brief assessment and facilitates the member re-establishing a relationship with their PCP and health care as needed. To date this arrangement has been quite successful and CEO was able to reach 301 out of the 1344 (about 22%) targeted members. The Catholic Charities module is very similar. Alliance participated in several joint meetings with CDPHP and CEO to discuss collaborative efforts and how the PAM tool could be added to their outreach efforts. CDPHP did not recognize the value of the PAM tool and was not agreeable to adding it to the outreach workflows. Alliance continues to meet with CDPHP monthly and is engaging other MCOs as well.
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.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	In the case of 2di milestone # 7 there is no provider level commitment and as such there is no provider level reporting required.
Include beneficiaries in development team to promote preventive care.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 8 there is no provider level commitment and as such there is no provider level reporting required
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 9 there is no provider level commitment and as such there is no provider level reporting required.
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	DY2Q2 Remediation Response:

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 10 there is no provider level commitment and as such there is no provider level reporting required.
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.	DY2Q4 Remediation Response: All training sessions set forth as part of the quarterly report were In-Person format. Additionally, each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. The required list of Community Navigators trained in Pam was previously submitted but Alliance did not indicate the format of the training as either on-line or in-person. In fact, the format of all trainings was in-person. Please see also attached document: R25 R28 2di M11 M14
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 12 there is no provider level commitment and as such there is no provider level reporting required.
Train community navigators in patient activation and education, including	DY2Q4 Remediation Response:

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
how to appropriately assist project beneficiaries using the PAM(R).	Please see attached R27 2.d.i M13 List of Community Navigators Trained in PAM including format
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.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. The required list of Community Navigators trained in Pam was previously submitted but Alliance is re-submitting it as part of remediation. Please see attached document which provides additional detail on the prominent placement of the Community Navigators: R25 R28 2di M11 M14
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 15 there is no provider level commitment and as such there is no provider level reporting required.
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	DY2Q4 Remediation Response: Each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 16 there is no provider level commitment and as such there is no provider level reporting required.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	DY2Q4 Remediation Response: Alliance PAM providers utilize the Flourish system to engaged patients based on their PAM score. Coaching for activation allows goal setting that is unique to the client. Barriers with data sharing restricts sharing EHRs and other IT platforms. Additionally, each project milestone carries a "Reporting Level" specification of either "Project" or "Provider." Those classified as "Project Reporting Type" do not have any associated provider engagement commitments. Those classified as "Provider Reporting Type" do have an associated provider engagement commitment, and furthermore – the specific provider type or types for which reporting is required is clearly delineated in MAPP. For project 2di, only milestones 11, 13 and 14 are Provider Reporting Type milestones, and in both cases the provider type "PAM Providers" is clearly delineated. In the case of 2di milestone # 17 there is no provider level commitment and as such there is no provider level reporting required.

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #15	Pass & Complete	
Milestone #16	Pass & Complete	
Milestone #17	Pass & Complete	

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 2.d.i. Patient Activation Mid-Point Assessment narrative	Completed	2.d.i. Patient Activation Mid-Point Assessment narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone C & G-CAHPS Survey Results Submission	Completed	C & G-CAHPS Survey Results Submission for Measurement Year 2 (7/1/2015 to 6/30/2016)	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone PAM Results Submission	Completed	Attached are two files, one for Measurement Year 1 (7/1/2014 to 6/30/2015) and one for Measurement Year 2 (7/1/2015 to 6/30/2016). Alliance administered 0 PAM surveys in MY 1 and 5,097 PAM surveys in MY 2. As none of these surveys were follow-up, both files contain all zeros.	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
2.d.i. Patient Activation Mid-Point Assessment narrative	
C & G-CAHPS Survey Results Submission	
PAM Results Submission	

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

Instructions :

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

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

Instructions :

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

Two regulations run counter to the project objectives of co-locating PC and BH services and are risks to the success of the project. The existing threshold billing regulations prohibit billing for Primary Care and Behavioral Health Services on the same day and the locations of Article 31 clinics are stringently defined. The PPS mitigation strategy has been to advocate for regulatory relief, apply for waivers permitted with the DSRIP initiative, explore alternative payment methodologies, and seek alternate ways to reduce the physical distance between providers. Successful mitigation will be seen in the regulatory waivers being granted.

Provider perceptions about patients with behavioral health and substance use disorders can negatively impact primary care provider engagement and, in turn, are risks to the success of this project. The PPS's mitigation strategy includes: providing age appropriate cultural competency and health literacy training to primary care practice sites and tracking completion of trainings; identifying and resolving physical barriers (i.e. entrances, waiting rooms, etc.) and stigma at practice sites that reduce provider participation; and, supporting care management according to patient need to address patient barriers to behavioral and medical care. Success of the mitigation strategy will be seen in the number of providers accepting patients with behavioral health and substance use disorders.

Another risk to the successful completion of this project is that the PPS does not achieve NCQA recognition for its primary care practices by DY3, Q4. To mitigate this risk, the PPS is identifying at least one project manager to PCMH certification. Current state of the practices will be assessed, technical assistance needs identified and technical assistance provided from the PPS central project management office. Success of the mitigation strategy is that all providers achieve NCQA recognition within the targeted timeframe.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of DSRIP with their existing commitments. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. PHIT rollout depends on sufficient capital funding from NY state & delay in the capital release will delay the rollout. The PPS will work closely with the RHIO, accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

As health care transitions to the outpatient setting, the PPS risks overwhelming providers with expectations associated with the DSRIP projects. The mitigation strategy is to bundle interventions as much as possible; to demonstrate the common links between DSRIP requirements, and to provide technical support, tools, training and measuring awareness will surveys to practices from the PPS administrative offices. Success of the mitigation strategy will be seen with project requirements being met within the targeted timeframes.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	25,890

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	883	2,943	5,050	9,968
	Quarterly Update	3,400	6,369	8,191	16,977
	Percent(%) of Commitment	385.05%	216.41%	162.20%	170.32%
IA Approved	Quarterly Update	0	6,344	0	16,978
	Percent(%) of Commitment	0.00%	215.56%	0.00%	170.33%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ3ai_MDL3ai2_PES_ROST_project_3ai_201703_submission_13924.xlsx	3ai DY2Q4 Patient Engagement Roster	04/27/2017 02:45 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Models Selected		
Model 1 ✓	Model 2 ✓	Model 3 ✗

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating eligible primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	DY3 Q4	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All eligible practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.			Provider	Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1.Identify project team members from working groups and define roles and responsibilities			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identify a project leader/ champion to spearhead the effort and work collaboratively with the PCMH Project Manager to coordinate efforts to obtain PCMH NCQA level 3 certification			Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Distribute a survey of interest to primary care sites in the community; identifying interest in the PCMH Collaborative Care Model.			Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Convene interested providers and sites to review requirements and capabilities to develop a PCMH Collaborative Care Model			Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify DSRIP project requirements, milestones			Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
(deliverable), and metrics and build these steps into the project team process.											
Task 6. Assess each providers capabilities and development/resource needs to meet project requirements and milestones.			Project		Completed	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Define future state of colocation of services			Project		Completed	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and that the timeline for each site is appropriate across projects requiring certification			Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9. Finalize strategy for achieving PCMH Level 3 certification for contracted providers at PPS level			Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards.			Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 11. Engage providers meeting the standards to participate in the model with behavioral health providers.			Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 12. Use evidence-based clinical practices, program design and management approaches where they are available.			Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 13. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within PCMH practices for the expected volume of patients and hours of service required.			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 14. For all entities and potential future partner entities document the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Federal regulations related to reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models											
Task 15. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co- location of services			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 16. Convene the project team to develop the collaborative care practices			Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9-24-15 Remediation Response: 17. Develop a project design for providing BH care at the PC sites. This will include the identification & placement of BH providers as well as physicial space within the PC site to perform screening and other services. Where appropriate, the model will include strategies to integrate PC and BH care through best practices such as case conferencing.			Project		In Progress	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9-24-15 Remediation Response 18. Collaborate with teh worforce team to strategize on recruitment, training, and involvement of behavioral health providers to ensure adequate services are available in the integration sites. Track & monitor workforce enhancements on a regular basis and adjust as needed to ensure success.			Project		In Progress	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9-24-15 Remediation Response 19. Report progress on all aspects of the project re-desgin, including but not limited to workforce enhancement on a quarterly basis to appropriate project leads, the Board of Managers and committees			Project		In Progress	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9-24-15 Remediation Response 20. Consider innovative programs, such as partnering with surrounding PPS's, leveraging career development programs at area learning institions, utilizing telemedicine avenues, etc...to ehance			Project		In Progress	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2

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recruitment & retention of behavioral health providers that will be necessary to ensure success.											
Task 9-24-15 Remediation Response - Stakeholder Engagment: 21. While we have 35 providers committed, we have more behaviorist within the network to consider for implementation.			Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 Q4	Model 1	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors.			Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Incorporate the identified standards and their sources into the communication action plan for providers.			Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Utilize nationally recognized evidence based tools to implement at co-located practices for behavioral health conditions with emphasis on behavioral health treating chronic health conditions			Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology			Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Implement processes to schedule, conduct and document scheduled formal meetings to develop collaborative care practices and ensure coordinated			Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3

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evidence-based care protocols are in place, including medication management and care engagement processes.											
Task 6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop the warm hand off process to the behavioral health resource and PCMH feedback process including scripting for communication.			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in primary care			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Develop the steps to implement tools and processes into PCMH and incorporate with care management; insert steps into the work plan.			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Track and evaluate programs roll out using rapid cycle team evaluation techniques			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	DY4 Q4	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are documented in Electronic Health Record.			Project		In Progress	04/01/2015	03/30/2019	04/01/2015	03/30/2019	03/31/2019	DY4 Q4
Task			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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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.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 1. Complete assessment to determine which preventive behavioral health screenings are currently used at each PCP sites			Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Include representatives from practices and the IT project team to identify feasibility to integrate a user friendly screening tools into EMR and practices			Project		Completed	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Develop methods to document number of clients screened via alternate techniques until IT solutions in place			Project		In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 4. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated			Project		In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 5. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support client screening			Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 7. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health interventions			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8. Define process for documenting results in EHR for			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patients that are deemed at-risk based on the screening											
Task 9. Establish the warm hand off process to the behavioral health resource and PCMH feedback process including patient scripting for communication.			Project		In Progress	09/01/2015	03/31/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10. Implement evidence based practices for clinical screenings			Project		In Progress	03/01/2016	03/31/2019	03/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task 11 Track and evaluate programs roll out using rapid cycle team evaluation techniques			Project		In Progress	03/01/2016	03/31/2019	03/01/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 1	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions.											
Task 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish a process for monitoring project milestones and performance			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	DY4 Q4	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Primary care services are co-located within behavioral Health practices and are available.			Provider	Mental Health	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1. Distribute a survey of interest to behavioral service sites in the community; identify interest in the Behavioral Health Collaborative Care Model.			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Convene interested providers and sites to review requirements and capabilities to develop a Behavioral Health Service Site model.			Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Identify model project requirements, milestones (deliverables), and metrics and build these steps into the project team process			Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Identify those providers that are co-located and secure legal advice to address any identified licensure issues.			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Assess each partner's capabilities and development/resource needs to meet project requirements and milestones.			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. Define future state of colocation of services			Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Use evidence-based clinical practices, program design and management approaches where they are available.			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8. Align plan for PCMH with project 2.a.i (Integrated Delivery System) to ensure that practices will meet NCQA standards and that the timeline for each site is appropriate across projects requiring certification			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9. Convene community, facility and PPS governance representatives to review PPS program structure, MOUs, financial plan and regulatory requirements for the Behavioral Health Site model structure			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10. Engage providers meeting the standards to participate in the model with behavioral health providers			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 11. Develop support and training modules for collaboration of providers and integration of roles			Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12. Classify providers according to criteria to their level of NCQA qualification: not recognized, Level 1, 2, and 3 using 2011 standards, and those that are in process of applying for 2014 standards.			Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 13. Engage providers meeting the standards to participate in the model with PCP and PCMH providers			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 14. Coordinate the availability and schedules of behavioral health services and providers to ensure adequate coverage within PCMH practices for the expected volume of patients and hours of service required.			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 15. For all entities and potential future partner entities document the level of care, scope of services, populations touched and managed, existing contractual arrangements between entities, and State/ Federal regulations related to reimbursement and contracting, existing QI processes with compensation based on outcomes and any forays into alternate payment models			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 16. Address any legal, financial and contractual issues, regulatory policies, waivers, licensure/certifications to provide co- location of services			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 17. Convene the project team to develop the collaborative care practices			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 9-24-15 Remediation Response: 18. Develop an overall program design & approach (including generic work flow) to provide primary care within the BH settting in an integrated manner.			Project		In Progress	09/24/2015	03/31/2019	09/24/2015	03/31/2019	03/31/2019	DY4 Q4
Task 9-24-15 Remediation Response:			Project		In Progress	09/24/2015	03/31/2019	09/24/2015	03/31/2019	03/31/2019	DY4 Q4

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19. Strategize with the Clinical LeadershipCouncil, Clinical Integration Conmmittee, CBO's and other relevant stakeholders to collaborate and include internal and external stakeholders in leveraging BH and SUD providers to particpate in co-location.											
Task 9-24-15 Remediation Response: 20. Develop timeline for workforce recrutiment strategy. Incorporate CBOs as key stakeholders in model development and execution.			Project		In Progress	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9-24-15 Remediation Response 21. Assess current state BH & SUD provider sites to identify opportunities to co-locate care and services using the Collaborative Care Model			Project		Completed	09/24/2015	09/30/2016	09/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9-24-15 Remediation Response 22. Identify primary care providers through stakeholder engagemnt that will particpate in screening and referral processes for BH and SUD referrals. Refer to lead health homes for additional BH care managment support and verify capacity of health homesis sufficient to handle all referrals.			Project		In Progress	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9-24-15 Remediation Response 23. Evaluate success of the program based on achievement of Domain 1 metrics and improved outcomes. Develop and produce quarterly outcomes dashboards for project teams, CIQC and Goverance committees to track program success and respond to opportunites for improvment when appropriate.			Project		Completed	09/24/2015	12/31/2016	09/24/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2 Q4	Model 2	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
place, including a medication management and care engagement process.											
Task 1. Establish the project work team that includes PCMH and behavioral health physician representatives, community resources and member advisors.			Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Incorporate the identified standards and their sources into the communication action plan for providers			Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Utilize nationally recognized evidence based tools to implement at co-located practices for primary care, preventative conditions and chronic health conditions.			Project		Completed	07/01/2015	07/31/2016	07/01/2015	07/31/2016	09/30/2016	DY2 Q2
Task 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology			Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Implement processes to schedule, conduct and document scheduled formal meetings to develop collaborative care practices and ensure coordinated evidence-based care protocols are in place, including medication management and care engagement processes.			Project		Completed	07/01/2015	07/31/2016	07/01/2015	07/31/2016	09/30/2016	DY2 Q2
Task 6. Document the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support 100% colocation			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop the warm hand off process to the PCP resource and behavioral health feedback process including scripting for communication			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Develop means to provide educational/training through learning management system (LMS) on evidence-based tools focusing on behavioral health challenges most commonly seen in behavioral health			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
9. Develop the steps to implement tools and processes into behavioral health services and incorporate with care management; insert steps into the work plan.											
Task 10. Track and evaluate programs roll out using rapid cycle team evaluation techniques			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated			Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including physical and behavioral health screenings.	DY4 Q4	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are documented in Electronic Health Record.			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task At least 90% of patients receive primary care services, as defined by preventive care screenings at the established project sites (Screenings are defined as physical health screenings for primary care services and industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT for behavioral health).			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Positive screenings result in "warm transfer" to behavioral health or primary care provider as indicated by screening as measured by documentation in Electronic Health Record (EHR).			Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Positive screenings result in "warm transfer" to behavioral health or primary care provider as indicated by screening as measured by documentation in Electronic Health Record (EHR).			Provider	Mental Health	In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task 1. Complete assessment to determine which			Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Alliance for Better Health Care, LLC (PPS ID:3)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
preventive behavioral health screenings are currently used at each behavioral health services sites											
Task 2. Include representatives from practices and the IT project team to identify a user friendly approach to integrate screening tools into EMR and practices			Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Outline the workflow steps including role/responsibility to screen, frequency, documentation, policies/procedures to support client screening			Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Outline the workflow steps from screening completion to include result evaluation, patient communication scripting, provider review, referral triggers, referral process and documentation			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 5. Define process for handling patients that are deemed at-risk based on the screen, including behavioral health interventions			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 6. Define process for documenting results in EHR for patients that are deemed at-risk based on the screening			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 7. Establish the warm hand off process to the PCP resource and behavioral health feedback process including patient scripting for communication			Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8. Implement evidence based screenings and brief intervention processes			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 9. Track and evaluate programs roll out using rapid cycle team evaluation techniques			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 10. Develop methods to document number of clients screened via alternate techniques until IT solutions in place			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 11. Report to Clinical Integration and Quality			Project		In Progress	04/01/2015	03/31/2019	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
committee quarterly and revise objectives to improve outcomes when indicated											
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 2	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish a process for monitoring project milestones and performance.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks.			Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	DY4 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures include process for consulting with Psychiatrist.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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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.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	DY4 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	DY4 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.			Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop collaborative evidence-based standards of care including medication management and care engagement process.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_R33_3ai_M2_M6_Alliance_Workgroup_Meetings_15881.pdf	DY2Q4 Remediation Response	06/21/2017 02:14 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_R32_3ai_M2_M6_Alliance_3ai_Workgroup_Meetings_15880.pdf	DY2Q4 Remediation Response	06/21/2017 02:14 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_WYH_Medication_Management_Guidelines11302016_13499.docx	Metric 2.2- Whitney Young - Medication Management Guidelines	04/26/2017 10:42 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_UHPP_policy_1.17_13498.docx	Metric 2.2- Upper Hudson Planned Parenthood Policy	04/26/2017 10:41 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_Risk_Assessment_Policy_SPHP_13497.DOCX	Metric 2.2- St Peters Health Partners - Risk Assessment Policy	04/26/2017 10:40 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_Referrals_to_Community_Resources_Ellis_13496.doc	Metric 2.2 - Ellis Referrals to Community Resources	04/26/2017 10:39 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_Primary_Care_CM_Policy_SMH_13495.PDF	Metric 2.2- St. Mary's Healthcare- Primary Care CM Policy	04/26/2017 10:33 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_Clozaril_Policy_SMH_13494.PDF	Metric 2.2- St. Mary's Healthcare - Clozaril Policy	04/26/2017 10:32 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_Care_Transitions_Policy_Ellis_13493.doc	Metric 2.2- Ellis - Care Transitions Policy	04/26/2017 10:31 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES2_DOC_03312017_3ai_R2M2.2_BH_PRO_Patient_Engagement_03292017_WY_13490.DOCX	Metric 2.2 BH Patient Engagement - Whitney Young	04/26/2017 10:29 PM
Develop collaborative evidence-based standards of care including medication management and care engagement process.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES6_DOC_R33_3ai_M2_M6_Alliance_Workgroup_Meetings_15882.pdf	DY2Q4 Remediation Response	06/21/2017 02:20 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES6_DOC_03312017_3ai_R6M6.2_Signed_BH.PCP_Collab_Agreement_S	Metric 6.2- St Peters Health Partners- Signed BH PCP Collaboration Agreement	04/26/2017 11:56 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			PHP_13513.PDF		
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES6_DOC_03312017_3ai_R6M6.2_Risk_Assessment_Policy_SPHP_13512.DOCX	Metric 6.2- St Peters Health Partners - Risk Assessment Policy	04/26/2017 11:54 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES6_DOC_03312017_3ai_R6M6.2_Physical_Health_Screening_in_BH_Policy_Ellis_13511.doc	Metric 6.2- Ellis - Physical Health Screening in BH Policy	04/26/2017 11:53 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES6_DOC_03312017_3ai_R6M6.2_SPHP_PCP_BH_Program_Design_13510.docx	Metric 6.2- St. Peters Health Partners- PCP BH Program Design	04/26/2017 11:51 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES6_DOC_03312017_3ai_R6M6.1_Alliance_3ai_Workgroup_Meetings_13508.pdf	Metric 6.1 Alliance 3ai Workgroup Meetings	04/26/2017 11:50 PM
Use EHRs or other technical platforms to track all patients engaged in this project.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_R34_3ai_M8_SPHP_Medical_Screen_for_BH_15887.pdf	DY2Q4 Remediation Response	06/21/2017 02:27 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_R34_3ai_M8_Screenshot_Outgoing_referral_in_ECW_032017_15886.docx	DY2Q4 Remediation Response	06/21/2017 02:27 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_R34_3ai_M8_PCP_record_screenshot_with_BH_import_fax_15885.pdf	DY2Q4 Remediation Response	06/21/2017 02:25 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_R34_3ai_M8_PC_BH_Integration_EHR_screenshot_Ellis_15884.docx	DY2Q4 Remediation Response	06/21/2017 02:24 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_R34_3ai_M8_PCP_Info_in_Avatar_SMH_15883.DOCX	DY2Q4 Remediation Response	06/21/2017 02:24 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_03312017_3ai_R8M8.2_Health_Screen_Report_in_BH_Clinic_WY_032017_13521.docx	Metric 8.2- Whitney Young - Health Screen Report in BH Clinic	04/27/2017 12:12 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_03312017_3ai_R8M8.2_Health_Assessment_Report_in_BH_Clinic_Ellis_13520.xlsx	Metric 8.2- Ellis- Health Assessment Report in BH Clinic	04/27/2017 12:11 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_03312017_3ai_R8M8.1PCP_Info_in_Avatar_SMH_13519.DOCX	Metric 8.1 - St. Mary's Healthcare - PCP Info in Avatar	04/27/2017 12:10 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_03312017_3ai_R8M8.1_SPHP_Medical_Screen_for_BH_13518.PDF	Metric 8.1- St Peters Health Partners -Medical Screen for BH	04/27/2017 12:08 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES8_DOC_03312017_3ai_R8M8.1_Screenshot_Outgoing_referral_in_ECW	Metric 8.1 Screenshot Outgoing referral in ECW	04/27/2017 12:07 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			_032017_13517.docx		
Use EHRs or other technical platforms to track all patients engaged in this project.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES4_DOC_03312017_3ai_R4M4.2_UHPP_Depression_tracking_in_PCP_13507.PDF	Metric 4.2- Upper Hudson Planned Parenthood- Depression tracking in Primary Care	04/26/2017 10:58 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES4_DOC_03312017_3ai_R4M4.2_St_Peters_Depresssion_Screen_in_PCP_13506.PDF	Metric 4.2- St Peters Health Partners - Depression Screening in Primary Care	04/26/2017 10:57 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES4_DOC_03312017_3ai_R4M4.1_UHPP_Screenshot_PC.BH_13505.PDF	Metric 4.1- Upper Hudson Planned Parenthood- Screenshot - Primary Care Behavioral Health	04/26/2017 10:55 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES4_DOC_03312017_3ai_R4M4.1_Screenshot_Outgoing_BH_Referral_WY_13503.DOCX	Metric 4.1- Whitney Young - Screenshot Outgoing Behavioral Health Referral	04/26/2017 10:54 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES4_DOC_03312017_3ai_R4M4.1_Schen_ARC_Screenshot_13502.pdf	Metric 4.1 - Schenectady ARC Screenshots	04/26/2017 10:53 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES4_DOC_03312017_3ai_R4M4.1_Referral_for_Positive_PQH-9_Screen_SMH_13501.PDF	Metric 4.1 - St. Mary's Healthcare- Referral for Positive PHQ 9 Screen	04/26/2017 10:52 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3ai_MDL3ai3_PRES4_DOC_03312017_3ai_R4M4.1_CFDS_PC-BH_Integrated_EHR_13500.PDF	Metric 4.1- CFDS- Primary Care Behavioral Health Integration in EHR	04/26/2017 10:49 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating eligible primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Tasks 17,18, 19, 20 have been moved to 9/30/2017 to reflect the ongoing nature of the work
Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2Q4 Remediation Response: The attached document shows an inventory of the meetings and the list of participants along with a sample agenda and minutes. Alliance believes these are consistent with the inventory requirements that are listed in the minimum standards (i.e. Inventory of meeting schedules, meeting agendas, meeting minutes and list of attendees). R32 R33 3ai M2 M6 Alliance 3ai Workgroup Meetings
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.	Tasks 6, 7, 8, 9 have been moved to 9/30/2017 to reflect the ongoing nature of the work.
Use EHRs or other technical platforms to track all patients engaged in this project.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate primary care services at behavioral health sites.	Tasks 7, 8, 9, 13, 20, 22 have been moved to 9/30/2017 reflect the ongoing nature of the work
Develop collaborative evidence-based standards of care including medication management and care engagement process.	DY2Q4 Remediation Response: The attached document shows an inventory of the meetings and the list of participants along with a sample agenda and minutes. Alliance believes these are consistent with the inventory requirements that are listed in the minimum standards (i.e. Inventory of meeting schedules, meeting agendas, meeting minutes and list of attendees). R32x R33x 3ai M2 M6 Alliance 3ai Workgroup Meetings
Conduct preventive care screenings, including physical and behavioral health screenings.	Tasks 4, 5, 6, 7 have been moved to 9/30/2017 to reflect the ongoing nature of the work
Use EHRs or other technical platforms to track all patients engaged in this project.	DY2Q4 Remediation Response: Alliance believes we have provided evidence in the form of screenshots from the EHR showing treatment by both medical and BH providers. Please see also attached documents: R34 3ai M8 PCP Info in Avatar SMH R34 3ai M8 PC BH Integration EHR screenshot Ellis R34 3ai M8 PCP record screenshot with BH import fax R34 3ai M8 Screenshot Outgoing referral in ECW 032017 R34 3ai M8 SPHP Medical Screen for BH
Implement IMPACT Model at Primary Care Sites.	
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	
Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

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Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 3.a.i Integration BH and PC Mid-Point Assessment Narrative	Completed	3.a.i Integration BH and PC Mid-Point Assessment Narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
3.a.i Integration BH and PC Mid-Point Assessment Narrative	

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

Instructions :

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Project 3.a.iv – Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

IPQR Module 3.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.

The AFBHC PPS recognizes that the 2012 CNA demonstrated a 15% increase in the numbers of patients presenting in the emergency departments for opiate and other drug related withdrawal issues. An identified risk to the development of withdrawal management services is the existing shortage of behavioral health providers in the area, particularly those DEA-X licensed physicians. This project may exacerbate the existing shortage of practicing X license physicians and behavioral health clinicians in general. This shortage in the PPS area has led to an imbalance of implementation support between medically-related projects and behavioral-health related projects. Mitigation strategy to address this risk is to build ambulatory detoxification centers within the community based treatment programs and to build on these programs once established. Initially five areas will be targeted for building services. The PPS with the help of behavioral health leads will identify a project medical director as a champion experienced with ambulatory detoxification to educate and motivate peers in provide practices and other settings to encourage participation in services. Success to the development of ambulatory withdrawal management will be measured by a decrease in volume of this patient population using local emergency rooms for services and an increase in use of ambulatory detox centers demonstrated with a quarterly review of project metrics and outcomes.

There are multiple IT Risks, such as data interoperability dependent upon working with multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions where available. The RHIO, which is expected to be the interoperable clinical platform, has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing the needs of DSRIP with their existing commitments. As Population Health IT (PHIT) systems and tools are required, any delay to PHIT implementation delays the projects & risks not meeting speed & scale requirements. PHIT rollout depends on sufficient capital funding from NY state & delay in the capital release will delay the rollout. The PPS will work closely with the RHIO, accelerate implementation of PHIT interoperability & tools, use alternate methods where EHRs & PHIT tool functionality aren't yet ready & work with NY to ensure capital is provided in sufficient time.

Another risk identified is the potential for an imbalance of implementation support between medically-related projects and behavioral-health related projects. The strategy to manage this risk will be to identify project leads for behavioral health projects as part of the Clinical Integration and Quality Committee to ensure behavioral health expectations are coordinated and integrated with other primary care project requirements. Representation of a project lead for the behavioral health projects will assist in supporting culture change to holistic patient approach. Culturally sensitive education sessions will be developed in conjunction with the clinical integration and workforce workstreams and provided to the engaged providers throughout the PPS, including but not limited to community based organizations, hospitals, primary care and non-primary care physicians. Session attendance will be tracked and number of participants will be reported quarterly to demonstrate increased awareness and sensitivity to withdrawal management patient and care protocols.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	3,752

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	310	1,031	1,340	2,062
	Quarterly Update	486	855	1,234	1,843
	Percent(%) of Commitment	156.77%	82.93%	92.09%	89.38%
IA Approved	Quarterly Update	0	853	0	1,836
	Percent(%) of Commitment	0.00%	82.74%	0.00%	89.04%

Warning: PPS Reported - Please note that your patients engaged to date (1,843) does not meet your committed amount (2,062) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ3aiv_MDL3aiv2_PES_ROST_project_3aiv_201703_submission_12945.xlsx	3aiv DY2Q4 Patient Engagement Roster	04/26/2017 01:54 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.	DY3 Q2	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Identify project lead at PPS level		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Form project teams, including behavorial service providers, residential providers, hospitals, outpatient service providers, withdrawal management service representatives, administrative and front line staff and PPS representatives		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Confirm provider and/or sites for community-based addictions services program (St. Peter's Health Partners, St. Mary's Troy, St. Mary's Outpatient-Amsterdam, SPARC Cohoes, SPARC Central Ave, SPARC Guilderland Equinox, Belvedere, Conifer Glenville & Conifer Troy)		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Assess current state withdrawal management services, including outpatient SUD sites with PCP integrated teams capabilities		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Consider an assessment of clinical, recovery and peer support service provider staff and resources that would be required to implement the project		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Recognize any geographical gap in services within community based programs		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7. Include key partners in project planning including OASAS,		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
social service providers, criminal justice, public health, health centers, urgent care centers, intervention hotlines, housing representatives and other representatives										
Task 8. Project team to make recommendations PPS to confirmed sites for community-based addiction treatment (refer to # 3 above)		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9. PPS has requested licensure or waivers necessary to perform withdrawal management services		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10. PPS has referral and care coordination agreements in place with providers and community partners within the PPS		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 11. Align program with OASAS levels of care		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 12. Determine hours of operation that will minimize gaps in services		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 13. Define future state of the withdrawal management program and develop plans to address gaps in services if identified		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14. Coordinate with other projects within the PPS, such as the ED Care Triage project, integration of primary care and behavioral health services and PCMH requirements		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 15. Implement clinical guidelines and processes to provide stabilization services		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 16. Coordinate with PCP practice based withdrawal management and maintenance clinical pathways and care models		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 17. Track and evaluate programs at each site using rapid cycle evaluation techniques		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 18. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #2 Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	DY3 Q2	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Hospital	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Mental Health	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Substance Abuse	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Regularly scheduled formal meetings are held to develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Coordinated evidence-based care protocols are in place for community withdrawal management services. Protocols include referral procedures.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Identify current state inpatient detoxification services and community treatment program stakeholders		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Establish referral relationships with a focus on withdrawal management practice capacity		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Initiate and conduct regularly scheduled meetings with relevant agendas for identified stakeholders and representatives to develop and recommend evidence based practice models		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Collaborate with other project groups within the PPS project to strengthen engagement and representation with key stakeholders, providers and patients with emphasis on behavioral focused projects to raise their awareness that the outpatient detox centers exist and can see their patients.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task		Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Adopt evidence based clinical and care pathways that include referral protocols to develop and strengthen collaborative care practices within the PPS. Submit approved pathways and referral process to the Clinical Integration & Quality committee for review.										
Task 6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 7. Implement adopted and approved clinical guidelines and referral processes to identified sites and to participating providers		Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 8. Project team to make recommendations to the project medical director and Clinical Integration and Quality committee on best methods to track outcomes and indicators to measure effectiveness of withdrawal management processes		Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #3 Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop a functional job description, with compensation and benefits methodology that links to workforce committee, who is board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone and other treatment modalities		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Recruit from existing network of stakeholders a project medical director as defined. Coordinate efforts with workforce strategies to widen search outside PPS provider network as necessary to recruit ideal candidate.		Project		Completed	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Designate and retain contractually project medical director		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Participate with PPS as project liaison between PPS, project team and other projects within the organization		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Develop communication pathways for project medical director to guide project development, measure and report outcomes and initiate change if required.										
Milestone #4 Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.	DY3 Q2	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Hospital	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Mental Health	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.		Provider	Substance Abuse	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Project team and Medical Director to collaborate with identification of stakeholders and form task force to link to providers for outpatient withdrawal management services		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Complete current state assessment of participating providers		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and programs and to determine current services and current clinical state										
Task 3. Link to evidence based approved protocols for triage, assessments, determination of appropriateness of care and referrals		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Establish relationships with identified providers and programs, review participating list and modify as necessary to reflect available resources		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 5. Integrate protocols and pathways with related projects, specifically co-location of behavioral health services, ED Care triage and other projects within the PPS to establish collaboration and integrate protocols/criteria of project		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone #5 Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place for community withdrawal management services.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff are trained on community-based withdrawal management protocols and care coordination procedures.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify sites and practitioners that will participate in community withdrawal management services		Project		Completed	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Convene project team with guidance from project medical director to review, select and apply protocols to designated programs		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Develop project work flow for triage, assessment, and determination of appropriate level of care		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Project team and project medical director to make recommendations to workforce committee regarding workforce and training needs specific to the delivery of ambulatory withdrawal management, including care coordination and connection to treatment programs		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 5. Explore opportunities to provide clients with 24 hour access to services; either through hotline or other forms of communication		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Explore transportation services in area to bolster transitions between levels of care and from community to program sites and develop transportation plan		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Adapt evidence based protocols for withdrawal management as necessary to support provider engagement		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Develop staff training protocols for care coordination that includes ability to address detox from alcohol, opiates, and sedatives, differentiation between withdrawal management agents, assessment and evaluation of behavioral health needs, and referral processes		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Develop staff training modules that reflect that training reflects co-occurring issues		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Offer and track training opportunities through a learning management system (LMS) to include cultural aspects of care and health literacy issues focusing on withdrawal management, substance abuse & behavioral health.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Develop care management services within the SUD treatment program.	DY3 Q2	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Coordinated evidence-based care protocols are in place for care management services within SUD treatment program.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Staff are trained to provide care management services within SUD treatment program.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Identify appropriate current state provider(s) for care management services within the SUD treatment programs		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Convene care management providers to establish linkages to treatment and stepped levels of care for care coordination and treatment to facilitate engagement		Project		Completed	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3. Adapt existing evidence-based protocols for withdrawal management to support care coordination and connection to treatment										
Task 4. Recommend care management service protocols through Clinical Integration committee of PPS, to coordinate with providers, outpatient services, Health homes and behavioral health support services as necessary		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 5. Identify community support resources, including transportation, child care, housing and employment training to care managers to use as resources		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 6. Offer and track training and education opportunities through a learning management system to include cultural aspects of care and health literacy issues focusing on withdrawal management		Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 7. Project subcommittee and project medical director to make recommendations to Clinical Integration and Quality committees of PPS best methods to track outcomes and revise as necessary		Project		In Progress	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #7 Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	DY3 Q2	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has engaged MCO to develop protocols for coordination of services under this project.		Project		In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Review the ambulatory detoxification program and protocols with MCO's in the region and review benefit designs and options for payment for ambulatory detox services.		Project		In Progress	10/01/2016	06/30/2017	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 2. Review prior authorization processes for withdrawal services and clarify member eligibility criteria for services.		Project		In Progress	10/01/2016	06/30/2017	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 3. Develop benefit coverage design with MCO's		Project		In Progress	10/01/2016	06/30/2017	10/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 4. Identify any issues that need to be raised with DOH for policy changes.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Develop contracting strategy on behalf of the PPS and its		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Alliance for Better Health Care, LLC (PPS ID:3)

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
partners relative to this project.										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish a process for monitoring project milestones and performance.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
systems.										
Task 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES3_DOC_03312017_3aiv_PR3M1_Dr_Maslack_CV_13927.PDF	Dr. Maslack CV	04/27/2017 02:53 PM
Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_R35x_3aiv_M5_Training_Counts_Added.pdf_15889.docx	DY2Q4 Remediation Response	06/21/2017 02:32 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_R35_3aiv_M5_Training_Counts_Added_15888.pdf	DY2Q4 Remediation Response	06/21/2017 02:31 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M2_St_Peter's_Trainings_List_13938.docx	Metric 5.2- St. Peters Health Partners Trainings List	04/27/2017 03:10 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M2_SMH_SU_Education_13937.pptx	Metric 5.2 SMH SU Education	04/27/2017 03:10 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M2_SMH_addiction_brochure_13936.pdf	Metric 5.2- SMH - Addiction Brochure	04/27/2017 03:09 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M2_Catholic_Charities_Training_List_13935.pdf	Metric 5.2- Catholic Charities Training List	04/27/2017 03:06 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M2__Addiction_Services_Educational_Outreach_to_SMH_Prima..._13934.docx	Metric 5.2- Addiction Services Educational Outreach to SMH Primary Care	04/27/2017 03:05 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M1_SPARC_Policy_13933.docx	Metric 5.1- SPARC Policy	04/27/2017 03:04 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M1_SMH_Policy_Assessment_13932.doc	Metric 5.1 - SMH Policy Assessment	04/27/2017 03:04 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES5_DOC_03312017_3aiv_R5M1_New_Choices_Protocols_13931.pdf	Metric 5.1 - New Choices Protocols	04/27/2017 03:03 PM
Use EHRs or other technical platforms to track all patients engaged in this project.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES8_DOC_03312017_3aiv_R8M1_Suboxone_report_SMA_13943.XLSX	SMH Suboxone Report	04/27/2017 03:19 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES8_DOC_03312017_3aiv_R8M1_Suboxone_Report_Ellis_13942.xlsx	Ellis Suboxone Report	04/27/2017 03:19 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES8_DOC_03312017_3aiv_R8M1_SPHP_Suboxone_Report_13941.xlsx	SPHP Suboxone Report	04/27/2017 03:18 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3aiv_MDL3aiv3_PRES8_DOC_03312017_3aiv_R8M1_SPARC_screenshot_13939.docx	SPARC Screenshot	04/27/2017 03:18 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.	
Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	
Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	
Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.	
Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.	DY2Q4 Remediation Response: There were two trainings submitted that did not have the count of people trained. Catholic Charities and SPARC updated their training documents to add the counts. They are attached as documents: R35 3aiv M5 Training Counts Added, and R35x 3aiv M5 Training Counts Added

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop care management services within the SUD treatment program.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 3.a.iv Ambulatory Detox Mid-Point Assessment narrative	Completed	3.a.iv Ambulatory Detox Mid-Point Assessment narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
3.a.iv Ambulatory Detox Mid-Point Assessment narrative	

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

Instructions :

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

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

Instructions :

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

Reimbursement practices are a key risk to provider engagement in this project. For example, MCO policies do not cover multiple prescriptions for the same inhaler so that inhalers can be simultaneously available at home, school, and other family member locations. Building on PPS partnership agreements with the regional MCO's, the PPS will mitigate this risk by advocating for enhanced coverage of home-based self-management that has been shown to reduce overall burden of asthma costs. Success of the mitigation strategy will be seen when MCO/PPS agreements have been made.
There are many IT Risks, such as data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO (the expected interoperable clinical platform) has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing DSRIP needs with existing commitments. Population Health IT (PHIT) systems & tools are required & delay to PHIT implementation delays the projects & risks not meeting speed/scale requirements. PHIT depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.

Care of asthma patients and the transition and/or expansion of home based self-management program needs to not only educate and increase awareness for the patient, caregivers, families, environment, and schools, but must also link to care transitions. The PPS will form an asthma task force to develop and coordinate in-services to educate providers and care managers about community-based resources and referrals. Traditional providers need to be linked with home-based programs and community health workers to minimize missed opportunities for home visits and access to patient homes; if not the project has an increased risk of resistance to change and stagnation in current state management. The AFBHC will leverage its active partnership with the Asthma Coalition, Asthma Support Groups and School-Based Asthma Management program to ensure equal resources are available throughout the geographic region. Engaging patients in their care will also be important to the success of this project. The PPS will develop strategies to provide culturally and linguistically appropriate care by hiring individuals who are representative of the patient population, and by leveraging CHW's and community asthma champions. Success of the program will be measured by a decrease in emergency asthma visits to ED, and an increase in community participation of various community based organization, clinics, health care organizations and pharmacies. Additionally, awareness of PCPs and non-PCPs will be measured and tracked by determining where patients' referrals originated (asthma registry and IT platforms). The PPS will also engage the marketing and communication committees to help with awareness and tactics for improving home management of respiratory complaints. Ideally, this project's success could also be measured with the success of tobacco use cessation project 4.b.i, since cessation in tobacco use can be correlated to a reduction in environmental triggers. The interplay between these projects will be tracked during the DSRIP project.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	11,007

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	820	2,732	3,732	6,064
	Quarterly Update	916	2,281	2,964	5,921
	Percent(%) of Commitment	111.71%	83.49%	79.42%	97.64%
IA Approved	Quarterly Update	0	2,277	0	5,858
	Percent(%) of Commitment	0.00%	83.35%	0.00%	96.60%

Warning: PPS Reported - Please note that your patients engaged to date (5,921) does not meet your committed amount (6,064) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ3dii_MDL3dii2_PES_ROST_project_3dii_201703_submission_14300.xlsx	DY2Q4 3dii Patient Engagement Roster	04/28/2017 02:17 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Using CNA results and population health tools, hot spot asthma diagnoses in the covered 6 county region		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Develop strategy to collaborate with neighboring PPS (see # 3 below) that selected projects asthma and tobacco use cessation projects		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Identify opportunities for collaboration with neighboring PPS's such as Albany Medical Center & Adirondack Health Institute.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4. Integrate project plan components with PPS projects that influence outcomes and collaborate with surrounding communities and other PPS as necessary		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Identify project lead at PPS level		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Identify those provider and/or sites, including PCPs, home care providers, health homes, pharmacies, school health and hospital that support the activities of the Asthma self-management program		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Finalize Contract/MOUs with PCP practices and community providers		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
8. Assess providers to determine current home based asthma programs, range of services provided, and referral mechanisms for identified patients.										
Task 9. Examine data to identify hot spotting areas for common asthma triggers in the identified population		Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 10. Target areas for the project utilizing hot spotting and assessment.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11. Phase roll-out of project plans to coincide with in place resources		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 13. Finalize strategy for expanding home-based asthma self-management program		Project		Completed	10/31/2015	06/30/2016	10/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task 14. Implement clinical guidelines and processes		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 15. Track and evaluate programs roll out using rapid cycle team evaluation techniques		Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9-24-15 Remediation Response 16. Identify entities & agencies that will be implementing home based medical and social services, including current providers		Project		Completed	09/24/2015	03/31/2016	09/24/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9-24-15 Remediation Response 17. Develop strategy with workforce team to identify gaps in needed community providers, monitor progress of filling gaps & identifying training opportunities to minimize shortages.		Project		Completed	09/24/2015	12/31/2016	09/24/2015	12/31/2016	12/31/2016	DY2 Q3
Task 9-24-15 Remediation Responses 18. Develop strategy for systematic rollout of home assessment workforce into the community to enhance home assessments & follow ups.		Project		Completed	09/24/2015	12/31/2016	09/24/2015	12/31/2016	12/31/2016	DY2 Q3
Task 9-24-15 Remediation Response 19. Develop plan for referral process from primary care & medical facilities that encounter asthma patients to community		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
medical and social service providers, including process for feedback and improvement to referring entity.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify project lead and clinical support team for project potentially utilizing members from the project implementation groups		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Select procedures and intervention protocols for project		Project		Completed	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Partner with resources such as the Asthma Coalition to fill in gaps if indicated		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology		Project		Completed	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Develop strategy to partner with community resources, such as pest control and housing to link clients with resources available for reducing environmental asthma triggers		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Develop plans with the tobacco cessation project (4 b i) to reduce second hand smoke as an asthma trigger and connect engaged patients and families with tobacco cessation tools and education.		Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7. Collaborate with the cultural competency & health literacy committee to establish age appropriate, culturally sensitive interventions to engage clients		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Collaborate with the workforce committee to leverage workforce resources such as community health workers (CHW) to engage clients		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 9. Partner with community resources, such as the Asthma Coalition, to create a resource directory for clients (not limited to mold, mites, dust, roaches, pets, etc)		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and implement evidence-based asthma management guidelines.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify nationally recognized evidence based guidelines such as NHLBI and/or EPR3 for asthma management, medication management and care pathways. Additionally, coordinate efforts with the Albany Medical Center Evidenced-Based Medicine Asthma guidelines DSRIP Project already created to align common efforts where the 2 projects overlaps		Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. Submit clinical guideline recommendations to the Clinical Integration & Quality committee for approval		Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Identify indoor trigger control guidelines from recognized entities such as the EPA and other environmental improvement agencies		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Implement adopted guidelines into participating sites and providers.		Project		Completed	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Track and evaluate programs roll out using rapid cycle team evaluation techniques		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Communicate with asthma project providers level of success of program quarterly		Project		Completed	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Project team to evaluate and choose age appropriate education model for asthma home-based self-management.		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Identify and/or develop asthma education materials		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Ensure materials are aligned with age-appropriate culturally competency and health literacy strategy.		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Present training and education material recommendations to the workforce committee for integration into the learning management system (LMS)		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Present training and education material recommendations to the cultural competency and health literacy task force for acceptance		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Develop roadmap for asthma training for providers		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Consider training across projects to increase awareness of asthma management and triggers with all providers		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Include and enlist community health coaches for training sessions for continuity of education		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Educate school based programs on project goals and their roles (eg- American Academy of Pediatrics use and feedback, school referrals to home-based self-management, etc.)		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Include asthma action plan templates for home care and process to track use at home and school (including triggers)		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
11. Evaluate LMS for training platform for asthma self-management and other IT training solutions.										
Task 12. Track and evaluate programs roll out using rapid cycle team evaluation techniques		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 13. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed and conducted training of all providers, including social services and support.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Finalize Contract/MOUs with social service organizations		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2. Finalize Contract/MOUs with members of asthma care coordination team, including school nurses, pharmacists, CHW, dieticians, home care agency staff, environment agencies, state supported agencies, housing		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Finalize strategy for coordinating care and social services for the home-based asthma self-management program		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Present recommendations to the Clinical Integration and Quality committee of the PPS on project methodology		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Determine requirements for clinical interoperability within systems in regards to avoiding medication errors or duplicate services.		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3

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6. Project team to work with IT to determine clinical workflow and technology tools to incorporate into this project										
Task 7. Develop a roll-out plan for systems to achieve interoperability, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8. Explore education programs including learning collaborative models, regional collaborative sessions and LMS for social service providers		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 9. Coordinate with IT roadmap for provider Clinical Interoperability System		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 10. Integrate communication avenues for medication reconciliation measures per IT roadmap		Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 11. Appraise the availability of providing asthma education and certification funding to social service providers and schools to improve outcomes		Project		In Progress	12/01/2015	03/31/2018	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop strategy for follow-up services after negative event, including consulting with partners that provide follow-up services		Project		Completed	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Finalize strategy for root cause analysis and teach back to patient and/or family, with focus of use of asthma action plan		Project		Completed	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Identify IT solutions for event notifications to project teams		Project		Completed	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Develop plan for project overlap education to ED care navigators, hospital to home providers, care transition providers, CHW, and other providers regarding RCA process and evolvement		Project		Completed	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 5. Connect providers to RCA process and plans for provisions of feedback to avoid future events		Project		Completed	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Consider creating tool for patient/family that can be used at the ED visit or post discharge from hospital as part of asthma action plan		Project		Completed	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Present follow up services strategy to cultural competency & health literacy taskforce to align with overall strategies		Project		Completed	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Present follow up strategy to workforce committee to use as tool to determine workforce related gap in services, if appropriate		Project		Completed	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Track and evaluate programs roll out using RCA conclusions quarterly		Project		Completed	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Report to Clinical Integration and Quality committee quarterly and revise objectives to improve outcomes when indicated		Project		Completed	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Consider piloting Community Emergency Management Services (EMS) program to conduct home visits for education, self-management support to improve asthma home management. Include information from EMS in home/environmental assessments		Project		Completed	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 12. PPS will measure outcomes of the program and follow up services as determined by the Clinical Integration & Quality Committee to ensure optimal success by utilizing a continuous process improvement model.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9-24-15 Remediation Response 13. Quarterly outcome dashboards will be developed and reported to project teams, Clinical Integration & Quality Committee and goverance committees to track program success.		Project		Completed	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task 1. Identify from MCO's in the region if they offer asthma at home trigger reduction programs and self-management programs		Project		In Progress	03/31/2016	06/30/2017	03/31/2016	06/30/2017	06/30/2017	DY3 Q1
Task 2. Identify benefit offerings including covered drugs for asthma with protocols for their use		Project		In Progress	03/31/2016	06/30/2017	03/31/2016	06/30/2017	06/30/2017	DY3 Q1
Task 3. Compare AFBHC desired guidelines with health plan offerings and establish approach to increase or change coverage if required		Project		In Progress	03/31/2016	06/30/2017	03/31/2016	06/30/2017	06/30/2017	DY3 Q1
Task 4. Establish role of health plan, health home care managers, and primary care providers and include these roles in respective provider contracts.		Project		In Progress	03/31/2016	06/30/2017	03/31/2016	06/30/2017	06/30/2017	DY3 Q1
Task 5. Finalize Contract/MOUs with MCOs at PPS level, specific to coverage of asthma health issue payments		Project		In Progress	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Review strategies and tools needed to promote DSRIP specific Patient Engagement		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Working with the project team document current and future state work flow in addition to capturing manual solutions in place at this time.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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tracking, system notification, and treatment plan creation.										
Task 5. Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the project needs and associated providers' needs		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Establish a process for monitoring project milestones and performance.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES2_DOC_20170331_3dii_R2_AllPartnerWorkforceTrainingPlan_11486.pdf	Asthma Alliance PPS-wide Workforce Training Plan	04/23/2017 04:22 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES2_DOC_20170331_3dii_R2_AllPartnerTrainingDocumentation_11485.xlsx	Asthma PPS Wide Training Documentation	04/23/2017 04:22 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop and implement evidence-based asthma management guidelines.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES3_DOC_20170331_3dii_R3_Ellis_AsthmaManagementGuidelines_11489.pdf	Ellis Medicine Asthma Management Guidelines	04/23/2017 04:31 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES3_DOC_20170331_3dii_R3_Ellis_AEPChecklist_11488.pdf	Ellis AEP Checklist	04/23/2017 04:30 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES3_DOC_20170331_3dii_R3_AllPartnersCIQminutes_11487.pdf	Alliance Clinical Integration and Quality Committee Minutes	04/23/2017 04:29 PM
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES4_DOC_20170331_3dii_R4_SPHP_AsthmaSelfManagementEducation_11492.pptx	St. Peters Health Partners Asthma Self Management Education	04/23/2017 04:38 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES4_DOC_20170331_3dii_R4_HometownHealth_AsthmaSelfManagementEducation_11491.pdf	Hometown Health Asthma Self Management Education	04/23/2017 04:37 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES4_DOC_20170331_3dii_R4_TheEddy_AsthmaSelfManagementEducation_11490.pptx	Eddy Visiting Nurse Association - Asthma Self Management Education	04/23/2017 04:36 PM
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES6_DOC_R36_3dii_M6_RCA_documentation_for_IA_3.31.17_request_15891.pdf	DY2Q4 Remediation Response	06/21/2017 03:00 PM
	mccarrol	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES6_DOC_R36_3dii_M6_Ellis_Medicine_RCA_Documentation_IA_3.31.17_15890.pptx	DY2Q4 Remediation Response	06/21/2017 02:59 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES6_DOC_20170331_3dii_R6_SPHP_RCA_11495.docx	St. Peters Health Partners RCA	04/23/2017 04:48 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES6_DOC_20170331_3dii_R6_SMH_RCA_11494.docx	St. Mary's Healthcare -RCA	04/23/2017 04:47 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES6_DOC_20170331_3dii_R6_Ellis_RCA_11493.pdf	Ellis RCA	04/23/2017 04:47 PM
Use EHRs or other technical platforms to track all patients engaged in this project.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES8_DOC_2010331_3dii_R8_SPHP_PtEngagementCaptureScreenshot_11501.jpg	St. Peters Health Partners- Patient Engagement Capture Screenshot	04/23/2017 05:06 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES8_DOC_20170331_3dii_R8_AlliancePtEngagementGuidance_11500.pdf	Alliance - Patient Engagement Guidance	04/23/2017 04:59 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES8_DOC_20170331_3dii_R8_WhitneyYoung_PatientEngagementCaptureScreenshot_11499.pdf	Whitney Young- Patient Engagement Capture Screenshot	04/23/2017 04:58 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES8_DOC_20170331_3dii_R8_Ellis_PtEngagementCaptureScreenshot_11	Ellis Medicine - Patient Engagement Capture Screenshot	04/23/2017 04:57 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			498.pdf		
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3dii_MDL3dii3_PRES8_DOC_2017_3dii_R8_SMH_PtEngagementCaptureScreenshot_11496.pdf	St. Mary's Healthcare - Patient Engagement Capture Screenshot	04/23/2017 04:56 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	
Develop and implement evidence-based asthma management guidelines.	
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	
Ensure coordinated care for asthma patients includes social services and support.	
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	DY2Q4 Remediation Response: Please see attached documents: R36 3dii M6 Ellis Medicine RCA Documentation IA 3.31.17 R36 3dii M6 RCA documentation for IA 3.31.17 request
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Metric/Deliverable moved to 3/31/2018 to reflect the Requirement due date of 3/31/2018.
Use EHRs or other technical platforms to track all patients engaged in this project.	

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Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 3.d.ii Asthma Home Based Mid-Point Assessment Narrative	Completed	3.d.ii Asthma Home Based Mid-Point Assessment Narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
3.d.ii Asthma Home Based Mid-Point Assessment Narrative	

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

Instructions :

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Project 3.g.i – Integration of palliative care into the PCMH Model

IPQR Module 3.g.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.

Palliative Care is not presently a covered benefit across all providers which places this project at risk for succeeding if providers refuse to engage in unreimbursed services. To mitigate this risk, the PPS will build upon our effective partnership with MCOs in DSRIP project design to advocate for reimbursement for services required by the DSRIP projects. Success of the mitigation strategy will be seen when MCO/PPS agreements have been made.

There are many IT Risks, such as manual tracking of data, data interoperability using multiple vendors that may not support existing standards- the risk mitigation strategy is to engage vendors early & determine supplemental solutions if available. The RHIO (the expected interoperable clinical platform) has expressed limitations on data sharing per NY state policies, working with EHR vendors to achieve data sharing & balancing DSRIP needs with existing commitments. Population Health IT (PHIT) systems & tools are required & delay to PHIT implementation delays the projects & risks not meeting speed/scale requirements. PHIT depends on sufficient capital funding from NY state & delay in capital release will delay the rollout. The PPS will work with the RHIO, accelerate implementation of PHIT interoperability, use alternate methods where EHRs & PHIT tool functionality aren't ready & work with NY to ensure capital is given in sufficient time.

As care shifts to the Primary Care Provider, the AFBHC risks overwhelming providers with expectations associated with the DSRIP projects. The mitigation strategy is to bundle interventions as much as possible; to demonstrate the common links between DSRIP requirements, and to provide technical support, tools and training to practices from the PPS administrative offices. The PPS will also extend the reach of its current palliative care services to accommodate patient referrals and decrease the burden to the PCP practice.

Another risk to the successful completion of this project is that the PPS does not achieve NCQA recognition for its primary care practices by DY3, Q4. To mitigate this risk, the PPS is dedicating at least one project manager to PCMH certification as well as employing consultant team to assist practices in obtaining certification. Current state of the practices will be assessed, technical assistance needs identified and technical assistance will be provided from the PPS central project management office. Success of the mitigation strategy will be seen in number of providers achieving NCQA recognition within the targeted timeframe.

Additional risks to successful engagement of patients in palliative care services are religious and cultural beliefs about end of life for both patients/families and providers/care givers. The is also an existing misunderstanding of patients, families and providers that palliative care is applicable only for patients at the end of life and that palliative care involves doing less for the patient. The PPS mitigation strategy is to: 1) develop culturally and linguistically appropriate approaches, There staff training and patient education materials; 2) educate patients/families and providers/care givers about the differences between palliative care and hospice;

Success of the mitigation strategy will be seen in patient and provider engagement in palliative care services and referrals.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Quarterly Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for Q4 should include patients previously reported in Q3 plus new patients engaged in Q4. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
Actively Engaged Speed	**Actively Engaged Scale**
DY4,Q4	15,486

	Year,Quarter	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4
PPS Reported	Baseline Commitment	479	1,596	2,898	5,933
	Quarterly Update	645	2,114	2,492	5,045
	Percent(%) of Commitment	134.66%	132.46%	85.99%	85.03%
IA Approved	Quarterly Update	0	2,114	0	5,035
	Percent(%) of Commitment	0.00%	132.46%	0.00%	84.86%

Warning: PPS Reported - Please note that your patients engaged to date (5,045) does not meet your committed amount (5,933) for 'DY2,Q4'

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ba628534	Rosters	3_DY2Q4_PROJ3gi_MDL3gi2_PES_ROST_project_3gi_201703_submission_12954.xlsx	3gi DY2Q4 Patient Engagement Roster	04/26/2017 01:58 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those eligible PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. The PPS PCMH Project Team will inventory partnering PCP practices, hospice providers, palliative care providers that will participate with integrating palliative care services into their practice model.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. PPS Operations Team will execute contract/MOU's with participating sites, CBO's and other identified providers		Project		Completed	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. In concert with the additional projects that require PCMH certification, the PPS PCMH Project Team will establish a strategy to assist participating non-PCMH certified practices to obtain Level 3 NCQA certification who are participating in this project		Project		Completed	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. The PPS will engage Project Implementation Palliative Care subject matter experts to conduct a "palliative care gap analysis" with each PCMH site, nursing home and non-PCHM practices to identified gaps in care		Project		Completed	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Project Implementation Group will develop a strategic plan for the PPS to create specific interventions of the identified gaps in care from the analysis		Project		Completed	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 6. PPS will conduct an assessment for the utilization of tele-medicine opportunities for palliative care consultations for participating providers sites and LTC facilities		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. The PPS will collaborate with the Workforce Committee to propose an anticipated plan to recruit, redeploy and reassign new and existing staff to support integration of palliative care services at participating sites including PCP practices, LTC facilities etc…		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. PPS will develop BAA's, MOUs, & provider agreements with CBO's and hospice to assist in obtaining medical provider support, Chaplain services, and enhance 24/7 on call support to create a patient centered palliative plan of care with their PCP and support services		Project		Completed	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. In concert with the Clinical Integration Committee, the Palliative Care Project Implementation Team will propose and advise on best practice modalities to integrate Palliative Care Services and Primary Care (ie: Advance care plan using Respecting Choices http://www.gundersenhealth.org/respecting-choices), pain & symptom management, addressing psychosocial & spiritual concerns, establishing goals of care and coordination of care.		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. PPS will survey participating sites to determine current state for offering/providing palliative care services and the expectation to enhance existing services		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. The PPS & Workforce Committee will conduct and assess the current state to determine potential workforce needs		Project		Completed	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. The PPS will engage in opportunities to collaborative and		Project		Completed	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
mentor neighboring PPS and service providers in overlapping counties to coordinate physician and clinical education, adopt evidence-based practice models and build a referral process for the region										
Task 6. In conjunction with Project 2 b iv and 2 b viii, engage hospice, home care agencies and CBO's to capacitate and strengthen palliative home care for use in all disease-related discharges from the hospitals and nursing homes		Project		Completed	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7. PPS will measure outcomes as determined by the Clinical Integration and Quality Committee to ensure optimal success by utilizing the Plan – Do – Study – Act methodology		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. The Clinical Operations Team will complete a current state assessment of which PCP practices are currently utilizing the MOLST form.		Project		Completed	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. For those participating practices that are not currently utilizing MOLST, the PPS will provide general MOLST education and assist practices to obtain current forms to provide consistency for advance direct health planning throughout the PPS		Project		Completed	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3. Palliative Care Team in collaboration with the Clinical Integration and Quality Committee will create, adopt and disseminate clinical guidelines that assist providers and other clinically trained staff to effectively administer the DOH -5003 MOLST form for individuals that are at end of life, have serious, chronic conditions and multiple co-morbidities.		Project		Completed	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. PPS will develop a standardized referral process for PCP sites		Project		Completed	11/01/2015	12/31/2016	11/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
to engaged Palliative Care consultation services. (ie: existing PC staff and/or tele-medicine)										
Task 5. Collaborate with the practitioner engagement task force and practicing sites to identify a physician and/or provider champion.		Project		Completed	11/01/2015	09/30/2016	11/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. Participating PCP practices can adopt the "Fast Facts" which is a peer-reviewed, evidence-based summaries for key palliative care topics that can be utilized by providers (https://www.capc.org/fast-facts/)		Project		Completed	11/01/2015	12/31/2016	11/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 7. With the Clinical Integration and Quality Committee, create common network triggers generated by EHRs & technical platforms to automatically alert the provider for review for appropriateness of palliative services		Project		Completed	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Each practice site "champion" will be paired with a Palliative Care subject matter expert and receive mentoring and education to integrate services		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Provide education to key clinical integration team members embedded in Projects 2.b.iv and 2.b.viii to increase awareness of palliative care services for hospitalized patients and their families to reduce preventable readmissions. Consider performing a gap analysis of the availability of hospital based palliative care services in our PPS, optimizing availability of inpatient palliative care services to be a support intervention		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Collaborate with Cultural Competency and Health Literacy Taskforce to incorporate age appropriate clinical guidelines and ensure care pathways encompass patient and family cultural competency and health literacy aspects.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Evaluate a PPS-wide Learning Management System (LMS) and other education resources to develop and implement a		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
standardized educational program on role appropriate palliative care skills/services and PPS adopted clinical guidelines.										
Task 2. PPS will assist practicing PCP sites and LTC facilities to have membership access to the Center to Advance Palliative Care (CAPC) website to obtain training materials and courses for providers and clinical champions		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. PPS will have subject matter experts available to participating practices and LTC facilities to provide education, mentorship and preceptorship approaches to best integrate palliative care into a PCP Practice & LTC Setting		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Introduce a 'train the trainer' approach through "Respecting Choices" for prompting and holding conversations leading to advance directives discussions		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Palliative Care Implementation Planning team will create a variety of approaches to provide PPS education through: online CME coursework as developed by CAPC, lunch and learn sessions, external mentors for specialized workshops, & webinars.		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Track training competency through LMS system		Project		Completed	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	DY3 Q4	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.		Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Review AFBHC adopted palliative care guidelines with Medicaid and Medicare MCOs in the region.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 2. Compare AFBHC guidelines to MCOs' palliative care guidelines and benefit structure associated with Medicare Advantage (MA), Fully Integrated Duals Advantage (FIDA), Managed Long Term Care (MLTC) programs. Also compare AFBHC guidelines to FFS Medicare		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 3. Determine if needed supports and services are missing from		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
the MCOs benefit structure and jointly present to DOH for coverage consideration and premium adjustments.										
Task 4. Based on conclusions from step 3, determine contracting strategy with MCOs for covered services and implications for an integrated PCMH/palliative care VBP methodology.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	DY2 Q4	Project	N/A	Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine requirements for identification of targeted patients and tracking actively engaged patients per state-provided specifications for the DSRIP program		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Review strategies and tools needed to promote DSRIP specific Patient Engagement for palliative care		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Working with the project committee document current and future state work flow of Palliative care project in addition to capturing manual solutions in place at this time.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Assess current EHR and other technical platforms in the PPS against established requirements for patient identification and tracking, system notification, and treatment plan creation.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Create a gap analysis based on the work flow analysis to determine incremental IT needs and associated budget, including short-term manual solutions		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Identify prioritization of systems to build or associated change with separate work streams focused on implementing new Electronic Health Record Systems vs. RHIO connectivity based on the DSRIP project needs and associated providers' needs		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Develop a roll-out plan for systems to achieve clinical data sharing, including a training plan to support the successful implementation of new platforms and processes		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Prescribed Due Date	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 8: Establish a process for monitoring project milestones and performance		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Where electronic functionality is not yet ready, implement alternate in the interim and track conversion to electronic systems		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: Review, revise and align policies, procedures and guidelines for capturing data requirements across the PPS		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 11: Develop a process for determining how success will be measured that incorporates feedback from practitioners and other key users of IT, including financial and patient engagement impact and risks.		Project		Completed	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES2_DOC_20170331_3gi_R2_Community_and_Provider_Resources_10415.docx	3gi R2 Community and Provider Resources	04/17/2017 10:52 AM
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES3_DOC_20170331_3gi_R3_Training_List_10425.xlsx	Training List	04/17/2017 11:06 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES3_DOC_20170331_3gi_R3_Partner_List_10424.docx	Partner List	04/17/2017 11:05 AM
	ba628534	Communication Documentation	3_DY2Q4_PROJ3gi_MDL3gi3_PRES3_COMM_20170331_3gi_R3_MOLST_Documentation_Capital_Care_10423.pdf	MOLST Documentation Capital Care	04/17/2017 11:05 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES3_DOC_20170331_3gi_R3_Master_Workflow_w_MOLST_mapp_10422.pdf	Master Workflow with MOLST	04/17/2017 11:03 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES3_DOC_20170331_3gi_R3_DNR-MOLST_Orders_SMHA_10418.doc	DNR-MOLST Orders SMHA	04/17/2017 10:56 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES3_DOC_20170331_3gi_R3_Clinical_Guidelines_10417.docx	Clinical Guidelines	04/17/2017 10:56 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES3_DOC_20170331_3gi_R3_Center_for_Disability_Workflow_Narrative_w_MOLST_10416.docx	Center for Disability Workflow Narrative with MOLST	04/17/2017 10:55 AM
Engage staff in trainings to increase role-appropriate	ba628534	Communication	3_DY2Q4_PROJ3gi_MDL3gi3_PRES4_COMM_201703	Training List	04/17/2017 11:12 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
competence in palliative care skills and protocols developed by the PPS.		Documentation	31_3gi_R4_Training_List_10427.xlsx		
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES4_DOC_20170331_3gi_R4_List_of_Training_materials_10426.docx	List of Training Materials	04/17/2017 11:11 AM
Use EHRs or other IT platforms to track all patients engaged in this project.	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_SPHP_Tracking_10454.docx	SPHP Tracking	04/17/2017 12:48 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_Palliative_Trigger_Main_Query_SQL_10453.JPG	Palliative Trigger Main Query SQL	04/17/2017 12:47 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_Palliative_in_Primary_Flow_SMHA_10452.docx	Palliative in Primary Flow SMHA	04/17/2017 12:46 PM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_MOLST_Documentation_Capital_Care_10437.pdf	MOLST Documentation Capital Care	04/17/2017 11:33 AM
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	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_Ellis_Tracking_and_IPOS_integrated_10434.docx	Ellis Tracking and IPOS integrated	04/17/2017 11:31 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_EHR_and_Patient_Engagement_Details_SMHA_10432.docx	EHR and Patient Engagement Details SMHA	04/17/2017 11:24 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_CFDS_sample_MOLST_report_Center_Health_Care_10431.pdf	CFDS sample MOLST report Center Health Care	04/17/2017 11:24 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_Center_for_Disability_Tracking_Screen_Shot_2_10429.jpg	Center for Disability Tracking Screen Shot 2	04/17/2017 11:22 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ3gi_MDL3gi3_PRES6_DOC_Center_for_Disability_Tracking_Screen_Shot_1_10428.jpg	Center for Disability Tracking Screen Shot 1	04/17/2017 11:22 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	
Engage with Medicaid Managed Care to address coverage of services.	Tasks 1, 2, 3, 4 have been moved to 9/30/2017 to reflect the ongoing nature of the work.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Use EHRs or other IT platforms to track all patients engaged in this project.	

Milestone Review Status

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 3.g.i Palliative Care	Completed	3.g.i Palliative Care	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
3.g.i Palliative Care	

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

Instructions :

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

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

Instructions :

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

An identified risk to this Domain 4 project is low provider participation for a variety of factors which could negatively impact the success of this project. One risk to the project would be low provider participation due to lack of reimbursement for meetings, workgroups, sessions and general time commitments of the providers. Through the PPS governance and workforce committees, this risk will be minimized by tracking provider engagement quarterly , partnering with behavioral health, substance abuse centers and community organizations to access changes in participation from current state to future state. An effort will be made to launch the screenings in all collaborative care sites and those providers willing to partner as a first step; then bring on other providers. In conjunction with the other behavioral health projects engaged by the AFBHC PPS, such as 3 a iv, providers will be educated on mental health issues and concerns in the catchment area, and sessions will be tracked through community based partnerships. Success will be measured by an increase in the use of the unified screening tool for patients accessing services of the PPS providers.

There is always the possibility that outlier providers not in the PPS network will interact with patients from the PPS network. The formation of a MEB taskforce by end of DY1, Collaborative Care Model provider champions determined by end of DY1 and work with the Clinical Integration and Quality Committee to develop standards and best practice guidelines will be shared with regularly scheduled meetings of neighboring PPS's, focusing on common projects to mitigate redundancies and identify specific collaborative opportunities, such as this project and others. Specifically, this project can effectively decrease the risk of a missed opportunity for screening these patients by incorporating the MEB tool into the projects within the PPS and sharing this tool as a collaborative means with other PPS in the area so incorporation of the tool can also be done at various sites. The AFBHC will build upon the expertise and experience of providers already using screenings to identify patient risk levels and will create replicable models for the delivery of screenings.
Interoperability of current state IT capabilities and the possibility that all participants will not be on a similar IT platform is a risk to the successful attainment of health care transition with this project. Successful partnership with the IT component of the PPS, evaluating current state of providers and plans to build and/or level resources will be necessary to ensure success. The AFBHC will work with IT in the development of embedded screening tools in EHRs with clinical prompts, especially related to specific diagnostic dyads of diabetes/depression and psychosis/substance use. Alternative methods to tracking and completing survey may have to be implemented, such as paper, data entry into dashboards, utilizing resources, until interoperability is obtained.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Participate in MEB health promotion and MEB disorder prevention partnerships.	In Progress	Participate in MEB health promotion and MEB disorder prevention partnerships.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Engage partnering providers to utilize the Adverse Childhood Experiences (ACE) tool to assess member's risk factors of illness and death and improve our efforts towards prevention and recovery.	In Progress	1. Engage partnering providers to utilize the Adverse Childhood Experiences (ACE) tool to assess member's risk factors of illness and death and improve our efforts towards prevention and recovery.	09/01/2015	06/30/2017	09/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 2. Implement the Collaborative Prevention Model for individuals at moderate or high risk of poor health outcomes	In Progress	2. Implement the Collaborative Prevention Model for individuals at moderate or high risk of poor health outcomes	09/01/2015	03/31/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 3. Develop a MEB taskforce to train participating providers and other health professionals in MEB health promotion & MEB disorder prevention by developing a trauma informed care approach using the prevention agenda strategies, goals and objectives. https://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse	Completed	3. Develop a MEB taskforce to train participating providers and other health professionals in MEB health promotion & MEB disorder prevention by developing a trauma informed care approach using the prevention agenda strategies, goals and objectives. https://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Engage multi-levels of community agencies and established taskforces to become members of the MEB taskforce to create a trauma-informed culture for care, to encourage MEB health promotion (by local government units, public health, prevention specialist/educators, etc.)	Completed	4. Engage multi-levels of community agencies and established taskforces to become members of the MEB taskforce to create a trauma-informed culture for care, to encourage MEB health promotion (by local government units, public health, prevention specialist/educators, etc.)	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Assess and collaborate with IT using a screening kiosk for members where results are	In Progress	5. Assess and collaborate with IT using a screening kiosk for members where results are electronically populated in an EHR for provider access	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
electronically populated in an EHR for provider access								
Task 6. Target populations into segments for achievement: community-settings on regional basis focusing on low income hotspots and on areas with highest behavioral health morbidity	In Progress	6. Target populations into segments for achievement: community-settings on regional basis focusing on low income hotspots and on areas with highest behavioral health morbidity	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	In Progress	Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Collaborate with our participating providers of physical health care to increase access to screening MEB conditions.	Completed	1. Collaborate with our participating providers of physical health care to increase access to screening MEB conditions.	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Integrate physical health MEB screenings into behavioral health outpatient setting in collaboration with the 3 a i project work group	In Progress	2. Integrate physical health MEB screenings into behavioral health outpatient setting in collaboration with the 3 a i project work group	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Develop cohesive team approach to integrate standardized, evidence based screening tools into care delivery	Completed	3. Develop cohesive team approach to integrate standardized, evidence based screening tools into care delivery	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Utilize funding for the MEB taskforce to purchase evidence-based screening tools & provide education in various settings to our providers.	In Progress	4. Utilize funding for the MEB taskforce to purchase evidence-based screening tools & provide education in various settings to our providers.	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Provide prevention/education via trauma informed care approach to members according to risk. Develop and utilize prevention curriculum to improve protective factors and reduce risk	In Progress	5. Provide prevention/education via trauma informed care approach to members according to risk. Develop and utilize prevention curriculum to improve protective factors and reduce risk	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6. Create a Collaborative Care Model in identified Primary Care and Behavioral Health practices	In Progress	6. Create a Collaborative Care Model in identified Primary Care and Behavioral Health practices	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Provide cultural and linguistic training on MEB health promotion, prevention and treatment.	In Progress	Provide cultural and linguistic training on MEB health promotion, prevention and treatment.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	In Progress	1. Collaborate with SUNY Buffalo Institute of Trauma and the project sub-	09/01/2015	03/31/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
1. Collaborate with SUNY Buffalo Institute of Trauma and the project sub-committee of 3 a i, to develop web-based, care training modules that can be accessed at various sites.		committee of 3 a i, to develop web-based, care training modules that can be accessed at various sites.						
Task 2. Create educational programs that are gender and culturally specific in regards to trauma assessment and care	In Progress	2. Create educational programs that are gender and culturally specific in regards to trauma assessment and care	09/01/2015	03/31/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 3. Link to PPS Cultural Competency initiative with focus on culture of poverty as it relates to trauma exposure and social living circumstances.	Completed	3. Link to PPS Cultural Competency initiative with focus on culture of poverty as it relates to trauma exposure and social living circumstances.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Through identified hot spots in our regional community needs assessment, develop outreach screening forums to community settings linked to low income populations & homelessness.	In Progress	4. Through identified hot spots in our regional community needs assessment, develop outreach screening forums to community settings linked to low income populations & homelessness.	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9-24-15 Remediation Response 5. PPS will measure outcomes of the program as determined by the Clinical Integration and Quality Committe to ensure optimal success by utilizing a continuous process improvement method.	In Progress	9-24-15 Remediation Response 5. PPS will measure outcomes of the program as determined by the Clinical Integration and Quality Committe to ensure optimal success by utilizing a continuous process improvement method.	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2
Task 9-24-15 Remediation Response 6. Quarterly outcome dashboards measuring certain metrics and consumer engagement results will be developed and reported to project teams, Clinical Integration and Quality committee and governance committees to track outcomes including satisfaction levels and adjust program methods, if required	In Progress	9-24-15 Remediation Response 6. Quarterly outcome dashboards measuring certain metrics and consumer engagement results will be developed and reported to project teams, Clinical Integration and Quality committee and governance committees to track outcomes including satisfaction levels and adjust program methods, if required	09/24/2015	03/31/2017	09/24/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone Share data and information on MEB health promotion and MEB disorder prevention and treatment.	In Progress	Share data and information on MEB health promotion and MEB disorder prevention and treatment.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Develop in concert with IT consultants, a longitudinal tracking of claims data for those who have participated in prevention/education services	In Progress	1. Develop in concert with IT consultants, a longitudinal tracking of claims data for those who have participated in prevention/education services that can be shared with providers	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
that can be shared with providers								
Task 2. Explore the ability of population health databases populations to assess effectiveness of prevention education for various subpopulations	In Progress	2. Explore the ability of population health databases populations to assess effectiveness of prevention education for various subpopulations	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Collaborate with community leaders, state agencies, service providers, insurers and CBO's to form an interdisciplinary team whose responsibilities are to prioritize needs related to data, training, technical assistance and evidence-based protocols necessary to support MEB health promotion.	Completed	3. Collaborate with community leaders, state agencies, service providers, insurers and CBO's to form an interdisciplinary team whose responsibilities are to prioritize needs related to data, training, technical assistance and evidence-based protocols necessary to support MEB health promotion.	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 4.a.iii MH/SUD Infrastructure Mid-Point Assessment Narrative	Completed	4.a.iii MH/SUD Infrastructure Mid-Point Assessment Narrative	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Participate in MEB health promotion and MEB disorder prevention partnerships.	Task 2 has been moved to 9/30/2017 to reflect the ongoing nature of the work.
Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.	
Provide cultural and linguistic training on MEB health promotion, prevention and treatment.	Tasks 1, 2, 5, 6 have been moved to 9/30/2017 to reflect the ongoing nature of the work.
Share data and information on MEB health promotion and MEB disorder prevention and treatment.	
4.a.iii MH/SUD Infrastructure Mid-Point Assessment Narrative	

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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

Instructions :

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

There are a number of inherent risks associated with the promotion of tobacco use cessation, especially among low SES populations and those with poor mental health. One risk is the potential for missed opportunities for patient screening and referral. The AFBHC and the AFBHC Team has already assembled a wide array of project partners from social service agencies, including St Peter's Center for Smoking Cessation, the Tobacco-Free Coalition, and the community resource Advancing Tobacco-Free Communities of Hamilton, Fulton and Montgomery Counties. The agencies and others will continue to promote tobacco use cessation for the population that they interact with. These teams are targeting community settings for patient identification and engagement. The goals of these organizations have and will remain high reaching, with success measured in their ability to connect with the population and measure success.
With the formation of the AFBHC, the communication and marketing strategies will be to integrate tobacco use cessation into its public focused outreach as a means to keep the population aware and engaged in the need to promote a smoke free environment. This is also a perfect opportunity for the PPS to collaborate with other projects within the DSRIP plan, such as with Project 2.b.iii. to ensure smoking status is communicated to primary care provider and Patient Navigator in ED Triage project process through a screening tool on health assessment. When identified, patients will be referred and connected with smoking cessation services along care continuum, tracked and measured for compliance and recidivism. Another avenue to evaluate the tobacco using population is through the 3 d ii project, linking tobacco use to environmental triggers. This can bolster outreach efforts by linking patients and/or home trigger tobacco users to the appropriate provider/CBO.
As there can be community inertia regarding smoking as the behavior is embedded in the local culture, the AFBHC will clinically integrate tobacco use cessation throughout the projects, engage champions at multiple levels, continue to promote smoke free environments and measure success as the community's health improves with an integrated and unified approach, not just in independent silos of improvement.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Adopt tobacco-free outdoor policies.	In Progress	Adopt tobacco-free outdoor policies.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. The PPS will collaborate with partners and community leaders to revise tobacco free policies to include E-cigarettes	In Progress	1. The PPS will collaborate with partners and community leaders to revise tobacco free policies to include E-cigarettes	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. Identify partnering sites within our communities, Advancing Tobacco Free Community contractors and with cross-county *independent PPS', that have existing tobacco free grounds—utilize existing strategies to become a "tobacco free campus" by engaging sites that serve our members, who currently do not have policies in place, to consider this initiative and decrease exposure to second hand smoke and promote reduction or eradication of current tobacco users. http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/planning.htm *Albany Medical Center PPS, Leatherstocking & AHI PPS'	Completed	2. Identify partnering sites within our communities, Advancing Tobacco Free Community contractors and with cross-county *independent PPS', that have existing tobacco free grounds—utilize existing strategies to become a "tobacco free campus" by engaging sites that serve our members, who currently do not have policies in place, to consider this initiative and decrease exposure to second hand smoke and promote reduction or eradication of current tobacco users. http://www.cdc.gov/nccdphp/dnpao/hwi/toolkits/tobacco/planning.htm *Albany Medical Center PPS, Leatherstocking & AHI PPS'	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3. PPS Tobacco Project Team will offer smoking cessation services and referral resources to sites that will begin transformation to a tobacco-free outdoor policy. Support efforts to decrease stigmatization, foster an atmosphere to assist staff and customers to quit, improve overall community health and wellbeing while reducing healthcare tobacco related costs.	In Progress	3. PPS Tobacco Project Team will offer smoking cessation services and referral resources to sites that will begin transformation to a tobacco-free outdoor policy. Support efforts to decrease stigmatization, foster an atmosphere to assist staff and customers to quit, improve overall community health and wellbeing while reducing healthcare tobacco related costs.	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4. The PPS, in collaboration with other community	In Progress	4. The PPS, in collaboration with other community mental health providers and cross-county PPS's develop a Health Promotion and Wellness	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
mental health providers and cross-county PPS's develop a Health Promotion and Wellness program targeting individuals with psychiatric illnesses to live a pro-health, positive image lifestyle.		program targeting individuals with psychiatric illnesses to live a pro-health, positive image lifestyle.						
Task 5. Through the Behavioral Health for Tobacco Free Living – contract with Behavioral Health providers to support this initiative & help create a culture of a tobacco free environment	In Progress	5. Through the Behavioral Health for Tobacco Free Living – contract with Behavioral Health providers to support this initiative & help create a culture of a tobacco free environment	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 6. Engage PPS and partnering executive leadership along with political community support to establish partnerships with identified sites to advance the transformation of a tobacco–free outdoor policy throughout all our communities and discuss additional strategies to address in-door, smoke-free housing where applicable.	In Progress	6. Engage PPS and partnering executive leadership along with political community support to establish partnerships with identified sites to advance the transformation of a tobacco–free outdoor policy throughout all our communities and discuss additional strategies to address in-door, smoke-free housing where applicable.	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Implement the US Public Health Services Guidelines for Treating Tobacco Use.	In Progress	Implement the US Public Health Services Guidelines for Treating Tobacco Use.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify participating providers and/or sites that are currently PCMH certified, where the USPHS Guidelines are already embedded.	In Progress	1. Identify participating providers and/or sites that are currently PCMH certified, where the USPHS Guidelines are already embedded.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. The AFBHC Leadership will develop strategies and timelines to assist non-PCMH providers to obtain certification	In Progress	2. The AFBHC Leadership will develop strategies and timelines to assist non-PCMH providers to obtain certification	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Partner with 4 a iii sub-committee to develop and provide community and healthcare education on tobacco cessation strategies	In Progress	3. Partner with 4 a iii sub-committee to develop and provide community and healthcare education on tobacco cessation strategies	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4. Tobacco Project Team will make recommendations to the Clinical Integration & Quality committee to review USPHS guidelines and develop methods to track outcomes and quality indications to ensure success.	In Progress	4. Tobacco Project Team will make recommendations to the Clinical Integration & Quality committee to review USPHS guidelines and develop methods to track outcomes and quality indications to ensure success.	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task	In Progress	5. Engage IT to assist not only with reporting but to standardize tobacco	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Engage IT to assist not only with reporting but to standardize tobacco use assessments on the EHR		use assessments on the EHR						
Milestone Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).	Completed	Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. To assess every patient, collaborate with IT to standardize the 5 A's and vital signs screening tool in the EHR.	Completed	1. To assess every patient, collaborate with IT to standardize the 5 A's and vital signs screening tool in the EHR.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Collaborate with IT to develop electronic reminder flags/prompts for providers to follow up (either in person or by phone) during the initial period of the treatment plan	Completed	2. Collaborate with IT to develop electronic reminder flags/prompts for providers to follow up (either in person or by phone) during the initial period of the treatment plan	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Provide 5 A training to our PPS healthcare providers that includes adherence with USPHS clinical guidelines through counseling, prescription and over the counter treatment options, and referrals to cessation services	Completed	3. Provide 5 A training to our PPS healthcare providers that includes adherence with USPHS clinical guidelines through counseling, prescription and over the counter treatment options, and referrals to cessation services	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Develop a roll-out plan for PPS, including a training plan to support the successful implementation of change requests and processes	Completed	4. Develop a roll-out plan for PPS, including a training plan to support the successful implementation of change requests and processes	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Review, revise and align policies, procedures and guidelines for completing the 5 A's across the PPS.	Completed	5. Review, revise and align policies, procedures and guidelines for completing the 5 A's across the PPS.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Facilitate referrals to the NYS Smokers' Quitline.	In Progress	Facilitate referrals to the NYS Smokers' Quitline.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Adopt the Opt-to-Quit™ Model to enhance triggers for the referral process and links tobacco using members to the evidence-based services of the New York State Smokers' Quitline.	In Progress	1. Adopt the Opt-to-Quit™ Model to enhance triggers for the referral process and links tobacco using members to the evidence-based services of the New York State Smokers' Quitline.	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. Collaborate with IT (and NYS Smokers' Quitline IT staff) to address system to system	In Progress	2. Collaborate with IT (and NYS Smokers' Quitline IT staff) to address system to system communication.	11/01/2015	03/31/2018	11/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

Alliance for Better Health Care, LLC (PPS ID:3)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
communication.								
Task 3. Bridge gaps among our PPS healthcare providers and health delivery systems to address tobacco use at each visit with tobacco using members.	In Progress	3. Bridge gaps among our PPS healthcare providers and health delivery systems to address tobacco use at each visit with tobacco using members.	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 4. Tobacco Project Team will coordinate PPS partnering sites to provide education to staff, administrators and practitioners to promote familiarity in addressing smoke cessation to expand the initiative to other DSRIP Projects.	In Progress	4. Tobacco Project Team will coordinate PPS partnering sites to provide education to staff, administrators and practitioners to promote familiarity in addressing smoke cessation to expand the initiative to other DSRIP Projects.	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.	In Progress	Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Meet with health plans to review the use of Medicaid pharmaceutical and counseling smoking cessation benefits and guidelines and compare to DOH and CDC guidelines	Completed	1. Meet with health plans to review the use of Medicaid pharmaceutical and counseling smoking cessation benefits and guidelines and compare to DOH and CDC guidelines	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Evaluate benefit use rates by diagnosis and age. Segment population by diagnostic grouping and use rates	In Progress	2. Evaluate benefit use rates by diagnosis and age. Segment population by diagnostic grouping and use rates	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 3. Evaluate results of the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) awarded to DOH by CMS for years 2011-2016 and consider using a like incentive program for the uptake of smoking cessation benefits if considered to be beneficial	In Progress	3. Evaluate results of the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) awarded to DOH by CMS for years 2011-2016 and consider using a like incentive program for the uptake of smoking cessation benefits if considered to be beneficial	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 4. Monitor uptake performance and smoking incidence over time, adapt strategy using PDCA approach	In Progress	4. Monitor uptake performance and smoking incidence over time, adapt strategy using PDCA approach	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Promote smoking cessation benefits among Medicaid providers.	In Progress	Promote smoking cessation benefits among Medicaid providers.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	In Progress	1. Educate providers on the current state of coverage that beneficiaries do	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

Alliance for Better Health Care, LLC (PPS ID:3)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
1. Educate providers on the current state of coverage that beneficiaries do have for smoking cessation treatment counseling and products via variety of online, webinars, and other venues		have for smoking cessation treatment counseling and products via variety of online, webinars, and other venues						
Task 2. Through the Clinical Integration & Quality Committee, develop policies within the PPS that ensures tobacco status is queried and treatment support/counseling is documented	In Progress	2. Through the Clinical Integration & Quality Committee, develop policies within the PPS that ensures tobacco status is queried and treatment support/counseling is documented	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 3. Provide quality monitoring feedback to providers on their performance of tobacco screening and treatment.	In Progress	3. Provide quality monitoring feedback to providers on their performance of tobacco screening and treatment.	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 4. Enhance connectivity for provider collaboration among medical and psychiatry during smoking cessation treatment to closely monitor actions or side effects of co-morbid conditions or medications. Collaborative with 3 a i Project Team.	In Progress	4. Enhance connectivity for provider collaboration among medical and psychiatry during smoking cessation treatment to closely monitor actions or side effects of co-morbid conditions or medications. Collaborative with 3 a i Project Team.	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 5. In collaboration with health plans, appropriate practitioner types, CBOs, and state health agencies develop specific strategies to increase benefit use rate by population segments that underutilize services	In Progress	5. In collaboration with health plans, appropriate practitioner types, CBOs, and state health agencies develop specific strategies to increase benefit use rate by population segments that underutilize services	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.	In Progress	Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Use findings from milestone 5 and evaluate consistency of prescription and over the counter cessation medications among health plan in the region; compare to DOH and CDC smoking cessation policies	In Progress	1. Use findings from milestone 5 and evaluate consistency of prescription and over the counter cessation medications among health plan in the region; compare to DOH and CDC smoking cessation policies	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Promote cessation counseling among all smokers, including people with disabilities.	In Progress	Promote cessation counseling among all smokers, including people with disabilities.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Collaborate with, cross-county independent	In Progress	1. Collaborate with, cross-county independent PPS', disability advocacy groups, community support organizations and associations to create a	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Alliance for Better Health Care, LLC (PPS ID:3)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS', disability advocacy groups, community support organizations and associations to create a systemic approach in planning, educating and promoting healthy behaviors		systemic approach in planning, educating and promoting healthy behaviors						
Task 2. Tobacco Project Team develops self-help materials that are tailored to specific audiences that are culturally & linguistically appropriate to enhance smoker's acceptance of treatment.	In Progress	2. Tobacco Project Team develops self-help materials that are tailored to specific audiences that are culturally & linguistically appropriate to enhance smoker's acceptance of treatment.	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone 4.b.i Tobacco Cessation Mid-Point Assessment	Completed	4.b.i Tobacco Cessation Mid-Point Assessment	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).	ba628534	Documentation/Certification	3_DY2Q4_PROJ4bi_MDL4bi2_PPS1147_DOC_20170331_4bi_R3_SMH_Tobacco_Screening_Policy_10653.pdf	SMH (St. Mary's Amsterdam) Tobacco Screening Policy	04/18/2017 11:30 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ4bi_MDL4bi2_PPS1147_DOC_20170331_4bi_R3_SMH_Screenshots5As_10651.pdf	SMH Screenshots 5As	04/18/2017 11:29 AM
	ba628534	Documentation/Certification	3_DY2Q4_PROJ4bi_MDL4bi2_PPS1147_DOC_20103 31_4bi_R3_New_Dimensions_screen_shots_10650.pdf	New Dimensions screen shots	04/18/2017 11:28 AM

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Adopt tobacco-free outdoor policies.	
Implement the US Public Health Services Guidelines for Treating Tobacco Use.	
Use electronic medical records to prompt providers to complete 5 A's (Ask, Assess, Advise, Assist, and Arrange).	
Facilitate referrals to the NYS Smokers' Quitline.	
Increase Medicaid and other health plan coverage of tobacco dependence treatment counseling and medications.	
Promote smoking cessation benefits among Medicaid providers.	

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Alliance for Better Health Care, LLC (PPS ID:3)

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Create universal, consistent health insurance benefits for prescription and over-the-counter cessation medications.	
Promote cessation counseling among all smokers, including people with disabilities.	
4.b.i Tobacco Cessation Mid-Point Assessment	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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Alliance for Better Health Care, LLC (PPS ID:3)

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

Instructions :

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

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Alliance for Better Health Care, LLC (PPS ID:3)

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 'Alliance for Better Health Care, LLC ', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	ELLIS HOSPITAL
Secondary Lead PPS Provider:	ST PETERS HOSPITAL ALBANY
Lead Representative:	Jacob M Reider
Submission Date:	06/21/2017 03:14 PM

Comments:	

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Alliance for Better Health Care, LLC (PPS ID:3)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY2, Q4	Adjudicated	Jacob M Reider	mrurak	06/30/2017 01:20 PM

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Alliance for Better Health Care, LLC (PPS ID:3)

Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The DY2, Q4 Quarterly Report has been adjudicated.	mrurak	06/30/2017 01:20 PM
Returned	The DY2, Q4 Quarterly Report has been returned for Remediation.	mrurak	05/31/2017 05:16 PM

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Alliance for Better Health Care, LLC (PPS ID:3)

Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY	Completed
	IPQR Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY	Completed
	IPQR Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)	Completed
	IPQR Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)	Completed
	IPQR Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)	Completed
	IPQR Module 1.11 - 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

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Alliance for Better Health Care, LLC (PPS ID:3)

Section	Module Name	Status
	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
	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

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Alliance for Better Health Care, LLC (PPS ID:3)

Section	Module Name	Status
	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
	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

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Alliance for Better Health Care, LLC (PPS ID:3)

Section	Module Name	Status
	IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects	Completed
	IPQR Module 10.5 - IT Requirements	Completed
	IPQR Module 10.6 - Performance Monitoring	Completed
	IPQR Module 10.7 - Community Engagement	Completed
	IPQR Module 10.8 - IA Monitoring	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending (Baseline)	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - Workforce Strategy Spending (Quarterly)	Completed
	IPQR Module 11.12 - IA Monitoring	

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Alliance for Better Health Care, LLC (PPS ID:3)

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

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Alliance for Better Health Care, LLC (PPS ID:3)

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

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Alliance for Better Health Care, LLC (PPS ID:3)

Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget - Waiver Revenue (Baseline) - READ ONLY	Pass & Ongoing	
	Module 1.2 - PPS Budget - Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds - Waiver Revenue (Baseline) - READ ONLY	Pass & Ongoing	
	Module 1.4 - PPS Flow of Funds - Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Complete	
	Module 1.7 - PPS Budget - Non-Waiver Revenue (Baseline)	Pass & Ongoing	
	Module 1.8 - PPS Budget - Non-Waiver Revenue (Quarterly)	Pass & Ongoing	
	Module 1.9 - PPS Flow of Funds - Non-Waiver Revenue (Baseline)	Pass & Ongoing	
	Module 1.10 - PPS Flow of Funds - Non-Waiver Revenue (Quarterly)	Pass & Ongoing	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass (with Exception) & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Complete	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Complete	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Complete	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Complete	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Complete	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Complete	

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Alliance for Better Health Care, LLC (PPS ID:3)

Section	Module Name / Milestone #	Review Status	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop a Value Based Payments Needs Assessment ("VNA")	Pass & Complete	
	Milestone #5 Develop an implementation plan geared towards addressing the needs identified within your VNA	Pass & Ongoing	
	Milestone #6 Develop partner engagement schedule for partners for VBP education and training	Pass & Ongoing	
	Milestone #7 ≥50% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 8%* (blended for 15% target for fully capitated plans (MLTC and SNPS) and 5% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 ≥80% of total MCO payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 20%* (blended for 35% target for fully capitated plans (MLTC and SNPS) and 15% target for not fully capitated plans) of total MCO payments captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	Pass & Complete	
	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Pass & Complete	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Pass & Complete	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Ongoing	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Complete	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Complete	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Complete	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass (with Exception) & Ongoing	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Complete	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Ongoing	
Section 08	Module 8.1 - Prescribed Milestones		

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Section	Module Name / Milestone #	Review Status	
	Milestone #1 Develop population health management roadmap.	Pass & Complete	
	Milestone #2 Finalize PPS-wide bed reduction plan.	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Complete	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Complete	
Section 11	Module 11.1 - Workforce Strategy Spending (Baseline)	Pass & Complete	
	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Complete	
	Milestone #5 Develop training strategy.	Pass & Complete	
	Module 11.10 - Staff Impact	Pass & Ongoing	
	Module 11.11 - Workforce Strategy Spending (Quarterly)	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
2.a.i	Module 2.a.i.2 - Prescribed Milestones		
	Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Pass & Ongoing	
	Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Pass & Complete	
	Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Pass & Complete	
	Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all eligible participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Complete	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	Fail	
	Module 2.b.iii.3 - Prescribed Milestones		
	Milestone #1 Establish ED care triage program for at-risk populations	Pass & Ongoing	
	Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & Ongoing	
	Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Pass (with Exception) & Complete	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Complete	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Fail	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Complete	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Ongoing	
	Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Complete	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Complete	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Complete	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Complete	
2.b.viii	Module 2.b.viii.2 - Patient Engagement Speed	Fail	
	Module 2.b.viii.3 - Prescribed Milestones		
	Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Pass & Ongoing	
	Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Pass & Complete	
	Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Fail	
	Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	Pass & Complete	
	Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Complete	

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Project ID	Module Name / Milestone #	Review Status
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Complete
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Complete
	Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Pass & Ongoing
	Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Pass & Ongoing
	Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Pass & Ongoing
	Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing
	Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Complete
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Fail
	Module 2.d.i.3 - Prescribed Milestones	
	Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Pass & Complete
	Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Pass & Complete
	Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Pass & Complete
	Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Pass & Complete
	Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Pass & Complete
	Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Pass & Complete
	Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Pass & Complete
	Milestone #8 Include beneficiaries in development team to promote preventive care.	Pass & Complete
	Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot	Pass & Complete

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

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	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Complete	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Complete	
	Milestone #7 Conduct preventive care screenings, including physical and behavioral health screenings.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Complete	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.a.iv	Module 3.a.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.iv.3 - Prescribed Milestones		
	Milestone #1 Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.	Pass & Ongoing	
	Milestone #2 Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	Pass & Ongoing	
	Milestone #3 Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	Pass & Complete	
	Milestone #4 Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.	Pass & Ongoing	
	Milestone #5 Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.	Pass & Complete	
	Milestone #6 Develop care management services within the SUD treatment program.	Pass & Ongoing	
	Milestone #7 Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Complete	
3.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.ii.3 - Prescribed Milestones		
	Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Pass & Ongoing	
	Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Pass & Complete	
	Milestone #3 Develop and implement evidence-based asthma management guidelines.	Pass & Complete	
	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Pass & Complete	
	Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Pass & Ongoing	
	Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Pass & Complete	
	Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Complete	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.g.i.3 - Prescribed Milestones		
	Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Pass & Ongoing	
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Complete	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Complete	
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Complete	
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Ongoing	
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Complete	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.b.i	Module 4.b.i.2 - PPS Defined Milestones	Pass & Ongoing	

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Providers Participating in Projects

	Selected Projects										
	Project 2.a.i	**Project 2.b.iii**	**Project 2.b.iv**	**Project 2.b.viii**	**Project 2.d.i**	**Project 3.a.i**	**Project 3.a.iv**	**Project 3.d.ii**	**Project 3.g.i**	**Project 4.a.iii**	**Project 4.b.i**
Provider Speed Commitments	DY3 Q4	DY3 Q4	DY3 Q4	DY3 Q4	DY2 Q4	DY4 Q4	DY3 Q2	DY3 Q4	DY3 Q4		

Provider Category		**Project 2.a.i**		**Project 2.b.iii**		**Project 2.b.iv**		**Project 2.b.viii**		**Project 2.d.i**		**Project 3.a.i**		**Project 3.a.iv**		**Project 3.d.ii**		**Project 3.g.i**		**Project 4.a.iii**		**Project 4.b.i**	
		Selected / Committed		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**		**Selected / Committed**	
Practitioner - Primary Care Provider (PCP)	Total	1	480	1	-	1	480	1	-	1	-	1	190	1	455	1	190	1	480	1	-	1	-
	Safety Net	0	30	0	30	0	30	0	30	0	30	0	27	0	23	0	27	0	30	0	-	0	-
Practitioner - Non-Primary Care Provider (PCP)	Total	1	299	1	-	1	299	1	-	1	-	1	98	1	267	1	98	1	299	1	-	1	-
	Safety Net	1	31	1	-	1	31	1	31	1	31	1	11	1	21	1	11	1	31	1	-	1	-
Hospital	Total	3	6	3	-	3	6	3	-	3	-	3	-	3	6	3	-	3	-	3	-	3	-
	Safety Net	3	7	3	7	3	7	3	7	3	7	3	-	3	7	3	-	3	-	3	-	3	-
Clinic	Total	6	23	7	-	8	-	7	-	6	-	7	15	6	23	10	15	10	23	6	-	9	-
	Safety Net	5	20	6	20	7	-	6	-	5	20	6	14	5	20	9	14	9	20	5	-	8	-
Case Management / Health Home	Total	2	13	3	-	4	13	4	-	3	-	2	-	2	13	2	13	3	-	2	-	2	-
	Safety Net	2	9	2	9	3	9	3	-	2	-	2	-	2	9	2	9	2	-	2	-	2	-
Mental Health	Total	2	67	2	-	2	-	2	-	2	-	5	24	4	67	2	-	2	-	2	-	2	-
	Safety Net	2	24	2	-	2	-	2	24	2	-	5	15	4	24	2	-	2	-	2	-	2	-
Substance Abuse	Total	3	17	3	-	3	-	3	-	3	-	4	11	4	17	3	-	3	-	3	-	3	-
	Safety Net	3	17	3	-	3	-	3	17	3	-	4	8	4	17	3	-	3	-	3	-	3	-
Nursing Home	Total	0	25	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
	Safety Net	0	22	0	-	0	-	0	22	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Pharmacy	Total	0	20	0	-	0	-	0	-	0	-	0	-	0	20	0	11	0	-	0	-	0	-
	Safety Net	0	1	0	-	0	-	0	1	0	1	0	-	0	1	0	1	0	-	0	-	0	-
Hospice	Total	1	1	1	-	1	-	1	-	1	-	1	-	1	-	1	-	1	1	1	-	1	-

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Provider Category		Project 2.a.i		Project 2.b.iii		Project 2.b.iv		Project 2.b.viii		Project 2.d.i		Project 3.a.i		Project 3.a.iv		Project 3.d.ii		Project 3.g.i		Project 4.a.iii		Project 4.b.i	
		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed		Selected / Committed	
	Safety Net	0	0	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	0	0	-	0	-
Community Based Organizations	Total	2	48	4	-	4	48	3	-	3	-	2	12	2	16	4	12	2	48	2	-	2	-
	Safety Net	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
All Other	Total	5	442	5	-	5	442	5	-	5	-	7	114	5	377	5	114	6	442	5	-	5	-
	Safety Net	4	76	4	-	4	76	4	76	4	76	6	26	4	51	4	26	5	76	4	-	4	-
Uncategorized	Total	0	-	1	-	0	-	0	-	0	-	1	-	0	-	0	-	0	-	0	-	0	-
	Safety Net	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
Additional Providers	Total	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-
	Safety Net	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-

Additional Project Scale Commitments

Instructions:

Please indicate the scale of the categories below that meet all of the project requirements committed to in the Project Plan Application. Documentation must be submitted in Excel format in the quarter when the PPS provider speed commitments for a particular project are due. This documentation should include the target category(e.g. Medical Villages, Emergency Departments with Care Triage, Community-based navigators, etc.), the project ID(e.g. 2.a.iv,2.a.v,3.a.ii, etc.), and the name of the providers/entities/individuals associated with this project, if applicable.

Project Scale Category	Project	Selected	Committed
Emergency Departments with Care Triage	2.b.iii	0	6
Home Care Facilities	2.b.viii	0	5
PAM(R) Providers	2.d.i	0	300

* Safety Net Providers in Green

Participating in Projects												
Provider Name	Provider Category	2.a.i	2.b.iii	2.b.iv	2.b.viii	2.d.i	3.a.i	3.a.iv	3.d.ii	3.g.i	4.a.iii	4.b.i
Gross Eric J Md	Practitioner - Primary Care Provider (PCP)											
Farrell Richard Md Jr	Practitioner - Primary Care Provider (PCP)											
Hardies Michael J Md	Practitioner - Primary Care Provider (PCP)											
Millora Angel B Md	Practitioner - Primary Care Provider (PCP)											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Leyhane James C Md	Practitioner - Primary Care Provider (PCP)											
Lavigne Richard E Pc Md	Practitioner - Primary Care Provider (PCP)											
Richman Charles H Md	Practitioner - Primary Care Provider (PCP)											
Malone Anthony F Md	Practitioner - Primary Care Provider (PCP)											
Petersen William A Md	Practitioner - Primary Care Provider (PCP)											
Rimash Rorick T Md	Practitioner - Primary Care Provider (PCP)											
Bertram Michael C Md	Practitioner - Primary Care Provider (PCP)											
Thompson Dean A Md	Practitioner - Primary Care Provider (PCP)											
Bello Scott C Md	Practitioner - Primary Care Provider (PCP)											
Toll Richard B Md	Practitioner - Primary Care Provider (PCP)											
Mitta Swatantra K Md	Practitioner - Primary Care Provider (PCP)											
Perkins Jeffrey Md	Practitioner - Primary Care Provider (PCP)											
Jain Rajinder Pc Md	Practitioner - Primary Care Provider (PCP)											
Rao Govind C K Md	Practitioner - Primary Care Provider (PCP)											
Saha Proshanta K Md	Practitioner - Primary Care Provider (PCP)											
Chen Jung Wen Md	Practitioner - Primary Care Provider (PCP)											
Scher Michael Lee Md	Practitioner - Primary Care Provider (PCP)											
Sin Zae Seol Pc Md	Practitioner - Primary Care Provider (PCP)											
Rappazzo Mary Elizabeth Md	Practitioner - Primary Care Provider (PCP)											
Agopovich Arsenio Md	Practitioner - Primary Care Provider (PCP)											
Ismail Mohammed Md	Practitioner - Primary Care Provider (PCP)											
Zeltner Theodore Harold Md	Practitioner - Primary Care Provider (PCP)											
Walders James D Md	Practitioner - Primary Care Provider (PCP)											
Woods Norbert J Md	Practitioner - Primary Care Provider (PCP)											
Glasgow Constance Lenore Mdpc	Practitioner - Primary Care Provider (PCP)											
Patil Nagaraja N Md	Practitioner - Primary Care Provider (PCP)											
Fruiterman Roy Md	Practitioner - Primary Care Provider (PCP)											
Baselice Marino Md	Practitioner - Primary Care Provider (PCP)											
Sulzman Charles Michael Md	Practitioner - Primary Care Provider (PCP)											
Gullott Richard Francis Pc Md	Practitioner - Primary Care Provider (PCP)											
Patel Vina R Md	Practitioner - Primary Care Provider (PCP)											

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Ford Bradley A Md	Practitioner - Primary Care Provider (PCP)											
Saperstone James D Md	Practitioner - Primary Care Provider (PCP)											
Busino William A Jr Md	Practitioner - Primary Care Provider (PCP)											
Strader Stephen Earl Md	Practitioner - Primary Care Provider (PCP)											
Welch Michael C Md	Practitioner - Primary Care Provider (PCP)											
Wolff Michael Leonard Md	Practitioner - Primary Care Provider (PCP)											
Marshall Robert Andrew Md	Practitioner - Primary Care Provider (PCP)											
Sgambati Stephen S Jr Md	Practitioner - Primary Care Provider (PCP)											
Goel Veena	Practitioner - Primary Care Provider (PCP)											
Tomiak Henry P Jr Md	Practitioner - Primary Care Provider (PCP)											
Nebres Jose F Md	Practitioner - Primary Care Provider (PCP)											
Kolanchick Gary J Md	Practitioner - Primary Care Provider (PCP)											
Phelps David Millard Md	Practitioner - Primary Care Provider (PCP)											
Rios Zandra M Md	Practitioner - Primary Care Provider (PCP)											
Dunkerley Gary Robert Md	Practitioner - Primary Care Provider (PCP)											
Musto Ronald V Md	Practitioner - Primary Care Provider (PCP)											
Weissberg Robert A Md	Practitioner - Primary Care Provider (PCP)											
Goddard Bryan L Md	Practitioner - Primary Care Provider (PCP)											
Cioffi James Michael Md	Practitioner - Primary Care Provider (PCP)											
Ramaswami Ravi Md	Practitioner - Primary Care Provider (PCP)											
Gaffuri Paul E Md	Practitioner - Primary Care Provider (PCP)											
Drislane Mary Ellen Md	Practitioner - Primary Care Provider (PCP)											
Sullivan Andrew Md	Practitioner - Primary Care Provider (PCP)											
Kumar Pashu Pati Md	Practitioner - Primary Care Provider (PCP)											
Perazzelli Michael E Md	Practitioner - Primary Care Provider (PCP)											
Taylor Robert John Md	Practitioner - Primary Care Provider (PCP)											
Sturges Charles E Md	Practitioner - Primary Care Provider (PCP)											
Conlon Alan T Md	Practitioner - Primary Care Provider (PCP)											
Sonnekalb Michael P Md	Practitioner - Primary Care Provider (PCP)											
Detweiler Samuel Dean Md	Practitioner - Primary Care Provider (PCP)											
Friedman Ross Md	Practitioner - Primary Care Provider (PCP)											

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Mayer William D Md	Practitioner - Primary Care Provider (PCP)											
Rochet Michael A Md	Practitioner - Primary Care Provider (PCP)											
Jue Donald Md	Practitioner - Primary Care Provider (PCP)											
Orsi Richard A Md	Practitioner - Primary Care Provider (PCP)											
Fogel Alan Jeffrey Md	Practitioner - Primary Care Provider (PCP)											
Grant Stephen A Md	Practitioner - Primary Care Provider (PCP)											
Glenn John Lester Md	Practitioner - Primary Care Provider (PCP)											
Caulfield Patrick Francis Md	Practitioner - Primary Care Provider (PCP)											
Carrozza Joseph K Md	Practitioner - Primary Care Provider (PCP)											
Mitnick Neil Craig Md	Practitioner - Primary Care Provider (PCP)											
Snitkoff Louis Md	Practitioner - Primary Care Provider (PCP)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gardner Michael J Md	Practitioner - Primary Care Provider (PCP)											
Goldberg Steven Marc Md	Practitioner - Primary Care Provider (PCP)											
Neilley Henry Md	Practitioner - Primary Care Provider (PCP)											
Gelman Leonard M Md	Practitioner - Primary Care Provider (PCP)											
Warner Robert Charles Jr Md	Practitioner - Primary Care Provider (PCP)											
Van Bellingham Wendy Md	Practitioner - Primary Care Provider (PCP)											
Stevens Arthur L Md	Practitioner - Primary Care Provider (PCP)											
Limeri Dean Joseph Md	Practitioner - Primary Care Provider (PCP)											
Pride Boone Janice Md	Practitioner - Primary Care Provider (PCP)											
Fort Maria D Md	Practitioner - Primary Care Provider (PCP)											
Johnston Mary Md	Practitioner - Primary Care Provider (PCP)											
Nightingale Luke Mahlon Md	Practitioner - Primary Care Provider (PCP)											
Vachon Francois Marc Andre Md	Practitioner - Primary Care Provider (PCP)											
Braverman Panza Jill	Practitioner - Primary Care Provider (PCP)											
Maggiore Peter Rocco Md	Practitioner - Primary Care Provider (PCP)											
Kroopnick Kenneth Md	Practitioner - Primary Care Provider (PCP)											
Manjunath Kallanna Md	Practitioner - Primary Care Provider (PCP)											
Klein Ronald Steven Md	Practitioner - Primary Care Provider (PCP)											
Bodnar Judith D	Practitioner - Primary Care Provider (PCP)											
Haas Douglas L Md	Practitioner - Primary Care Provider (PCP)											

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Lecours Laura Yates Md	Practitioner - Primary Care Provider (PCP)											
Tetreault William Robert Md	Practitioner - Primary Care Provider (PCP)											
Marinello Anthony James Md	Practitioner - Primary Care Provider (PCP)											
Katz Michael Scott Md	Practitioner - Primary Care Provider (PCP)											
Spinelli Karen Ann Md	Practitioner - Primary Care Provider (PCP)											
Talma Theodore E Md	Practitioner - Primary Care Provider (PCP)											
Quimby Robert R Md	Practitioner - Primary Care Provider (PCP)											
Trout Charles A Md	Practitioner - Primary Care Provider (PCP)											
Kineke Stephen Francis Md	Practitioner - Primary Care Provider (PCP)											
Wong Winston C Md	Practitioner - Primary Care Provider (PCP)											
Duff Thomas Edward Jr Md	Practitioner - Primary Care Provider (PCP)											
Hoenzsch Ronald Ernest Md	Practitioner - Primary Care Provider (PCP)											
Kronick Gary Archer Md	Practitioner - Primary Care Provider (PCP)											
Yan Richard	Practitioner - Primary Care Provider (PCP)											
Fitz Grahame Wright Md	Practitioner - Primary Care Provider (PCP)											
Quarrier John V Md	Practitioner - Primary Care Provider (PCP)											
Sheridan Michael Martin Do	Practitioner - Primary Care Provider (PCP)											
Rienzi Peter Anthony Md	Practitioner - Primary Care Provider (PCP)											
Marthy-Noonan Anne K Md	Practitioner - Primary Care Provider (PCP)											
Barbarotto Paul David Md	Practitioner - Primary Care Provider (PCP)											
Zitwer Seth Darryl Md	Practitioner - Primary Care Provider (PCP)											
Dorsey Susan Serra Md	Practitioner - Primary Care Provider (PCP)											
Nafziger Anne N Md	Practitioner - Primary Care Provider (PCP)											
Sapio Nancy C Md	Practitioner - Primary Care Provider (PCP)											
Herdzik Katherine Joan Md	Practitioner - Primary Care Provider (PCP)											
Murphy Christopher J Md	Practitioner - Primary Care Provider (PCP)											
Salehi Freshteh Md	Practitioner - Primary Care Provider (PCP)											
Dasher George E Md	Practitioner - Primary Care Provider (PCP)											
Cope Kevin Patrick Md	Practitioner - Primary Care Provider (PCP)											
Haber Eugene Curtis Md	Practitioner - Primary Care Provider (PCP)											
Mirza Shahida Parveen Md	Practitioner - Primary Care Provider (PCP)											

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Hughes Patricia A Md	Practitioner - Primary Care Provider (PCP)											
Murphy Suzanne Marie Md	Practitioner - Primary Care Provider (PCP)											
Schwartz Kenneth Md	Practitioner - Primary Care Provider (PCP)											
Morin Michael P Md	Practitioner - Primary Care Provider (PCP)											
Skory David S Md	Practitioner - Primary Care Provider (PCP)											
Warszawa-Ambros Maryla A Md	Practitioner - Primary Care Provider (PCP)											
David Jose M Jr Md	Practitioner - Primary Care Provider (PCP)											
Dort Janice Beth	Practitioner - Primary Care Provider (PCP)											
Smith Robert James	Practitioner - Primary Care Provider (PCP)											
Arnold Hendrick Jr Md	Practitioner - Primary Care Provider (PCP)											
Pascual Arsenio George Md	Practitioner - Primary Care Provider (PCP)											
Klausner Eric G Md	Practitioner - Primary Care Provider (PCP)											
Bedford Sharon L Md	Practitioner - Primary Care Provider (PCP)											
Bellin Joyce Lea Pa	Practitioner - Primary Care Provider (PCP)											
Lemanski Paul Md	Practitioner - Primary Care Provider (PCP)											
Rebehn Keith Alan Md	Practitioner - Primary Care Provider (PCP)											
Saxena Parul Md	Practitioner - Primary Care Provider (PCP)											
Viola Theresa Md	Practitioner - Primary Care Provider (PCP)											
Migden Hedy L	Practitioner - Primary Care Provider (PCP)											
Renauld Cynthia Rose Md	Practitioner - Primary Care Provider (PCP)											
Morris Barbara A Md	Practitioner - Primary Care Provider (PCP)											
Thorn Lisa Marie Md	Practitioner - Primary Care Provider (PCP)											
Vellis Peter Alexander Md	Practitioner - Primary Care Provider (PCP)											
Craig James Charles Iii Md	Practitioner - Primary Care Provider (PCP)											
Balsamo Steven Joseph Md	Practitioner - Primary Care Provider (PCP)											
Jolie Patricia Lynn Md	Practitioner - Primary Care Provider (PCP)											
Schnakenberg Eric C Md	Practitioner - Primary Care Provider (PCP)											
Pezzulo John Phillip Md	Practitioner - Primary Care Provider (PCP)											
Lee Arthur Farren Md Pc	Practitioner - Primary Care Provider (PCP)											
Clark Richard A	Practitioner - Primary Care Provider (PCP)											
Justa Shelley Md	Practitioner - Primary Care Provider (PCP)											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Gardner Jeffrey Louis Md	Practitioner - Primary Care Provider (PCP)											
Bapat Aruna V Md	Practitioner - Primary Care Provider (PCP)											
Strizich Gregory Md	Practitioner - Primary Care Provider (PCP)											
Gaylord James Md	Practitioner - Primary Care Provider (PCP)											
Fusella Joseph Ii Do	Practitioner - Primary Care Provider (PCP)											
Ianniello Louis Md	Practitioner - Primary Care Provider (PCP)											
Walsh Amy Md	Practitioner - Primary Care Provider (PCP)											
Osborn Mark Edward Md	Practitioner - Primary Care Provider (PCP)											
Seyburn David F Md	Practitioner - Primary Care Provider (PCP)											
Merritt Patricia Md	Practitioner - Primary Care Provider (PCP)											
Tuttle Donna Md	Practitioner - Primary Care Provider (PCP)											
Bevilacqua Lisa Rose Md	Practitioner - Primary Care Provider (PCP)											
Woods Margaret Mary Md	Practitioner - Primary Care Provider (PCP)											
Black Joy Merry Rpa	Practitioner - Primary Care Provider (PCP)											
Sipperly Stephen F Do	Practitioner - Primary Care Provider (PCP)											
Gregory Elizabeth Marie Md	Practitioner - Primary Care Provider (PCP)											
Benoit Marcel M Md	Practitioner - Primary Care Provider (PCP)											
Yousuf Asim Md	Practitioner - Primary Care Provider (PCP)											
Raphael Hong Thi-Le Md	Practitioner - Primary Care Provider (PCP)											
Baghel Ashok Md	Practitioner - Primary Care Provider (PCP)											
Cavanna Angela C Do	Practitioner - Primary Care Provider (PCP)											
Pramenko John M Md	Practitioner - Primary Care Provider (PCP)											
Swicker Stefan Andrew Md	Practitioner - Primary Care Provider (PCP)											
Roche Sean Patrick Md	Practitioner - Primary Care Provider (PCP)											
Chava Prabhakar Rao Md	Practitioner - Primary Care Provider (PCP)											
Cotugno Steffani Do	Practitioner - Primary Care Provider (PCP)											
Sirico Theresa A Do	Practitioner - Primary Care Provider (PCP)											
Diaz Miguel Remigio Md	Practitioner - Primary Care Provider (PCP)											
Windle Edwin Robert Md	Practitioner - Primary Care Provider (PCP)											
Hawthorne Jami M	Practitioner - Primary Care Provider (PCP)											
Pizarro Glenn Md	Practitioner - Primary Care Provider (PCP)											

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Brasch Mary L Md	Practitioner - Primary Care Provider (PCP)											
Ali Shehzad	Practitioner - Primary Care Provider (PCP)											
Effendi Tahir	Practitioner - Primary Care Provider (PCP)											
Battu Vasantha Kumari	Practitioner - Primary Care Provider (PCP)											
Caruso Lori A	Practitioner - Primary Care Provider (PCP)											
Catalano Kathleen M Do	Practitioner - Primary Care Provider (PCP)											
Kostun William A Md	Practitioner - Primary Care Provider (PCP)											
Liljeberg Peter M Md	Practitioner - Primary Care Provider (PCP)											
Parikh Nita S	Practitioner - Primary Care Provider (PCP)											
Pica Laura E Md	Practitioner - Primary Care Provider (PCP)											
Sinchak Joseph Richard Md	Practitioner - Primary Care Provider (PCP)											
Albert Kevin Constantine Md	Practitioner - Primary Care Provider (PCP)											
Feygin Polina Md	Practitioner - Primary Care Provider (PCP)											
Kraev Igor Alexander Md	Practitioner - Primary Care Provider (PCP)											
Bidot Ramon Md	Practitioner - Primary Care Provider (PCP)											
Cirenza Emanuel Nicholas Md	Practitioner - Primary Care Provider (PCP)											
Kessler Robert Blake Md	Practitioner - Primary Care Provider (PCP)											
Azad Abul Kazam Md	Practitioner - Primary Care Provider (PCP)											
Kopff Heather S Do	Practitioner - Primary Care Provider (PCP)											
Graney Sheela Md	Practitioner - Primary Care Provider (PCP)											
Fatone Christopher T Md	Practitioner - Primary Care Provider (PCP)											
Letteriello Denise Do	Practitioner - Primary Care Provider (PCP)											
Santos Kristen A Do	Practitioner - Primary Care Provider (PCP)											
Wenacur Russell Md	Practitioner - Primary Care Provider (PCP)											
Grabovetsky Mikhail Md	Practitioner - Primary Care Provider (PCP)											
Smith Jane Patterson	Practitioner - Primary Care Provider (PCP)											
Cafiero Madeline R	Practitioner - Primary Care Provider (PCP)											
Caton Alice	Practitioner - Primary Care Provider (PCP)											
Casals Gail Jordan	Practitioner - Primary Care Provider (PCP)											
Cicchino Dennis	Practitioner - Primary Care Provider (PCP)											
Wilson James Henry Md	Practitioner - Primary Care Provider (PCP)											

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Gebhard Paul E Jr Md	Practitioner - Primary Care Provider (PCP)											
Merriman Joann	Practitioner - Primary Care Provider (PCP)											
Bala Virinchi	Practitioner - Primary Care Provider (PCP)											
Fera Frank	Practitioner - Primary Care Provider (PCP)											
Donohue Robert	Practitioner - Primary Care Provider (PCP)											
Byron Paul Joseph	Practitioner - Primary Care Provider (PCP)											
Dincer Yusuf M Md	Practitioner - Primary Care Provider (PCP)											
Gregorian Antonio Md	Practitioner - Primary Care Provider (PCP)											
Drzymalski Zofia Wanda Md	Practitioner - Primary Care Provider (PCP)											
Platzman Michael Do	Practitioner - Primary Care Provider (PCP)											
Gandham Vijaya L Md	Practitioner - Primary Care Provider (PCP)											
Robie Kristin	Practitioner - Primary Care Provider (PCP)											
Manzoor Sikander Md	Practitioner - Primary Care Provider (PCP)											
Gay Margaret Anne	Practitioner - Primary Care Provider (PCP)											
Carmody Janet Mary	Practitioner - Primary Care Provider (PCP)											
Cultrara Katherine Tanner	Practitioner - Primary Care Provider (PCP)											
Mccabe Megan	Practitioner - Primary Care Provider (PCP)											
Gomez-Di Cesare Caroline M Md	Practitioner - Primary Care Provider (PCP)											
Delaparte Marie Patricia	Practitioner - Primary Care Provider (PCP)											
Murphy Christine M Md	Practitioner - Primary Care Provider (PCP)											
Sam Olai V Md	Practitioner - Primary Care Provider (PCP)											
Schaeffer Michael Eric Md	Practitioner - Primary Care Provider (PCP)											
Chinyere Ofonagoro Physician Pllc	Practitioner - Primary Care Provider (PCP)											
Evans Stephanie B Md	Practitioner - Primary Care Provider (PCP)											
Collen Kimberly A Rpa	Practitioner - Primary Care Provider (PCP)											
Kowal William J Md	Practitioner - Primary Care Provider (PCP)											
Adonai Chisara Md	Practitioner - Primary Care Provider (PCP)											
Kaplan Irina Inna Md	Practitioner - Primary Care Provider (PCP)											
Pesquera Maria Margarita Md	Practitioner - Primary Care Provider (PCP)											
Gaston Shenelle R Md	Practitioner - Primary Care Provider (PCP)											
Zimring Debra Carol Md	Practitioner - Primary Care Provider (PCP)											

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Amirbekian Satik Md	Practitioner - Primary Care Provider (PCP)											
Brueggemann Christina Mchugh	Practitioner - Primary Care Provider (PCP)											
Denno Matthew L Md	Practitioner - Primary Care Provider (PCP)											
Mayott Catherine Kreyer	Practitioner - Primary Care Provider (PCP)											
Mead Daniel H Pa	Practitioner - Primary Care Provider (PCP)											
Reyes Juanito Antonio S Md	Practitioner - Primary Care Provider (PCP)											
Etzkorn Emily Md	Practitioner - Primary Care Provider (PCP)											
Petersen Lauris	Practitioner - Primary Care Provider (PCP)											
Tonneau Benoit Md	Practitioner - Primary Care Provider (PCP)											
Hoffman Darlene Joan	Practitioner - Primary Care Provider (PCP)											
Dyer-Martin Mary Kyle Do	Practitioner - Primary Care Provider (PCP)											
Cunningham Matthew Md	Practitioner - Primary Care Provider (PCP)											
Jorgensen Stephanie E Md	Practitioner - Primary Care Provider (PCP)											
Gupta Saaket Md	Practitioner - Primary Care Provider (PCP)											
Sherwood David Edward Md	Practitioner - Primary Care Provider (PCP)											
Aitken Geri Lynn Do	Practitioner - Primary Care Provider (PCP)											
Murphy Eileen	Practitioner - Primary Care Provider (PCP)											
Boka Suzanna P Md	Practitioner - Primary Care Provider (PCP)											
Palmieri Suzanne Do	Practitioner - Primary Care Provider (PCP)											
Shulof Jennifer Amy	Practitioner - Primary Care Provider (PCP)											
Price Darin Michael Md	Practitioner - Primary Care Provider (PCP)											
Hunter Philip Raymond Md	Practitioner - Primary Care Provider (PCP)											
Karatnycky Adrian Paul Md	Practitioner - Primary Care Provider (PCP)											
Ojukwu Ifeoma Clarissa Md	Practitioner - Primary Care Provider (PCP)											
Carrelle Raymond J Md	Practitioner - Primary Care Provider (PCP)											
Wise Birute Marija Md	Practitioner - Primary Care Provider (PCP)											
Lemons Lorraine S Do	Practitioner - Primary Care Provider (PCP)											
Gradner Jill A Md	Practitioner - Primary Care Provider (PCP)											
Conway Lillian Marie	Practitioner - Primary Care Provider (PCP)											
Brennan-Jordan Nancy	Practitioner - Primary Care Provider (PCP)											
Puthuparampil Beulah J Md	Practitioner - Primary Care Provider (PCP)											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Dooley Kevin M Md	Practitioner - Primary Care Provider (PCP)											
Eaton Carolyn A Md	Practitioner - Primary Care Provider (PCP)											
Stein Rhonda Danielle Md	Practitioner - Primary Care Provider (PCP)											
Braungart Carol Fritz	Practitioner - Primary Care Provider (PCP)											
Petraccione Lisa F Rpa	Practitioner - Primary Care Provider (PCP)											
Mcgarry Karen A Rpa	Practitioner - Primary Care Provider (PCP)											
Campbell Kathleen Kissane Rpa	Practitioner - Primary Care Provider (PCP)											
Denovio Bradley M Rpac	Practitioner - Primary Care Provider (PCP)											
Larner Virginia Blake Rpa	Practitioner - Primary Care Provider (PCP)											
Kasarda Karen Marie Rpa	Practitioner - Primary Care Provider (PCP)											
Greenblatt Michael J Md	Practitioner - Primary Care Provider (PCP)											
Coates Andrew Donnally Md	Practitioner - Primary Care Provider (PCP)											
Seaman Tami Md	Practitioner - Primary Care Provider (PCP)											
Santoro Carol Rinko Md	Practitioner - Primary Care Provider (PCP)											
Mirza Ali Y Md	Practitioner - Primary Care Provider (PCP)											
Smith Karen R	Practitioner - Primary Care Provider (PCP)											
Jacon Mary Grace	Practitioner - Primary Care Provider (PCP)											
Chakraborty Ranen Kumar Md	Practitioner - Primary Care Provider (PCP)											
Mantello Melinda A Md	Practitioner - Primary Care Provider (PCP)											
Peregrim Kimberly A Do	Practitioner - Primary Care Provider (PCP)											
Chan Cindy Hoying Md	Practitioner - Primary Care Provider (PCP)											
Luke Lynne Laura	Practitioner - Primary Care Provider (PCP)											
Navarro Brian Scott Md	Practitioner - Primary Care Provider (PCP)											
Kayayan Ara Md	Practitioner - Primary Care Provider (PCP)											
Gutnik Igor Md	Practitioner - Primary Care Provider (PCP)											
Decker Georgia M	Practitioner - Primary Care Provider (PCP)											
Duncan-Bornt Cynthia	Practitioner - Primary Care Provider (PCP)											
Hill Barbara	Practitioner - Primary Care Provider (PCP)											
Janowski Darcy A	Practitioner - Primary Care Provider (PCP)											
Lasker Susan	Practitioner - Primary Care Provider (PCP)											
O'Loughlin Suzanne	Practitioner - Primary Care Provider (PCP)											

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Olszewski Peter	Practitioner - Primary Care Provider (PCP)											
Rabbin Linda S	Practitioner - Primary Care Provider (PCP)											
Salmon Randie R	Practitioner - Primary Care Provider (PCP)											
Warner Deborah P	Practitioner - Primary Care Provider (PCP)											
Angert Victoria	Practitioner - Primary Care Provider (PCP)											
Roske Julia H Rpa	Practitioner - Primary Care Provider (PCP)											
Cunningham Fred B	Practitioner - Primary Care Provider (PCP)											
Sgarlata Donna L	Practitioner - Primary Care Provider (PCP)											
Wheeler Tammy H	Practitioner - Primary Care Provider (PCP)											
Nicholson Timothy Joseph	Practitioner - Primary Care Provider (PCP)											
Phelan Carol Beberwyk	Practitioner - Primary Care Provider (PCP)											
Bashant John Michael Md	Practitioner - Primary Care Provider (PCP)											
Kelly Judith Niederwerfer	Practitioner - Primary Care Provider (PCP)											
Kondo Kathleen	Practitioner - Primary Care Provider (PCP)											
Heffernan Donna Marie Md	Practitioner - Primary Care Provider (PCP)											
Cleney Holly K Md	Practitioner - Primary Care Provider (PCP)											
Gurrala Geetha Md	Practitioner - Primary Care Provider (PCP)											
Schaefer Donna J	Practitioner - Primary Care Provider (PCP)											
Kamerling Lisa Benay Md	Practitioner - Primary Care Provider (PCP)											
Cleveland Byrd Md	Practitioner - Primary Care Provider (PCP)											
Kim Regina Y Md	Practitioner - Primary Care Provider (PCP)											
Bogdanov Assen Petrov Md	Practitioner - Primary Care Provider (PCP)											
Daas Mamoon	Practitioner - Primary Care Provider (PCP)											
Tenenbaum Diane Cantor Md	Practitioner - Primary Care Provider (PCP)											
Glick Cheryl M	Practitioner - Primary Care Provider (PCP)											
Leroy Martha A	Practitioner - Primary Care Provider (PCP)											
Doherty-Wells Karen A	Practitioner - Primary Care Provider (PCP)											
Haldeman Iii Richard J	Practitioner - Primary Care Provider (PCP)											
Yadegari-Lewis Nasrene Md	Practitioner - Primary Care Provider (PCP)											
Lathers Susan E	Practitioner - Primary Care Provider (PCP)											
Reilly Marcelle J Do	Practitioner - Primary Care Provider (PCP)											

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Sherman Sherry D	Practitioner - Primary Care Provider (PCP)											
Venditti Thomas H Rpa	Practitioner - Primary Care Provider (PCP)											
Aragona Sharon L	Practitioner - Primary Care Provider (PCP)											
Brown Jean	Practitioner - Primary Care Provider (PCP)											
Gabay Michelle	Practitioner - Primary Care Provider (PCP)											
Riede Barbara	Practitioner - Primary Care Provider (PCP)											
Tolentino Rommel M Md	Practitioner - Primary Care Provider (PCP)											
Spindler John B Rpa	Practitioner - Primary Care Provider (PCP)											
Greenblatt Carol Lynn Do	Practitioner - Primary Care Provider (PCP)											
Mance Joan M	Practitioner - Primary Care Provider (PCP)											
Martin Kristen Hedger Md	Practitioner - Primary Care Provider (PCP)											
Lucchesi Allison Ruff Md	Practitioner - Primary Care Provider (PCP)											
Berman Jessica Dembitz Md	Practitioner - Primary Care Provider (PCP)											
Mazzei-Klokiw Renata N Md	Practitioner - Primary Care Provider (PCP)											
Campagna Kristine J Do	Practitioner - Primary Care Provider (PCP)											
Woodruff Barbara A Rpa	Practitioner - Primary Care Provider (PCP)											
Gildersleeve Rebecca Ann Md	Practitioner - Primary Care Provider (PCP)											
Kim Jai Md	Practitioner - Primary Care Provider (PCP)											
Barats Lev Leonidovich Md	Practitioner - Primary Care Provider (PCP)											
Mcgaffin Christina E	Practitioner - Primary Care Provider (PCP)											
D'Avella Wendy K	Practitioner - Primary Care Provider (PCP)											
Etienne Mineke Enola Md	Practitioner - Primary Care Provider (PCP)											
Horn Elizabeth C	Practitioner - Primary Care Provider (PCP)											
Irani Danesh S Rpa	Practitioner - Primary Care Provider (PCP)											
Hickey Lynn Leitner Md	Practitioner - Primary Care Provider (PCP)											
Compa Kristen Leigh Md	Practitioner - Primary Care Provider (PCP)											
Dalzell Melissa J Md	Practitioner - Primary Care Provider (PCP)											
Leonidas Leonard Al Md	Practitioner - Primary Care Provider (PCP)											
Ludwig Samantha Md	Practitioner - Primary Care Provider (PCP)											
Schwam Ariel Sergio Md	Practitioner - Primary Care Provider (PCP)											
Michelena Karen X	Practitioner - Primary Care Provider (PCP)											

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Pawlinga Christophe	Practitioner - Primary Care Provider (PCP)											
Pathirana Priyangika Atanikitha Md	Practitioner - Primary Care Provider (PCP)											
Hassan Syed Riaz Ul Md	Practitioner - Primary Care Provider (PCP)											
Steckley Renee E Rpa	Practitioner - Primary Care Provider (PCP)											
Rao Mohan Cn Md	Practitioner - Primary Care Provider (PCP)											
Hildreth Deborah A Rpa	Practitioner - Primary Care Provider (PCP)											
Winchester Susan B Np	Practitioner - Primary Care Provider (PCP)											
Stetzer Rebecca	Practitioner - Primary Care Provider (PCP)											
Kucij Lyn Irene Rpa	Practitioner - Primary Care Provider (PCP)											
Cruz Alan Md	Practitioner - Primary Care Provider (PCP)											
Saxena Shravan	Practitioner - Primary Care Provider (PCP)											
Madden Jeena Md	Practitioner - Primary Care Provider (PCP)											
Broderick Bethany Md	Practitioner - Primary Care Provider (PCP)											
Petrillo John M Md	Practitioner - Primary Care Provider (PCP)											
Callaghan Olin Rpa	Practitioner - Primary Care Provider (PCP)											
Burke Michael Kevin Md	Practitioner - Primary Care Provider (PCP)											
Hobbs Patricia	Practitioner - Primary Care Provider (PCP)											
Rodden Mary Np	Practitioner - Primary Care Provider (PCP)											
Auld Clara Stringer	Practitioner - Primary Care Provider (PCP)											
Morgan Ayman Md	Practitioner - Primary Care Provider (PCP)											
Sheridan Brian Md	Practitioner - Primary Care Provider (PCP)											
Osborn Kyle Thomas Md	Practitioner - Primary Care Provider (PCP)											
Berg Jonathan B Md	Practitioner - Primary Care Provider (PCP)											
Argubano Renee Arruira Md	Practitioner - Primary Care Provider (PCP)											
Mckinney Sue Peterson Rpa	Practitioner - Primary Care Provider (PCP)											
Wasniewski Holly L Md	Practitioner - Primary Care Provider (PCP)											
Vasquez Deborah A Md	Practitioner - Primary Care Provider (PCP)											
Bleser Karen Md	Practitioner - Primary Care Provider (PCP)											
Beauchamp Cara E Rpa	Practitioner - Primary Care Provider (PCP)											
Raveendranath Brooke A	Practitioner - Primary Care Provider (PCP)											
Salas Stephanie Ann Md	Practitioner - Primary Care Provider (PCP)											

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Habib Nazia Md	Practitioner - Primary Care Provider (PCP)											
Smith Marsha	Practitioner - Primary Care Provider (PCP)											
Hashemiyoon Rameen Md	Practitioner - Primary Care Provider (PCP)											
Foye-Petrillo Melissa Do	Practitioner - Primary Care Provider (PCP)											
Smitas Catherine Malone Md	Practitioner - Primary Care Provider (PCP)											
Lahtinen-Aley Kristina Marie Md	Practitioner - Primary Care Provider (PCP)											
Garbrecht Fred	Practitioner - Primary Care Provider (PCP)											
Betit Alan	Practitioner - Primary Care Provider (PCP)											
Cummings Walter D Do	Practitioner - Primary Care Provider (PCP)											
Madala Padmaja Md	Practitioner - Primary Care Provider (PCP)											
Derenzo Timothy	Practitioner - Primary Care Provider (PCP)											
Coelho Luiz	Practitioner - Primary Care Provider (PCP)											
Tera N Hetrick-Platte Md	Practitioner - Primary Care Provider (PCP)											
Colleen M Gassett Anp-C	Practitioner - Primary Care Provider (PCP)											
Schneider Nicole Marie	Practitioner - Primary Care Provider (PCP)											
Afroza Liton	Practitioner - Primary Care Provider (PCP)											
Oneill Rita Monica	Practitioner - Primary Care Provider (PCP)											
Dykstra Todd Bryan Rpa	Practitioner - Primary Care Provider (PCP)											
Stetzer Lee	Practitioner - Primary Care Provider (PCP)											
Martorana Sebastian Vincent	Practitioner - Primary Care Provider (PCP)											
Craig Maier	Practitioner - Primary Care Provider (PCP)											
Elguero Carlos	Practitioner - Primary Care Provider (PCP)											
Parveen Khukshid Md	Practitioner - Primary Care Provider (PCP)											
Nair Amita N Md	Practitioner - Primary Care Provider (PCP)											
Mahar Katherine Ellen	Practitioner - Primary Care Provider (PCP)											
Rehman Syed	Practitioner - Primary Care Provider (PCP)											
Mack Brigid	Practitioner - Primary Care Provider (PCP)											
Marshall Ryan	Practitioner - Primary Care Provider (PCP)											
Sheehan Rebecca	Practitioner - Primary Care Provider (PCP)											
Gabree Samara	Practitioner - Primary Care Provider (PCP)											
Rosenbaum Elena	Practitioner - Primary Care Provider (PCP)											

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Dollard Michael Anthony	Practitioner - Primary Care Provider (PCP)											
Gardner Nathan James Rpa	Practitioner - Primary Care Provider (PCP)											
Lopez Pablo	Practitioner - Primary Care Provider (PCP)											
Wachtmeister Erika Britt Md	Practitioner - Primary Care Provider (PCP)											
Norton Neal David Jr Rpa	Practitioner - Primary Care Provider (PCP)											
Vollmer Kelly J	Practitioner - Primary Care Provider (PCP)											
Rahman Abdul	Practitioner - Primary Care Provider (PCP)											
Rimmer Linda Marie Gawronski	Practitioner - Primary Care Provider (PCP)											
Louis Betina Dr.	Practitioner - Primary Care Provider (PCP)											
Lawyer Sarah Alicia Np	Practitioner - Primary Care Provider (PCP)											
Bowdy Michele Marie Trela	Practitioner - Primary Care Provider (PCP)											
Locke Elizabeth Anne Md	Practitioner - Primary Care Provider (PCP)											
Yen-Mancuso Sovonna Sintarea Rpa	Practitioner - Primary Care Provider (PCP)											
Afejuku-Adelaja Neema Roli Md	Practitioner - Primary Care Provider (PCP)											
Shelley M Gilbert	Practitioner - Primary Care Provider (PCP)											
Gagne Amy Lee	Practitioner - Primary Care Provider (PCP)											
Scarabino Karissa	Practitioner - Primary Care Provider (PCP)											
Cruz Faith	Practitioner - Primary Care Provider (PCP)											
Hang Kyu Park	Practitioner - Primary Care Provider (PCP)											
Barry Kelli Ann	Practitioner - Primary Care Provider (PCP)											
Nguyen Catherine Tuong Khanh Md	Practitioner - Primary Care Provider (PCP)											
Fish Erica Ann	Practitioner - Primary Care Provider (PCP)											
Lahey Barbara Jean	Practitioner - Primary Care Provider (PCP)											
Marks Elizabeth R Md	Practitioner - Primary Care Provider (PCP)											
Pachucki Kevin Christopher Rpa	Practitioner - Primary Care Provider (PCP)											
Keefer Jennifer Lynn	Practitioner - Primary Care Provider (PCP)											
Parker Dawne Louise	Practitioner - Primary Care Provider (PCP)											
Brilliant Rachelle I	Practitioner - Primary Care Provider (PCP)											
Wait Allison Jamie	Practitioner - Primary Care Provider (PCP)											
Yannetti Kristin	Practitioner - Primary Care Provider (PCP)											
Kanthal Marissa Loren	Practitioner - Primary Care Provider (PCP)											

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Brown Sheryl	Practitioner - Primary Care Provider (PCP)											
Sarwer Wafia	Practitioner - Primary Care Provider (PCP)											
Pedreira Denia	Practitioner - Primary Care Provider (PCP)											
Ramanathan Nalini	Practitioner - Primary Care Provider (PCP)											
Gowdara Divakara Murthy Md	Practitioner - Primary Care Provider (PCP)											
Saha Manish	Practitioner - Primary Care Provider (PCP)											
Alin Avi	Practitioner - Primary Care Provider (PCP)											
Wrzesinski Tamara Jennifer	Practitioner - Primary Care Provider (PCP)											
Rutter Ann	Practitioner - Primary Care Provider (PCP)											
Guptill Gloria G	Practitioner - Primary Care Provider (PCP)											
Barraclough Nancy L Np	Practitioner - Primary Care Provider (PCP)											
Dvorscak Amanda Jayne	Practitioner - Primary Care Provider (PCP)											
Cristalli Gaetano	Practitioner - Primary Care Provider (PCP)											
Veino Melissa J	Practitioner - Primary Care Provider (PCP)											
Lynch Meghan Margaret Jude	Practitioner - Primary Care Provider (PCP)											
Besong Alice	Practitioner - Primary Care Provider (PCP)											
Paul S Walter	Practitioner - Primary Care Provider (PCP)											
Young Linda	Practitioner - Primary Care Provider (PCP)											
Blanch Tanya Malka	Practitioner - Primary Care Provider (PCP)											
Shin Joong	Practitioner - Primary Care Provider (PCP)											
Brandow Ruth	Practitioner - Primary Care Provider (PCP)											
Matta Mandeep	Practitioner - Primary Care Provider (PCP)											
Clark Catherine Nielsen	Practitioner - Primary Care Provider (PCP)											
Lauren T Siy	Practitioner - Primary Care Provider (PCP)											
Stephanie Noyes	Practitioner - Primary Care Provider (PCP)											
Antohi Petronela	Practitioner - Primary Care Provider (PCP)											
Stracke Carsten Paul Md	Practitioner - Primary Care Provider (PCP)											
Valerie Thomas	Practitioner - Primary Care Provider (PCP)											
Ward Theresa Marie	Practitioner - Primary Care Provider (PCP)											
Wesselhoeft Karen Beth	Practitioner - Primary Care Provider (PCP)											
Rodriguez-Iglesias Realba	Practitioner - Primary Care Provider (PCP)											

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Mccrory Krisemily Anderson	Practitioner - Primary Care Provider (PCP)											
Cieszynski Veronica Eileen	Practitioner - Primary Care Provider (PCP)											
Mondelo Doreen Perez	Practitioner - Primary Care Provider (PCP)											
Montelone Kimberly Ann Np	Practitioner - Primary Care Provider (PCP)											
Searfoss Linda A	Practitioner - Primary Care Provider (PCP)											
Cunningham Jane M	Practitioner - Primary Care Provider (PCP)											
Cody Megan P	Practitioner - Primary Care Provider (PCP)											
Jeannie Ngygen	Practitioner - Primary Care Provider (PCP)											
Wilkinson Sarah Jane	Practitioner - Primary Care Provider (PCP)											
Snyder Ilona	Practitioner - Primary Care Provider (PCP)											
Colman David Lawrence	Practitioner - Primary Care Provider (PCP)											
Dunne Laurie Anne	Practitioner - Primary Care Provider (PCP)											
Clark Kristina Marie	Practitioner - Primary Care Provider (PCP)											
Nemith Lindsay Mumford	Practitioner - Primary Care Provider (PCP)											
Dumrese Danielle Lee	Practitioner - Primary Care Provider (PCP)											
Tumuluri Srilaxmi	Practitioner - Primary Care Provider (PCP)											
Romero-Demontero Cristina	Practitioner - Primary Care Provider (PCP)											
Ditursi Mary Kathleen Williams	Practitioner - Primary Care Provider (PCP)											
Tzoumas Vasilios	Practitioner - Primary Care Provider (PCP)											
Mary Patricia Shierly	Practitioner - Primary Care Provider (PCP)											
Khan Khyber	Practitioner - Primary Care Provider (PCP)											
Kennedy Karen Olsen	Practitioner - Primary Care Provider (PCP)											
Ronan Alisha Lynn	Practitioner - Primary Care Provider (PCP)											
Blatz Sarah J Pa	Practitioner - Primary Care Provider (PCP)											
Sajid Farah	Practitioner - Primary Care Provider (PCP)											
Dibble Colleen M	Practitioner - Primary Care Provider (PCP)											
Lawson Jessica L	Practitioner - Primary Care Provider (PCP)											
Li Jianyu	Practitioner - Primary Care Provider (PCP)											
Lariscy David	Practitioner - Primary Care Provider (PCP)											
Krass Jessica A	Practitioner - Primary Care Provider (PCP)											
Samuel Jency Thomas	Practitioner - Primary Care Provider (PCP)											

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Morgan Lacey Elizabeth	Practitioner - Primary Care Provider (PCP)											
Hennessy Elisa	Practitioner - Primary Care Provider (PCP)											
Rizzuto Michael J	Practitioner - Primary Care Provider (PCP)											
Sick Megan Mackenzie	Practitioner - Primary Care Provider (PCP)											
Meghani Mustafain	Practitioner - Primary Care Provider (PCP)											
Lieu Jason	Practitioner - Primary Care Provider (PCP)											
Mahon Hiromi Kimura	Practitioner - Primary Care Provider (PCP)											
Vachon Cary Ian	Practitioner - Primary Care Provider (PCP)											
Akinyede Olufemi	Practitioner - Primary Care Provider (PCP)											
Rose Jennifer	Practitioner - Primary Care Provider (PCP)											
Salei Inesa	Practitioner - Primary Care Provider (PCP)											
Van Amburgh Marilyn	Practitioner - Primary Care Provider (PCP)											
Laurent Yvenalie	Practitioner - Primary Care Provider (PCP)											
Millea Kerry	Practitioner - Primary Care Provider (PCP)											
Kuwitzky Kaitlin S	Practitioner - Primary Care Provider (PCP)											
Durosier Garry	Practitioner - Primary Care Provider (PCP)											
Bardin Susan	Practitioner - Primary Care Provider (PCP)											
Dolinsky Steven H	Practitioner - Primary Care Provider (PCP)											
Rodriguez-Jaquez Carlos R	Practitioner - Primary Care Provider (PCP)											
Majeed Mahvash	Practitioner - Primary Care Provider (PCP)											
Tatagari Jayasree	Practitioner - Primary Care Provider (PCP)											
Farrell Claudia Sales	Practitioner - Primary Care Provider (PCP)											
Aliggayu Darryl A	Practitioner - Primary Care Provider (PCP)											
Galarza Richard A	Practitioner - Primary Care Provider (PCP)											
Henson Jennifer T	Practitioner - Primary Care Provider (PCP)											
Chan York Sing	Practitioner - Primary Care Provider (PCP)											
Chauvin Rebecca L	Practitioner - Primary Care Provider (PCP)											
Bourne Claudianus H	Practitioner - Primary Care Provider (PCP)											
Quinn Barbara Hunter	Practitioner - Primary Care Provider (PCP)											
Sazon Tatiana	Practitioner - Primary Care Provider (PCP)											
Hanson Anne Catherine	Practitioner - Primary Care Provider (PCP)											

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Lammly Adam	Practitioner - Primary Care Provider (PCP)											
Lehman Geraldine Mary	Practitioner - Primary Care Provider (PCP)											
Muhammad Rahshon	Practitioner - Primary Care Provider (PCP)											
Sheaffer Margaret A	Practitioner - Primary Care Provider (PCP)											
Schneiderheinze Michelle L	Practitioner - Primary Care Provider (PCP)											
Mack Kristin Lake	Practitioner - Primary Care Provider (PCP)											
Karyn Marie Hughes	Practitioner - Primary Care Provider (PCP)											
Torre Jenny Ann	Practitioner - Primary Care Provider (PCP)											
Kohanski Dawn M	Practitioner - Primary Care Provider (PCP)											
Bossolini Marybeth M	Practitioner - Primary Care Provider (PCP)											
Bindlish Shagun	Practitioner - Primary Care Provider (PCP)											
Delamater Jeffrey T	Practitioner - Primary Care Provider (PCP)											
Yu Alice	Practitioner - Primary Care Provider (PCP)											
Rhude Kathryn	Practitioner - Primary Care Provider (PCP)											
Lundy Lauren	Practitioner - Primary Care Provider (PCP)											
Forman Peter Howard Md	Practitioner - Primary Care Provider (PCP)											
Cooke Kristin	Practitioner - Primary Care Provider (PCP)											
Itabor Azuka Stephen	Practitioner - Primary Care Provider (PCP)											
Elliott Rebecca Lynne Md	Practitioner - Primary Care Provider (PCP)											
Rehman Hafeez U Md	Practitioner - Primary Care Provider (PCP)											
Potratz Meagan A	Practitioner - Primary Care Provider (PCP)											
Akhtar Naveed M	Practitioner - Primary Care Provider (PCP)											
Ya Winkler Annie Chen	Practitioner - Primary Care Provider (PCP)											
Cheruiyot Wendy	Practitioner - Primary Care Provider (PCP)											
Adetona Adetutu Basirat Md	Practitioner - Primary Care Provider (PCP)											
Kasbekar Vishwala	Practitioner - Primary Care Provider (PCP)											
Ethier Gloria	Practitioner - Primary Care Provider (PCP)											
Espinoso Cristine Maria	Practitioner - Primary Care Provider (PCP)											
Kausel Ana Maria	Practitioner - Primary Care Provider (PCP)											
Jaffrey Ira S Facp Md	Practitioner - Non-Primary Care Provider (PCP)											
Nicholson John M W Md	Practitioner - Non-Primary Care Provider (PCP)											

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Ford Jockular B Pc Md	Practitioner - Non-Primary Care Provider (PCP)											
Odabashian Harry C Md	Practitioner - Non-Primary Care Provider (PCP)											
Kosinski Norbert Dpm	Practitioner - Non-Primary Care Provider (PCP)											
Rosenberg Stuart A Md	Practitioner - Non-Primary Care Provider (PCP)											
Rockwell David R Md	Practitioner - Non-Primary Care Provider (PCP)											
Schwartz Kenneth D Pc Dds	Practitioner - Non-Primary Care Provider (PCP)											
Storm Fred Charles Md	Practitioner - Non-Primary Care Provider (PCP)											
Naveh Marcia Spiegel Md	Practitioner - Non-Primary Care Provider (PCP)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Beer Yoram Md	Practitioner - Non-Primary Care Provider (PCP)											
Menzel Charles H Md	Practitioner - Non-Primary Care Provider (PCP)											
Gort Dennis A Md	Practitioner - Non-Primary Care Provider (PCP)											
Syed Iftikhar A Fasc General	Practitioner - Non-Primary Care Provider (PCP)											
Miller Nelson L Md	Practitioner - Non-Primary Care Provider (PCP)											
Hennessey William J Md Pc	Practitioner - Non-Primary Care Provider (PCP)											
Strosberg James Mark Md	Practitioner - Non-Primary Care Provider (PCP)											
Fabregas Ramon Md	Practitioner - Non-Primary Care Provider (PCP)											
Corbett Lawrence P Md	Practitioner - Non-Primary Care Provider (PCP)											
Lanka John Thomas Dds	Practitioner - Non-Primary Care Provider (PCP)											
Bruce David H Md	Practitioner - Non-Primary Care Provider (PCP)											
Mesch John C Md	Practitioner - Non-Primary Care Provider (PCP)											
Engelstein Martin S Md	Practitioner - Non-Primary Care Provider (PCP)											
Irwin Robert W Md	Practitioner - Non-Primary Care Provider (PCP)											
Wright Gordon L Dds	Practitioner - Non-Primary Care Provider (PCP)											
Ghazi Moghadam M R Md	Practitioner - Non-Primary Care Provider (PCP)											
Zornow David H Md	Practitioner - Non-Primary Care Provider (PCP)											
Sandak William J Dds	Practitioner - Non-Primary Care Provider (PCP)											
Cretella Alfred J Md	Practitioner - Non-Primary Care Provider (PCP)											
Makarachi Ahad Md	Practitioner - Non-Primary Care Provider (PCP)											
Valero Maximo B Jr Md	Practitioner - Non-Primary Care Provider (PCP)											
Brooks Richard B Md	Practitioner - Non-Primary Care Provider (PCP)											
Huggins Eustace A Md	Practitioner - Non-Primary Care Provider (PCP)											

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Bartoletti Albert L Md	Practitioner - Non-Primary Care Provider (PCP)											
Lindenberg Barry Scott Md	Practitioner - Non-Primary Care Provider (PCP)											
Nakao Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Sinensky Gary B Md	Practitioner - Non-Primary Care Provider (PCP)											
Sharma Perumunda Krishna Md	Practitioner - Non-Primary Care Provider (PCP)											
Ferrary Susan C Md	Practitioner - Non-Primary Care Provider (PCP)											
Marar Hani G Md	Practitioner - Non-Primary Care Provider (PCP)											
Reiter Paul Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Dworkin Paul Md	Practitioner - Non-Primary Care Provider (PCP)											
Ninan Oommen Md	Practitioner - Non-Primary Care Provider (PCP)											
Rosman Paul Martin Do	Practitioner - Non-Primary Care Provider (PCP)											
Bruce Melody A Md	Practitioner - Non-Primary Care Provider (PCP)											
Sattar Fouad A Md Pc	Practitioner - Non-Primary Care Provider (PCP)											
Kaufman Stephen Md	Practitioner - Non-Primary Care Provider (PCP)											
Lader Ellis Wayne Md	Practitioner - Non-Primary Care Provider (PCP)											
Desantis Jonathan M Md	Practitioner - Non-Primary Care Provider (PCP)											
Vacca William M Md	Practitioner - Non-Primary Care Provider (PCP)											
Baran Andrij Ostap Dimitry Md	Practitioner - Non-Primary Care Provider (PCP)											
Geehr Robert B Md	Practitioner - Non-Primary Care Provider (PCP)											
Ellis David A Md	Practitioner - Non-Primary Care Provider (PCP)											
Spurgas Paul Edward Md	Practitioner - Non-Primary Care Provider (PCP)											
Knudsen Nancy Slezak Md	Practitioner - Non-Primary Care Provider (PCP)											
Sokol Harold Marc Md	Practitioner - Non-Primary Care Provider (PCP)											
Gebert John Kevin Md	Practitioner - Non-Primary Care Provider (PCP)											
Braim Timothy E Od	Practitioner - Non-Primary Care Provider (PCP)											
Perumal Kandasamychetty Md	Practitioner - Non-Primary Care Provider (PCP)											
Elacqua Mary S	Practitioner - Non-Primary Care Provider (PCP)											
Atkins Carl D Md	Practitioner - Non-Primary Care Provider (PCP)											
Cecil Russell N A Md	Practitioner - Non-Primary Care Provider (PCP)											
Saran Brij Mohan Md	Practitioner - Non-Primary Care Provider (PCP)											
Kratzer Joseph Harold Md	Practitioner - Non-Primary Care Provider (PCP)											

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Bloomfield Naomi Terry Md	Practitioner - Non-Primary Care Provider (PCP)											
Hannan Edward Joseph Md	Practitioner - Non-Primary Care Provider (PCP)											
Warheit Andrew Md	Practitioner - Non-Primary Care Provider (PCP)											
Zakariyya Hasan Md	Practitioner - Non-Primary Care Provider (PCP)											
Jaffe Joshua Md	Practitioner - Non-Primary Care Provider (PCP)											
Smith Steven P Md	Practitioner - Non-Primary Care Provider (PCP)											
Woodhouse Richard Phd	Practitioner - Non-Primary Care Provider (PCP)											
Sunkin Arthur L Md	Practitioner - Non-Primary Care Provider (PCP)											
Troitino Anthony Md	Practitioner - Non-Primary Care Provider (PCP)											
Parkes Robert J Md	Practitioner - Non-Primary Care Provider (PCP)											
Parikh Dineshkant N	Practitioner - Non-Primary Care Provider (PCP)											
Castro Carlos A Md	Practitioner - Non-Primary Care Provider (PCP)											
Del Russo Timothy C Md	Practitioner - Non-Primary Care Provider (PCP)											
Finn Daniel Joseph Md	Practitioner - Non-Primary Care Provider (PCP)											
Phillips Roland Turner Md	Practitioner - Non-Primary Care Provider (PCP)											
Hogan William James Dds	Practitioner - Non-Primary Care Provider (PCP)											
Mitta Srinivas Rao Md	Practitioner - Non-Primary Care Provider (PCP)											
Mishkin Jonathan Md	Practitioner - Non-Primary Care Provider (PCP)											
Manor Denis P Md	Practitioner - Non-Primary Care Provider (PCP)											
Heasley Paul Edward Md	Practitioner - Non-Primary Care Provider (PCP)											
Gunther Andrew George Md	Practitioner - Non-Primary Care Provider (PCP)											
Parsley Lawrence J Md Jr	Practitioner - Non-Primary Care Provider (PCP)											
Cowen Edwin Alan Md	Practitioner - Non-Primary Care Provider (PCP)											
Coplin Bruce Evan Md	Practitioner - Non-Primary Care Provider (PCP)											
Liebers David Md	Practitioner - Non-Primary Care Provider (PCP)											
Passaretti Zachary Hobart Md	Practitioner - Non-Primary Care Provider (PCP)											
Cagino Anthony John Md	Practitioner - Non-Primary Care Provider (PCP)											
Laity Sandra Ann Dpm	Practitioner - Non-Primary Care Provider (PCP)											
Palat David S Md	Practitioner - Non-Primary Care Provider (PCP)											
Silk Yusuf Nuruddin Md	Practitioner - Non-Primary Care Provider (PCP)											
Muller Reid Thomas Md	Practitioner - Non-Primary Care Provider (PCP)											

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Marmulstein Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Cohen Gary S Md	Practitioner - Non-Primary Care Provider (PCP)											
Abelseth Jill M Md	Practitioner - Non-Primary Care Provider (PCP)											
Kapuscinska Barbara Md	Practitioner - Non-Primary Care Provider (PCP)											
Lovely Thomas John Md	Practitioner - Non-Primary Care Provider (PCP)											
Feinstein Ralph Steven Md	Practitioner - Non-Primary Care Provider (PCP)											
Ford Patricia Ann Md	Practitioner - Non-Primary Care Provider (PCP)											
Sarmiento Augusto Salvosa	Practitioner - Non-Primary Care Provider (PCP)											
Hughes Stephen Arnold Md	Practitioner - Non-Primary Care Provider (PCP)											
Schrom Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Rattner Robert Michael Md	Practitioner - Non-Primary Care Provider (PCP)											
Ifudu Onyekachi Md	Practitioner - Non-Primary Care Provider (PCP)											
Jordan Mark Md	Practitioner - Non-Primary Care Provider (PCP)											
Turi Anthony R Md	Practitioner - Non-Primary Care Provider (PCP)											
Savage Duncan E Md	Practitioner - Non-Primary Care Provider (PCP)											
Rowley Richard F Md	Practitioner - Non-Primary Care Provider (PCP)											
Charland James M Md	Practitioner - Non-Primary Care Provider (PCP)											
Figge James J Md Mba	Practitioner - Non-Primary Care Provider (PCP)											
Casler Susan E	Practitioner - Non-Primary Care Provider (PCP)											
Basso Deborah Md	Practitioner - Non-Primary Care Provider (PCP)											
Kandath David D Md	Practitioner - Non-Primary Care Provider (PCP)											
Heysler Rebecca A Np	Practitioner - Non-Primary Care Provider (PCP)											
Carrozza Claire Chenette	Practitioner - Non-Primary Care Provider (PCP)											
Hennessy Carol S	Practitioner - Non-Primary Care Provider (PCP)											
Khair Mohammed Dds	Practitioner - Non-Primary Care Provider (PCP)											
Fisher William Thomas Md	Practitioner - Non-Primary Care Provider (PCP)											
Genovese Frank L Md	Practitioner - Non-Primary Care Provider (PCP)											
Barrowman Roger A Md	Practitioner - Non-Primary Care Provider (PCP)											
Sosnow Peter Lewis Md	Practitioner - Non-Primary Care Provider (PCP)											
Dachs Robert J Md	Practitioner - Non-Primary Care Provider (PCP)											
Campbell Robert J Md	Practitioner - Non-Primary Care Provider (PCP)											

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Galati James Edward Dds	Practitioner - Non-Primary Care Provider (PCP)											
Frank Michael Jr Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Nijjar Gurkirpal S Md	Practitioner - Non-Primary Care Provider (PCP)											
Strumpf David A Md	Practitioner - Non-Primary Care Provider (PCP)											
Gold Louis Harold Md	Practitioner - Non-Primary Care Provider (PCP)											
Castillo Sergio Augusto Md	Practitioner - Non-Primary Care Provider (PCP)											
Biggers Ellen Marie Md	Practitioner - Non-Primary Care Provider (PCP)											
Patacsil Domiciano P Jr Md	Practitioner - Non-Primary Care Provider (PCP)											
Phillip James L Md	Practitioner - Non-Primary Care Provider (PCP)											
Dweck Laurie Jo	Practitioner - Non-Primary Care Provider (PCP)											
Peterson Charles Craig Md	Practitioner - Non-Primary Care Provider (PCP)											
Roccario Eric Stephen Md	Practitioner - Non-Primary Care Provider (PCP)											
Vassolas George A Md	Practitioner - Non-Primary Care Provider (PCP)											
Mehta Pankaj Md	Practitioner - Non-Primary Care Provider (PCP)											
Reddy Suguna C	Practitioner - Non-Primary Care Provider (PCP)											
Esper Daniel William Md	Practitioner - Non-Primary Care Provider (PCP)											
Margono Franz Md	Practitioner - Non-Primary Care Provider (PCP)											
Reilly Michael J Md	Practitioner - Non-Primary Care Provider (PCP)											
O'Brien Jerald R Md	Practitioner - Non-Primary Care Provider (PCP)											
Card Harold George Md	Practitioner - Non-Primary Care Provider (PCP)											
Patel Shailesh Rasiklal Md Pc	Practitioner - Non-Primary Care Provider (PCP)											
East Hudson Oral And Maxillofacial	Practitioner - Non-Primary Care Provider (PCP)											
Brown Kevin R Md	Practitioner - Non-Primary Care Provider (PCP)											
Khandaker Dilara Zabeen Md	Practitioner - Non-Primary Care Provider (PCP)											
Yee Lily Fong Cho Md	Practitioner - Non-Primary Care Provider (PCP)											
Ratner Lee Mark Md	Practitioner - Non-Primary Care Provider (PCP)											
Prasad Chittaranjan Md	Practitioner - Non-Primary Care Provider (PCP)											
Rappaport Steven S Md	Practitioner - Non-Primary Care Provider (PCP)											
Cospito Peter D Md	Practitioner - Non-Primary Care Provider (PCP)											
Narkewicz Karen J Md	Practitioner - Non-Primary Care Provider (PCP)											
Friscia Marisa Md	Practitioner - Non-Primary Care Provider (PCP)											

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Nocilla Frank John Md	Practitioner - Non-Primary Care Provider (PCP)											
Martinelli Michael J Md	Practitioner - Non-Primary Care Provider (PCP)											
Schleiger Laurie Ann Pt	Practitioner - Non-Primary Care Provider (PCP)											
Sosa-Suarez Guillermo Eduardo	Practitioner - Non-Primary Care Provider (PCP)											
Crisafulli Kathleen M Md	Practitioner - Non-Primary Care Provider (PCP)											
Gillman David John	Practitioner - Non-Primary Care Provider (PCP)											
Niedzwiadek Walter Md	Practitioner - Non-Primary Care Provider (PCP)											
Hutchins Tara M	Practitioner - Non-Primary Care Provider (PCP)											
Butterfield Kelly D	Practitioner - Non-Primary Care Provider (PCP)											
Williams David C	Practitioner - Non-Primary Care Provider (PCP)											
Ortiz Gerald James Md	Practitioner - Non-Primary Care Provider (PCP)											
Dhingra Arun K Md	Practitioner - Non-Primary Care Provider (PCP)											
Almonte Oscar Foz Md	Practitioner - Non-Primary Care Provider (PCP)											
Syed Zainul-Abideen Md	Practitioner - Non-Primary Care Provider (PCP)											
Van Bellingham Heidi Md	Practitioner - Non-Primary Care Provider (PCP)											
Shuman Barry A Md	Practitioner - Non-Primary Care Provider (PCP)											
Ravi Natarajan Md	Practitioner - Non-Primary Care Provider (PCP)											
King Kevin Md	Practitioner - Non-Primary Care Provider (PCP)											
Farooq Joseph Md	Practitioner - Non-Primary Care Provider (PCP)											
Wright Laurie Grace	Practitioner - Non-Primary Care Provider (PCP)											
Cristiani Christine	Practitioner - Non-Primary Care Provider (PCP)											
Sharfstein Sophia Ratushny Md	Practitioner - Non-Primary Care Provider (PCP)											
Sung Steve C Md	Practitioner - Non-Primary Care Provider (PCP)											
Obrien Michael J Md	Practitioner - Non-Primary Care Provider (PCP)											
Kermani Sirus Asky Md	Practitioner - Non-Primary Care Provider (PCP)											
Bernstein Jeffrey P Md	Practitioner - Non-Primary Care Provider (PCP)											
Diana Mary G Md	Practitioner - Non-Primary Care Provider (PCP)											
Anyaegbunam William I Md	Practitioner - Non-Primary Care Provider (PCP)											
Reddy Sarada Modugu Md	Practitioner - Non-Primary Care Provider (PCP)											
Reich Herbert Md	Practitioner - Non-Primary Care Provider (PCP)											
Kufs William Michael Md	Practitioner - Non-Primary Care Provider (PCP)											

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Herrmannsdoerfer Axel J Md	Practitioner - Non-Primary Care Provider (PCP)											
Ferrera Peter Charles Md	Practitioner - Non-Primary Care Provider (PCP)											
Baumkirchner Irene	Practitioner - Non-Primary Care Provider (PCP)											
Dimova Aneta Kosta Md	Practitioner - Non-Primary Care Provider (PCP)											
Millett Jeanne Marie	Practitioner - Non-Primary Care Provider (PCP)											
Barkowski Nancy Ann C Md	Practitioner - Non-Primary Care Provider (PCP)											
Rapisarda Sergio Vito Md	Practitioner - Non-Primary Care Provider (PCP)											
Cassin Ruth A	Practitioner - Non-Primary Care Provider (PCP)											
Butz Jr. Robert A	Practitioner - Non-Primary Care Provider (PCP)											
Byrne Coccetti Kelly A	Practitioner - Non-Primary Care Provider (PCP)											
Clements Philip C	Practitioner - Non-Primary Care Provider (PCP)											
Danskin Lesley A Md	Practitioner - Non-Primary Care Provider (PCP)											
Jajoor Nagaraj O	Practitioner - Non-Primary Care Provider (PCP)											
Lavigne Gregory L Md	Practitioner - Non-Primary Care Provider (PCP)											
Malerba Robert Fortune Ii	Practitioner - Non-Primary Care Provider (PCP)											
Nordhauser Micaela Urbano	Practitioner - Non-Primary Care Provider (PCP)											
Roldan Ernesto	Practitioner - Non-Primary Care Provider (PCP)											
Root Jeffrey R	Practitioner - Non-Primary Care Provider (PCP)											
Wolner Ron K	Practitioner - Non-Primary Care Provider (PCP)											
Chang Theodore Tuan Md	Practitioner - Non-Primary Care Provider (PCP)											
Taccad-Reyes Sandra Carlos Md	Practitioner - Non-Primary Care Provider (PCP)											
Aronson Cynthia L Csw	Practitioner - Non-Primary Care Provider (PCP)											
Rogge Scott W Md	Practitioner - Non-Primary Care Provider (PCP)											
Ashley Kenneth F Md	Practitioner - Non-Primary Care Provider (PCP)											
Patterson-Marshall Bridget Md	Practitioner - Non-Primary Care Provider (PCP)											
Fedullo John Lewis Do	Practitioner - Non-Primary Care Provider (PCP)											
Laregina Victor G Md	Practitioner - Non-Primary Care Provider (PCP)											
Rapoport Robert J Md	Practitioner - Non-Primary Care Provider (PCP)											
Maloney Cynthia M	Practitioner - Non-Primary Care Provider (PCP)											
Kondo Nicholas Ivan	Practitioner - Non-Primary Care Provider (PCP)											
Goyer Richard Paul Jr Md	Practitioner - Non-Primary Care Provider (PCP)											

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Kurtz Bryan E Md	Practitioner - Non-Primary Care Provider (PCP)											
De Lair Paula Crehan	Practitioner - Non-Primary Care Provider (PCP)											
Czerwinski Maria H Md	Practitioner - Non-Primary Care Provider (PCP)											
Block-Galarza Jessie A Md	Practitioner - Non-Primary Care Provider (PCP)											
Bourke Diane A Md	Practitioner - Non-Primary Care Provider (PCP)											
Vinsel Paul J	Practitioner - Non-Primary Care Provider (PCP)											
Burky Christophe	Practitioner - Non-Primary Care Provider (PCP)											
Stracke Lothar	Practitioner - Non-Primary Care Provider (PCP)											
Hajar Marilyn	Practitioner - Non-Primary Care Provider (PCP)											
Banson Martin L Md	Practitioner - Non-Primary Care Provider (PCP)											
Pratt Stephen Randal Md	Practitioner - Non-Primary Care Provider (PCP)											
Levine Carolyn Robbins	Practitioner - Non-Primary Care Provider (PCP)											
Ross Donald Md	Practitioner - Non-Primary Care Provider (PCP)											
Axford James P Jr Md	Practitioner - Non-Primary Care Provider (PCP)											
Tompkins Raymonda	Practitioner - Non-Primary Care Provider (PCP)											
Baker Kenneth J Md	Practitioner - Non-Primary Care Provider (PCP)											
Khan Tarekul H Md	Practitioner - Non-Primary Care Provider (PCP)											
Mccormack Thomas M Md	Practitioner - Non-Primary Care Provider (PCP)											
Maslack Bruce	Practitioner - Non-Primary Care Provider (PCP)											
Holcomb Margaret Isabelle Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Olkowski Piotr K Md	Practitioner - Non-Primary Care Provider (PCP)											
Morris Adrian Anthony Md	Practitioner - Non-Primary Care Provider (PCP)											
Cavoli Salvatore Richard	Practitioner - Non-Primary Care Provider (PCP)											
Nardacci Elizabeth Anne	Practitioner - Non-Primary Care Provider (PCP)											
Gordon Brian M Md	Practitioner - Non-Primary Care Provider (PCP)											
Peters Robert Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Soscia Gina Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Toole Nancy E Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Duda Lawrence	Practitioner - Non-Primary Care Provider (PCP)											
Kreienberg Suzanne E Md	Practitioner - Non-Primary Care Provider (PCP)											
Weitz Steven H Md	Practitioner - Non-Primary Care Provider (PCP)											

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Cameron Jefrey Stuart Pa	Practitioner - Non-Primary Care Provider (PCP)											
Midani Hani Al	Practitioner - Non-Primary Care Provider (PCP)											
Mcpadden Marion C Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Klim Kathleen	Practitioner - Non-Primary Care Provider (PCP)											
Ashley Christopher Charles Md	Practitioner - Non-Primary Care Provider (PCP)											
Smith-Booth Brenda Karen	Practitioner - Non-Primary Care Provider (PCP)											
Rao Leela	Practitioner - Non-Primary Care Provider (PCP)											
Clark Denise C Md	Practitioner - Non-Primary Care Provider (PCP)											
Stipano Melissa Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Pallis Evangelos N Md	Practitioner - Non-Primary Care Provider (PCP)											
Mcconnell Theresa Marie	Practitioner - Non-Primary Care Provider (PCP)											
Prieto Alfonso Francisco Jose	Practitioner - Non-Primary Care Provider (PCP)											
Pradhan Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Murray Colleen Diane	Practitioner - Non-Primary Care Provider (PCP)											
Lamoutte Kathryn	Practitioner - Non-Primary Care Provider (PCP)											
Nichols Joel Lawrence Dpm	Practitioner - Non-Primary Care Provider (PCP)											
Usow Mark H Md	Practitioner - Non-Primary Care Provider (PCP)											
Mazur Tatiana V Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Ryan Sean Patrick Md	Practitioner - Non-Primary Care Provider (PCP)											
Petitti Nicola Md	Practitioner - Non-Primary Care Provider (PCP)											
Watson Dottie L Md	Practitioner - Non-Primary Care Provider (PCP)											
Silvernail Donna L Pa	Practitioner - Non-Primary Care Provider (PCP)											
Gulyanich Taras M Rn	Practitioner - Non-Primary Care Provider (PCP)											
Dempsey Stephen J Md	Practitioner - Non-Primary Care Provider (PCP)											
O'Brien Maureen	Practitioner - Non-Primary Care Provider (PCP)											
Halpert Jonathan S Md	Practitioner - Non-Primary Care Provider (PCP)											
Nardin Gary Steven Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Aiossa Jennifer Ann	Practitioner - Non-Primary Care Provider (PCP)											
Basavaraju Nerlige G	Practitioner - Non-Primary Care Provider (PCP)											
Knapp Robin Gail Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Fabre Lynn D	Practitioner - Non-Primary Care Provider (PCP)											

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Rock Kerrith	Practitioner - Non-Primary Care Provider (PCP)											
Clancy Maureen	Practitioner - Non-Primary Care Provider (PCP)											
Bae Jina Md	Practitioner - Non-Primary Care Provider (PCP)											
Khan Abdul Suneel Md	Practitioner - Non-Primary Care Provider (PCP)											
Dorflinger Joseph Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Duncan Ethel B	Practitioner - Non-Primary Care Provider (PCP)											
Haff Margret C	Practitioner - Non-Primary Care Provider (PCP)											
Murray Brian P	Practitioner - Non-Primary Care Provider (PCP)											
Bishop Gregory C Md	Practitioner - Non-Primary Care Provider (PCP)											
Singh Chanderdeep Md	Practitioner - Non-Primary Care Provider (PCP)											
Voorhees Luann Marie	Practitioner - Non-Primary Care Provider (PCP)											
Salanger Stephanie A Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Suna Carla Joyce	Practitioner - Non-Primary Care Provider (PCP)											
Hirt Deborah	Practitioner - Non-Primary Care Provider (PCP)											
Allen Christine	Practitioner - Non-Primary Care Provider (PCP)											
Goldberg Craig R Md	Practitioner - Non-Primary Care Provider (PCP)											
Hyde Natalie Ann	Practitioner - Non-Primary Care Provider (PCP)											
Fairbank Matthew K Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Brown Linda S Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Gara Maureen	Practitioner - Non-Primary Care Provider (PCP)											
Chank Shelly M	Practitioner - Non-Primary Care Provider (PCP)											
Gabriel Nancy	Practitioner - Non-Primary Care Provider (PCP)											
Griffin Margaret Anne	Practitioner - Non-Primary Care Provider (PCP)											
Gendron Kim Retell	Practitioner - Non-Primary Care Provider (PCP)											
Matties Regina K	Practitioner - Non-Primary Care Provider (PCP)											
Yamin Mary Christine	Practitioner - Non-Primary Care Provider (PCP)											
Zampier Alison A	Practitioner - Non-Primary Care Provider (PCP)											
Johnson Alan J	Practitioner - Non-Primary Care Provider (PCP)											
Dorney Patricia Mary Md	Practitioner - Non-Primary Care Provider (PCP)											
Kutzer William M	Practitioner - Non-Primary Care Provider (PCP)											
Thornton Allen	Practitioner - Non-Primary Care Provider (PCP)											

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Keefe John P	Practitioner - Non-Primary Care Provider (PCP)											
Dare Ian D Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Silber Dennis I Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Conard Joanna L	Practitioner - Non-Primary Care Provider (PCP)											
Zlotnick Joan C	Practitioner - Non-Primary Care Provider (PCP)											
Hosterman Kandy L	Practitioner - Non-Primary Care Provider (PCP)											
Dluge-Aungst Dawn B Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Carlin Christophe S	Practitioner - Non-Primary Care Provider (PCP)											
Syta Cheryl Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Berkery Leah Rebecca Md	Practitioner - Non-Primary Care Provider (PCP)											
Somoza Clara Emma Md	Practitioner - Non-Primary Care Provider (PCP)											
Yunker Cathy	Practitioner - Non-Primary Care Provider (PCP)											
Martin David	Practitioner - Non-Primary Care Provider (PCP)											
Kim Alice Y Md	Practitioner - Non-Primary Care Provider (PCP)											
Lynch William P Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Joy Robert A Md	Practitioner - Non-Primary Care Provider (PCP)											
Ismail Mahmoud Ismail Md	Practitioner - Non-Primary Care Provider (PCP)											
Corcoran Vincent A Md	Practitioner - Non-Primary Care Provider (PCP)											
Krisa John Md	Practitioner - Non-Primary Care Provider (PCP)											
091645951cleary Daniel G	Practitioner - Non-Primary Care Provider (PCP)											
Pericak Arlene	Practitioner - Non-Primary Care Provider (PCP)											
Butler Renita Danette Md	Practitioner - Non-Primary Care Provider (PCP)											
Pandya Tejas Ramesh Dpm	Practitioner - Non-Primary Care Provider (PCP)											
Priola Margaret E	Practitioner - Non-Primary Care Provider (PCP)											
Miles Matthew James Md	Practitioner - Non-Primary Care Provider (PCP)											
Montalto Nicholas J Jr Md	Practitioner - Non-Primary Care Provider (PCP)											
Clausi Robert Lambert	Practitioner - Non-Primary Care Provider (PCP)											
Esperti Angela M	Practitioner - Non-Primary Care Provider (PCP)											
Flaherty Maureen P	Practitioner - Non-Primary Care Provider (PCP)											
Naumowicz Edward T	Practitioner - Non-Primary Care Provider (PCP)											
Stiller Jamie M	Practitioner - Non-Primary Care Provider (PCP)											

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Burke Jessica Narr Phd	Practitioner - Non-Primary Care Provider (PCP)											
Sebastian Michael	Practitioner - Non-Primary Care Provider (PCP)											
Coleman Kenneth Md	Practitioner - Non-Primary Care Provider (PCP)											
Gregg Michael	Practitioner - Non-Primary Care Provider (PCP)											
Murray Sherrie L	Practitioner - Non-Primary Care Provider (PCP)											
Benjamin Anthony P Md	Practitioner - Non-Primary Care Provider (PCP)											
Loffredo Barry Dds	Practitioner - Non-Primary Care Provider (PCP)											
Mcdermott Patrick F Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Porter Jean E	Practitioner - Non-Primary Care Provider (PCP)											
Sheehan Kelly L	Practitioner - Non-Primary Care Provider (PCP)											
Gorman Michael A	Practitioner - Non-Primary Care Provider (PCP)											
Mcgrann Ellen Mary Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Platis Pamela Anne	Practitioner - Non-Primary Care Provider (PCP)											
Risdell Dennis P	Practitioner - Non-Primary Care Provider (PCP)											
Rand Carolyn Christine Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Lynch Kevin W	Practitioner - Non-Primary Care Provider (PCP)											
Stoecklin William	Practitioner - Non-Primary Care Provider (PCP)											
Yash Jeffrey V Pt	Practitioner - Non-Primary Care Provider (PCP)											
Villacorta-Pasco Jacqueline F	Practitioner - Non-Primary Care Provider (PCP)											
Chan Ho Dds	Practitioner - Non-Primary Care Provider (PCP)											
Wood Bret James Do	Practitioner - Non-Primary Care Provider (PCP)											
Mittal Peeyush Md	Practitioner - Non-Primary Care Provider (PCP)											
Henriques Edgar R Md	Practitioner - Non-Primary Care Provider (PCP)											
Ferguson-Yarush Michelle	Practitioner - Non-Primary Care Provider (PCP)											
Johnson-Della Sala Cheryl	Practitioner - Non-Primary Care Provider (PCP)											
Pellerin Gene R Jr Do	Practitioner - Non-Primary Care Provider (PCP)											
Porto Justin Ignatius Do	Practitioner - Non-Primary Care Provider (PCP)											
Bedinotti Ingrid	Practitioner - Non-Primary Care Provider (PCP)											
Lindow Matthew	Practitioner - Non-Primary Care Provider (PCP)											
Schuman Peter	Practitioner - Non-Primary Care Provider (PCP)											
Hettrich Amy L Rpa	Practitioner - Non-Primary Care Provider (PCP)											

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Deserre Steven Francis Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Gorman Amy M	Practitioner - Non-Primary Care Provider (PCP)											
Wilson Kathleen Carol	Practitioner - Non-Primary Care Provider (PCP)											
Reiser Sandra L	Practitioner - Non-Primary Care Provider (PCP)											
Beardsley Alicia A	Practitioner - Non-Primary Care Provider (PCP)											
Tucker Anthony Md	Practitioner - Non-Primary Care Provider (PCP)											
Mirrow Dareena	Practitioner - Non-Primary Care Provider (PCP)											
Marballi Pradeep D Md	Practitioner - Non-Primary Care Provider (PCP)											
Drzymalski Jolanta	Practitioner - Non-Primary Care Provider (PCP)											
Kinlan Bernard P	Practitioner - Non-Primary Care Provider (PCP)											
Pan Phillip Md	Practitioner - Non-Primary Care Provider (PCP)											
Zamer Joshua D Md	Practitioner - Non-Primary Care Provider (PCP)											
Lehr David Md	Practitioner - Non-Primary Care Provider (PCP)											
Ciarmiello Sue	Practitioner - Non-Primary Care Provider (PCP)											
Abdullah Sinan Dds	Practitioner - Non-Primary Care Provider (PCP)											
Stalker Constance A	Practitioner - Non-Primary Care Provider (PCP)											
Alloway Janet L Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Opar-Gaslow Carolyn M	Practitioner - Non-Primary Care Provider (PCP)											
Clarke Terence J	Practitioner - Non-Primary Care Provider (PCP)											
Hughes Mary	Practitioner - Non-Primary Care Provider (PCP)											
Venerosa Joan B Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Phang Robert S Md	Practitioner - Non-Primary Care Provider (PCP)											
Ezeifedi Robert Md	Practitioner - Non-Primary Care Provider (PCP)											
Stamas Mary E	Practitioner - Non-Primary Care Provider (PCP)											
Akbari Ghulam Abobaker	Practitioner - Non-Primary Care Provider (PCP)											
Cook Cynthia L	Practitioner - Non-Primary Care Provider (PCP)											
Galea Patricia	Practitioner - Non-Primary Care Provider (PCP)											
Motta James F	Practitioner - Non-Primary Care Provider (PCP)											
Nadal Laurie Lambert	Practitioner - Non-Primary Care Provider (PCP)											
O'Meara-Zimmer Kimberly J Np	Practitioner - Non-Primary Care Provider (PCP)											
Tenhulzen Amanda B	Practitioner - Non-Primary Care Provider (PCP)											

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Palmer Michelle N	Practitioner - Non-Primary Care Provider (PCP)											
Carlson Aimee Isabelle	Practitioner - Non-Primary Care Provider (PCP)											
Wang Robert Shih-Ning Md	Practitioner - Non-Primary Care Provider (PCP)											
Sidhu Sonya Mahijit Md	Practitioner - Non-Primary Care Provider (PCP)											
Comley Sood Shannon Md	Practitioner - Non-Primary Care Provider (PCP)											
Mcdonough Joanne Md	Practitioner - Non-Primary Care Provider (PCP)											
Gomez Francisco Javier Md	Practitioner - Non-Primary Care Provider (PCP)											
Bernad Jason Edward Md	Practitioner - Non-Primary Care Provider (PCP)											
Jafri Parvez Md	Practitioner - Non-Primary Care Provider (PCP)											
Habura Lara X	Practitioner - Non-Primary Care Provider (PCP)											
Yoxthimer Elizabeth X	Practitioner - Non-Primary Care Provider (PCP)											
Debauche Suzanne X	Practitioner - Non-Primary Care Provider (PCP)											
Mcbride Talin X	Practitioner - Non-Primary Care Provider (PCP)											
Chaudry Shahina K Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Filanova Vincent Dds	Practitioner - Non-Primary Care Provider (PCP)											
Saunders Jessica Ann Md	Practitioner - Non-Primary Care Provider (PCP)											
Natarajan Vasantha Md	Practitioner - Non-Primary Care Provider (PCP)											
Applebee Garrick A Md	Practitioner - Non-Primary Care Provider (PCP)											
Chowdhery Naseer Amd	Practitioner - Non-Primary Care Provider (PCP)											
Yarra Srinadh Md	Practitioner - Non-Primary Care Provider (PCP)											
Langer Bharat	Practitioner - Non-Primary Care Provider (PCP)											
William Arshad	Practitioner - Non-Primary Care Provider (PCP)											
Dalfino Thea M Md	Practitioner - Non-Primary Care Provider (PCP)											
Bang Christopher S Do	Practitioner - Non-Primary Care Provider (PCP)											
Jones-Assini Carolyn	Practitioner - Non-Primary Care Provider (PCP)											
Magai Colleen S Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Pastore Kathleen Md	Practitioner - Non-Primary Care Provider (PCP)											
Atiles Glorimar	Practitioner - Non-Primary Care Provider (PCP)											
Kaw Pamela Md	Practitioner - Non-Primary Care Provider (PCP)											
Roglieri Joseph Marc Do	Practitioner - Non-Primary Care Provider (PCP)											
Tompkins Terry L Rpa	Practitioner - Non-Primary Care Provider (PCP)											

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Petridis Deborah	Practitioner - Non-Primary Care Provider (PCP)											
Healy Kirsten O Md	Practitioner - Non-Primary Care Provider (PCP)											
Abriel Linda Marie Np	Practitioner - Non-Primary Care Provider (PCP)											
Vandepol-Rimash Maria	Practitioner - Non-Primary Care Provider (PCP)											
Lawlor Pamela J	Practitioner - Non-Primary Care Provider (PCP)											
Pliscofsky Gail	Practitioner - Non-Primary Care Provider (PCP)											
Panemanglore Vishnudas	Practitioner - Non-Primary Care Provider (PCP)											
Dooley Radana Md	Practitioner - Non-Primary Care Provider (PCP)											
Cunningham Christine	Practitioner - Non-Primary Care Provider (PCP)											
Heckman Jason Todd Md	Practitioner - Non-Primary Care Provider (PCP)											
Menakuru Padmapriya Md	Practitioner - Non-Primary Care Provider (PCP)											
Subramanian Vinodhini M Md	Practitioner - Non-Primary Care Provider (PCP)											
Rossetti David	Practitioner - Non-Primary Care Provider (PCP)											
Memon Nazir Ahmed	Practitioner - Non-Primary Care Provider (PCP)											
Knauer William	Practitioner - Non-Primary Care Provider (PCP)											
Bachwani Avinash S Md	Practitioner - Non-Primary Care Provider (PCP)											
Bloss Christopher A Md	Practitioner - Non-Primary Care Provider (PCP)											
Ingram Malene	Practitioner - Non-Primary Care Provider (PCP)											
Weidner Kristine	Practitioner - Non-Primary Care Provider (PCP)											
Gaynor Patricia Np	Practitioner - Non-Primary Care Provider (PCP)											
Sundaram Shobharani Chitra Md	Practitioner - Non-Primary Care Provider (PCP)											
Krishnappa Kachigere Siddegowda Md	Practitioner - Non-Primary Care Provider (PCP)											
Pittman Theresa	Practitioner - Non-Primary Care Provider (PCP)											
Talwar Indu	Practitioner - Non-Primary Care Provider (PCP)											
Palmer Aaron R Md	Practitioner - Non-Primary Care Provider (PCP)											
Shahata Hani L Md	Practitioner - Non-Primary Care Provider (PCP)											
Verpile Kendy Md	Practitioner - Non-Primary Care Provider (PCP)											
Marshall Jonah Scott Md	Practitioner - Non-Primary Care Provider (PCP)											
Yerdon Christina M Np	Practitioner - Non-Primary Care Provider (PCP)											
Ciccateri Ruth A	Practitioner - Non-Primary Care Provider (PCP)											
Gasson Christian Anthony Md	Practitioner - Non-Primary Care Provider (PCP)											

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Patel Sonali Jagdish Md	Practitioner - Non-Primary Care Provider (PCP)											
Shidal Allison	Practitioner - Non-Primary Care Provider (PCP)											
Atkinson Kelly	Practitioner - Non-Primary Care Provider (PCP)											
Prichett Janice	Practitioner - Non-Primary Care Provider (PCP)											
Stack Aliza	Practitioner - Non-Primary Care Provider (PCP)											
Shvachuk Ivan Md	Practitioner - Non-Primary Care Provider (PCP)											
Filippone John D Md	Practitioner - Non-Primary Care Provider (PCP)											
Gadalla Makar Gadalla Md	Practitioner - Non-Primary Care Provider (PCP)											
Milanese Gretchen L Rpt	Practitioner - Non-Primary Care Provider (PCP)											
Balles Linda Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Kandiyil Prabhna	Practitioner - Non-Primary Care Provider (PCP)											
Ciccarelli Michael F Do	Practitioner - Non-Primary Care Provider (PCP)											
Kuo Ramsay	Practitioner - Non-Primary Care Provider (PCP)											
Varghese Noel Md	Practitioner - Non-Primary Care Provider (PCP)											
Hong C Shelley Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Ahmad Yousuf	Practitioner - Non-Primary Care Provider (PCP)											
Jean-Pierre Elmise	Practitioner - Non-Primary Care Provider (PCP)											
Dente Tania	Practitioner - Non-Primary Care Provider (PCP)											
Mathew Thomas Md	Practitioner - Non-Primary Care Provider (PCP)											
Graham Claudia Ann	Practitioner - Non-Primary Care Provider (PCP)											
Kaufman Gabriel	Practitioner - Non-Primary Care Provider (PCP)											
Christie Linda J Md	Practitioner - Non-Primary Care Provider (PCP)											
Field Gregory Md	Practitioner - Non-Primary Care Provider (PCP)											
Dinar Abdelhakim	Practitioner - Non-Primary Care Provider (PCP)											
Amsden Tracy Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Teppo Deborah Lynn Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Vener Jennifer	Practitioner - Non-Primary Care Provider (PCP)											
Tessler Patric	Practitioner - Non-Primary Care Provider (PCP)											
Hazimeh Yusef Md	Practitioner - Non-Primary Care Provider (PCP)											
Gellert Jane Carla Phd	Practitioner - Non-Primary Care Provider (PCP)											
Miroslav Vytrisal Md	Practitioner - Non-Primary Care Provider (PCP)											

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Westenfeld Erin	Practitioner - Non-Primary Care Provider (PCP)											
Goodemote Melissa	Practitioner - Non-Primary Care Provider (PCP)											
Finnegan Michael James	Practitioner - Non-Primary Care Provider (PCP)											
Uzzilia Jeffrey	Practitioner - Non-Primary Care Provider (PCP)											
Sanchez Mark Frank	Practitioner - Non-Primary Care Provider (PCP)											
Omar Malick	Practitioner - Non-Primary Care Provider (PCP)											
Sullenberger Lance Eugene	Practitioner - Non-Primary Care Provider (PCP)											
Swaminathan Jyoti	Practitioner - Non-Primary Care Provider (PCP)											
Anne Marie Comber	Practitioner - Non-Primary Care Provider (PCP)											
Kirsten K Cestaro Md	Practitioner - Non-Primary Care Provider (PCP)											
Gregory John Tillou	Practitioner - Non-Primary Care Provider (PCP)											
Edwards-D'Alessandro Karen	Practitioner - Non-Primary Care Provider (PCP)											
Torregrossa Martha	Practitioner - Non-Primary Care Provider (PCP)											
Volkova Irina V Md	Practitioner - Non-Primary Care Provider (PCP)											
Anameze Samuel Onwuka Md	Practitioner - Non-Primary Care Provider (PCP)											
Lee Rosemary K Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Roeth Maureen	Practitioner - Non-Primary Care Provider (PCP)											
Tariq Sayed	Practitioner - Non-Primary Care Provider (PCP)											
Sternlicht Jeffrey	Practitioner - Non-Primary Care Provider (PCP)											
Posca Anthony P Md	Practitioner - Non-Primary Care Provider (PCP)											
Hare Raymond	Practitioner - Non-Primary Care Provider (PCP)											
Sullivan Jill	Practitioner - Non-Primary Care Provider (PCP)											
Kim Yun Jeong Md	Practitioner - Non-Primary Care Provider (PCP)											
Samenfeld-Specht James	Practitioner - Non-Primary Care Provider (PCP)											
Lefner Jennifer	Practitioner - Non-Primary Care Provider (PCP)											
Depoo Deowchand	Practitioner - Non-Primary Care Provider (PCP)											
Muthavarapu Satish	Practitioner - Non-Primary Care Provider (PCP)											
Anisman Steven David	Practitioner - Non-Primary Care Provider (PCP)											
Kumar Neena	Practitioner - Non-Primary Care Provider (PCP)											
Lieberman Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Dheeraj Khurana Mbbs	Practitioner - Non-Primary Care Provider (PCP)											

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Reimenschneider Justin	Practitioner - Non-Primary Care Provider (PCP)											
Verma Manish	Practitioner - Non-Primary Care Provider (PCP)											
Lambert Lisa Ann	Practitioner - Non-Primary Care Provider (PCP)											
Wise Heather	Practitioner - Non-Primary Care Provider (PCP)											
Zieziulewicz Kathleen Rn/Cde	Practitioner - Non-Primary Care Provider (PCP)											
Kepner Heather Marie Np	Practitioner - Non-Primary Care Provider (PCP)											
Hurlburt Justin	Practitioner - Non-Primary Care Provider (PCP)											
Heather L Juby	Practitioner - Non-Primary Care Provider (PCP)											
Higgins Jennifer	Practitioner - Non-Primary Care Provider (PCP)											
Airhienbuwa Noghama	Practitioner - Non-Primary Care Provider (PCP)											
Perrella Angela	Practitioner - Non-Primary Care Provider (PCP)											
Riccio Alexandra	Practitioner - Non-Primary Care Provider (PCP)											
Schwartz M Miles	Practitioner - Non-Primary Care Provider (PCP)											
Nguyen Le	Practitioner - Non-Primary Care Provider (PCP)											
Roberto J Ochoa	Practitioner - Non-Primary Care Provider (PCP)											
Nnabugwu Ada	Practitioner - Non-Primary Care Provider (PCP)											
Singh Manjinder	Practitioner - Non-Primary Care Provider (PCP)											
Gay Olumuyiwa	Practitioner - Non-Primary Care Provider (PCP)											
Porter Brandon Beyer Md	Practitioner - Non-Primary Care Provider (PCP)											
Haque Anwar Mohammed Md	Practitioner - Non-Primary Care Provider (PCP)											
Sohi Arshwinde	Practitioner - Non-Primary Care Provider (PCP)											
Jennifer Amorosi	Practitioner - Non-Primary Care Provider (PCP)											
Welansa Asrat	Practitioner - Non-Primary Care Provider (PCP)											
Sandra L Foster	Practitioner - Non-Primary Care Provider (PCP)											
Israr Khankhel	Practitioner - Non-Primary Care Provider (PCP)											
Jaworowski Piotr	Practitioner - Non-Primary Care Provider (PCP)											
Barcomb Timothy F	Practitioner - Non-Primary Care Provider (PCP)											
Walebowa Oteng	Practitioner - Non-Primary Care Provider (PCP)											
Rukavishnikova Natalya	Practitioner - Non-Primary Care Provider (PCP)											
Hogan Eileen Fox	Practitioner - Non-Primary Care Provider (PCP)											
Morra Nicholas	Practitioner - Non-Primary Care Provider (PCP)											

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Desantis Antony	Practitioner - Non-Primary Care Provider (PCP)											
Dinkels Michael	Practitioner - Non-Primary Care Provider (PCP)											
Johnson Sheena Marie	Practitioner - Non-Primary Care Provider (PCP)											
Stevens Laura Kathryn Rpa	Practitioner - Non-Primary Care Provider (PCP)											
Brennan Sarah Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Evan E Wolf Rpa-C	Practitioner - Non-Primary Care Provider (PCP)											
Young Jamie Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Jaleel Ned	Practitioner - Non-Primary Care Provider (PCP)											
Harris Nancy A	Practitioner - Non-Primary Care Provider (PCP)											
Ji Ma	Practitioner - Non-Primary Care Provider (PCP)											
Choumarov Kyril	Practitioner - Non-Primary Care Provider (PCP)											
Fleck Barbara J	Practitioner - Non-Primary Care Provider (PCP)											
Iseman Elizabeth Dinnel	Practitioner - Non-Primary Care Provider (PCP)											
Brunelle Trudy	Practitioner - Non-Primary Care Provider (PCP)											
Lisa E Preller	Practitioner - Non-Primary Care Provider (PCP)											
Djalo Annabi	Practitioner - Non-Primary Care Provider (PCP)											
Page Diana Luisa	Practitioner - Non-Primary Care Provider (PCP)											
Knight William	Practitioner - Non-Primary Care Provider (PCP)											
Kim Susan Sunjung	Practitioner - Non-Primary Care Provider (PCP)											
Assad Refat	Practitioner - Non-Primary Care Provider (PCP)											
Greene Jill	Practitioner - Non-Primary Care Provider (PCP)											
Robinson Stacy P	Practitioner - Non-Primary Care Provider (PCP)											
Greenblatt Daniel Edward	Practitioner - Non-Primary Care Provider (PCP)											
Mohammad F B Rujubali	Practitioner - Non-Primary Care Provider (PCP)											
Adam Donald Stallmer	Practitioner - Non-Primary Care Provider (PCP)											
Graziadei Allison Doyle	Practitioner - Non-Primary Care Provider (PCP)											
Datt Chandradai	Practitioner - Non-Primary Care Provider (PCP)											
Gorbachev Sergey Y	Practitioner - Non-Primary Care Provider (PCP)											
Joyce Ta-Mao Yang	Practitioner - Non-Primary Care Provider (PCP)											
Sapovits John D	Practitioner - Non-Primary Care Provider (PCP)											
Brignola Ellen Alicia	Practitioner - Non-Primary Care Provider (PCP)											

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Murry Natalie	Practitioner - Non-Primary Care Provider (PCP)											
Mooney Timothy B	Practitioner - Non-Primary Care Provider (PCP)											
Sundell Milstein Amy M	Practitioner - Non-Primary Care Provider (PCP)											
Burton Laurie-Grego	Practitioner - Non-Primary Care Provider (PCP)											
Kulzer Daniel	Practitioner - Non-Primary Care Provider (PCP)											
Pfaffenbach Amy	Practitioner - Non-Primary Care Provider (PCP)											
Ali Neelam	Practitioner - Non-Primary Care Provider (PCP)											
Mahatme Arvind	Practitioner - Non-Primary Care Provider (PCP)											
Isenovski Thomas Joseph	Practitioner - Non-Primary Care Provider (PCP)											
Gialanella Theodore	Practitioner - Non-Primary Care Provider (PCP)											
Labate Katrina Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Shoemaker Vanita	Practitioner - Non-Primary Care Provider (PCP)											
Rostocki Bernice Ann	Practitioner - Non-Primary Care Provider (PCP)											
Lynn A Sutton	Practitioner - Non-Primary Care Provider (PCP)											
Black Erica	Practitioner - Non-Primary Care Provider (PCP)											
Spencer Taylor	Practitioner - Non-Primary Care Provider (PCP)											
Koblenzer Jude A	Practitioner - Non-Primary Care Provider (PCP)											
Shen Jian	Practitioner - Non-Primary Care Provider (PCP)											
Ramos Glenn Patrick	Practitioner - Non-Primary Care Provider (PCP)											
Piacentine Stephen Michael	Practitioner - Non-Primary Care Provider (PCP)											
Klausner Theresa Intilli	Practitioner - Non-Primary Care Provider (PCP)											
Wrzesinski Stephen Md	Practitioner - Non-Primary Care Provider (PCP)											
Kerner Rene Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Fay Mary E	Practitioner - Non-Primary Care Provider (PCP)											
Pacheco Joshua Michael	Practitioner - Non-Primary Care Provider (PCP)											
Murtagh Colleen	Practitioner - Non-Primary Care Provider (PCP)											
Comley Lynne	Practitioner - Non-Primary Care Provider (PCP)											
Bass Anna	Practitioner - Non-Primary Care Provider (PCP)											
Mchugh Robert	Practitioner - Non-Primary Care Provider (PCP)											
Maingi Shail	Practitioner - Non-Primary Care Provider (PCP)											
Irizarry Eddie	Practitioner - Non-Primary Care Provider (PCP)											

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Richman Ryan William Howard	Practitioner - Non-Primary Care Provider (PCP)											
Persad-Smail Sabita	Practitioner - Non-Primary Care Provider (PCP)											
Negandhi Ami Miten	Practitioner - Non-Primary Care Provider (PCP)											
Keim Rebecca L	Practitioner - Non-Primary Care Provider (PCP)											
Sculco Deborah A	Practitioner - Non-Primary Care Provider (PCP)											
Preventive Diagnostics Inc	Practitioner - Non-Primary Care Provider (PCP)											
Lynch-Rinadi Maureen Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Paone Patricia L	Practitioner - Non-Primary Care Provider (PCP)											
Allen Christina L	Practitioner - Non-Primary Care Provider (PCP)											
Broderick Diane	Practitioner - Non-Primary Care Provider (PCP)											
Dibble Christophe	Practitioner - Non-Primary Care Provider (PCP)											
Phoenix Jennifer	Practitioner - Non-Primary Care Provider (PCP)											
Kachurek David P	Practitioner - Non-Primary Care Provider (PCP)											
Timofeev Konstantin	Practitioner - Non-Primary Care Provider (PCP)											
Yager Janet	Practitioner - Non-Primary Care Provider (PCP)											
Wetzel Jr Frederick	Practitioner - Non-Primary Care Provider (PCP)											
Sandu Diana	Practitioner - Non-Primary Care Provider (PCP)											
Lagace Samantha Lynne	Practitioner - Non-Primary Care Provider (PCP)											
Janssen Daniel James	Practitioner - Non-Primary Care Provider (PCP)											
Harrigan Timothy James	Practitioner - Non-Primary Care Provider (PCP)											
Bobde Rajanish Manohar	Practitioner - Non-Primary Care Provider (PCP)											
Krauss Beverley	Practitioner - Non-Primary Care Provider (PCP)											
Fields Jennifer L	Practitioner - Non-Primary Care Provider (PCP)											
Wintle Catherine Ann	Practitioner - Non-Primary Care Provider (PCP)											
Murawski Julie Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Williams Marguerite H	Practitioner - Non-Primary Care Provider (PCP)											
Kee Elaine F	Practitioner - Non-Primary Care Provider (PCP)											
Amirbekian Vardan	Practitioner - Non-Primary Care Provider (PCP)											
Burns Lisa Marie	Practitioner - Non-Primary Care Provider (PCP)											
Ghimire Prajesh Mani	Practitioner - Non-Primary Care Provider (PCP)											
Matima Mabatho Lucia	Practitioner - Non-Primary Care Provider (PCP)											

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Singh Sukhraj	Practitioner - Non-Primary Care Provider (PCP)											
Rifenberick Mary Ann Carol	Practitioner - Non-Primary Care Provider (PCP)											
Medina Christopher	Practitioner - Non-Primary Care Provider (PCP)											
Kittle Richard Eric	Practitioner - Non-Primary Care Provider (PCP)											
Karhan Beth Lauren	Practitioner - Non-Primary Care Provider (PCP)											
Weiss Brian Paul	Practitioner - Non-Primary Care Provider (PCP)											
Rashid Numan	Practitioner - Non-Primary Care Provider (PCP)											
Walled Douglas	Practitioner - Non-Primary Care Provider (PCP)											
Zack Yelena S	Practitioner - Non-Primary Care Provider (PCP)											
Valley Katie Jayne	Practitioner - Non-Primary Care Provider (PCP)											
Tomy Sinda Kuttentharappel	Practitioner - Non-Primary Care Provider (PCP)											
Assini Mary Anne B	Practitioner - Non-Primary Care Provider (PCP)											
Daigle Linda A	Practitioner - Non-Primary Care Provider (PCP)											
Christine M Stanavich	Practitioner - Non-Primary Care Provider (PCP)											
Duross Susan K	Practitioner - Non-Primary Care Provider (PCP)											
Morrison Victoria	Practitioner - Non-Primary Care Provider (PCP)											
Maneen Alex John	Practitioner - Non-Primary Care Provider (PCP)											
Su Xiao	Practitioner - Non-Primary Care Provider (PCP)											
Williams Teresa Marie Giaquinto	Practitioner - Non-Primary Care Provider (PCP)											
Arif Shoaib	Practitioner - Non-Primary Care Provider (PCP)											
Reilly Kerry Kathleen	Practitioner - Non-Primary Care Provider (PCP)											
Memmelaar Angela R	Practitioner - Non-Primary Care Provider (PCP)											
Cavanagh Anthony J	Practitioner - Non-Primary Care Provider (PCP)											
Mamot Baker Margaret	Practitioner - Non-Primary Care Provider (PCP)											
Van Anda Beryle Lee	Practitioner - Non-Primary Care Provider (PCP)											
Hanham Connie Nina	Practitioner - Non-Primary Care Provider (PCP)											
Mains Suzanne Alexandra	Practitioner - Non-Primary Care Provider (PCP)											
Hostig Kimberly	Practitioner - Non-Primary Care Provider (PCP)											
Bauman Steven P	Practitioner - Non-Primary Care Provider (PCP)											
Xu Fei	Practitioner - Non-Primary Care Provider (PCP)											
Andre Rachel Mary	Practitioner - Non-Primary Care Provider (PCP)											

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Voloshinov Veronica	Practitioner - Non-Primary Care Provider (PCP)											
Shapiro Lois A	Practitioner - Non-Primary Care Provider (PCP)											
Lipscomb Deanna M	Practitioner - Non-Primary Care Provider (PCP)											
Breault Melissa	Practitioner - Non-Primary Care Provider (PCP)											
Truax Marian B	Practitioner - Non-Primary Care Provider (PCP)											
O'Connell Sherie M	Practitioner - Non-Primary Care Provider (PCP)											
Bronson Jenny L	Practitioner - Non-Primary Care Provider (PCP)											
Shannon Patrick Lawrence	Practitioner - Non-Primary Care Provider (PCP)											
Ciccarelli Amelia Anne	Practitioner - Non-Primary Care Provider (PCP)											
Challapalli Haritha	Practitioner - Non-Primary Care Provider (PCP)											
Trees Debra E	Practitioner - Non-Primary Care Provider (PCP)											
Nagarkar Ketaki	Practitioner - Non-Primary Care Provider (PCP)											
Stokes Lindsay	Practitioner - Non-Primary Care Provider (PCP)											
Browne Linda	Practitioner - Non-Primary Care Provider (PCP)											
Weiss Adam J	Practitioner - Non-Primary Care Provider (PCP)											
Hinch Phrances Blay	Practitioner - Non-Primary Care Provider (PCP)											
Babich Frank J	Practitioner - Non-Primary Care Provider (PCP)											
Stefanova-Stephens Nadejda	Practitioner - Non-Primary Care Provider (PCP)											
Jain Sanjeev	Practitioner - Non-Primary Care Provider (PCP)											
Cohn Jamie	Practitioner - Non-Primary Care Provider (PCP)											
Macaluso Christopher	Practitioner - Non-Primary Care Provider (PCP)											
Obrien Erin	Practitioner - Non-Primary Care Provider (PCP)											
Vukovic Joseph Thomas	Practitioner - Non-Primary Care Provider (PCP)											
Khiangte Zothanmawii	Practitioner - Non-Primary Care Provider (PCP)											
Gallagher Ellen E	Practitioner - Non-Primary Care Provider (PCP)											
Schaefer Benjamin M	Practitioner - Non-Primary Care Provider (PCP)											
Guerrier Mahalia Ruth	Practitioner - Non-Primary Care Provider (PCP)											
Oksenholt Robert Lee	Practitioner - Non-Primary Care Provider (PCP)											
Shaw Colleen Margaret	Practitioner - Non-Primary Care Provider (PCP)											
Galusha Jill Brisbin	Practitioner - Non-Primary Care Provider (PCP)											
Frasier Kasandra C	Practitioner - Non-Primary Care Provider (PCP)											

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Petith-Paulsen Joan M	Practitioner - Non-Primary Care Provider (PCP)											
Bhoiwala Dipti	Practitioner - Non-Primary Care Provider (PCP)											
Seguel Joseph Michael	Practitioner - Non-Primary Care Provider (PCP)											
Lawton Kelley Lynne	Practitioner - Non-Primary Care Provider (PCP)											
Ford Jon Patrick	Practitioner - Non-Primary Care Provider (PCP)											
Schwab Marjorie	Practitioner - Non-Primary Care Provider (PCP)											
Varga-Huettner Victoria Eva	Practitioner - Non-Primary Care Provider (PCP)											
Jacob Jackcy	Practitioner - Non-Primary Care Provider (PCP)											
Poulos Artemis E	Practitioner - Non-Primary Care Provider (PCP)											
Thalheimer Justin Kyle	Practitioner - Non-Primary Care Provider (PCP)											
Sims-Oneil Cathy	Practitioner - Non-Primary Care Provider (PCP)											
Adepoju Grace Adeola	Practitioner - Non-Primary Care Provider (PCP)											
Kovalovich Andrew	Practitioner - Non-Primary Care Provider (PCP)											
Gilbertson Dorothy	Practitioner - Non-Primary Care Provider (PCP)											
Pugliese Patricia M	Practitioner - Non-Primary Care Provider (PCP)											
Filippone Amanda L	Practitioner - Non-Primary Care Provider (PCP)											
Chenel Tyler Richard	Practitioner - Non-Primary Care Provider (PCP)											
Fidelman Leila H	Practitioner - Non-Primary Care Provider (PCP)											
Mary Annelle Collins	Practitioner - Non-Primary Care Provider (PCP)											
Howard Melanie Daryl	Practitioner - Non-Primary Care Provider (PCP)											
Rafiq Faisal Muhammad	Practitioner - Non-Primary Care Provider (PCP)											
Koh Daniel Yea Suk	Practitioner - Non-Primary Care Provider (PCP)											
Van Deusen Heidi Harlow	Practitioner - Non-Primary Care Provider (PCP)											
Celestine Erica	Practitioner - Non-Primary Care Provider (PCP)											
Kestler Margaret	Practitioner - Non-Primary Care Provider (PCP)											
Kristie Lee Simonds	Practitioner - Non-Primary Care Provider (PCP)											
Ahmed Naeem	Practitioner - Non-Primary Care Provider (PCP)											
Nunez Garcia Arismendy	Practitioner - Non-Primary Care Provider (PCP)											
Gulliver Rpa Heather M	Practitioner - Non-Primary Care Provider (PCP)											
Lowry Timothy P	Practitioner - Non-Primary Care Provider (PCP)											
Bulibek Batyrjan Kadyrkhan	Practitioner - Non-Primary Care Provider (PCP)											

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Wojtyk Mary Amanda	Practitioner - Non-Primary Care Provider (PCP)											
Ariste Clotaire	Practitioner - Non-Primary Care Provider (PCP)											
Occhiogrosso Marie Anne	Practitioner - Non-Primary Care Provider (PCP)											
Gray Wendy Jo	Practitioner - Non-Primary Care Provider (PCP)											
Richard Thomas Cleary Jackson	Practitioner - Non-Primary Care Provider (PCP)											
Singh Mandeep	Practitioner - Non-Primary Care Provider (PCP)											
Bauer Richard Thomas Iii	Practitioner - Non-Primary Care Provider (PCP)											
Turner Latasha M	Practitioner - Non-Primary Care Provider (PCP)											
Tedeschi Jo Ann	Practitioner - Non-Primary Care Provider (PCP)											
Lagace Richard Edward	Practitioner - Non-Primary Care Provider (PCP)											
El Kouachi Siham	Practitioner - Non-Primary Care Provider (PCP)											
Santiago Nichole	Practitioner - Non-Primary Care Provider (PCP)											
Devarakonda Mahalakshmi	Practitioner - Non-Primary Care Provider (PCP)											
Dellerba Peter Joseph	Practitioner - Non-Primary Care Provider (PCP)											
Sharp Meghan	Practitioner - Non-Primary Care Provider (PCP)											
Chism-Fraine Lisamarie	Practitioner - Non-Primary Care Provider (PCP)											
Torres Lynette Hattiemae	Practitioner - Non-Primary Care Provider (PCP)											
Mullin Kerry Ann	Practitioner - Non-Primary Care Provider (PCP)											
Clements Jamie Marie	Practitioner - Non-Primary Care Provider (PCP)											
Nora Breen	Practitioner - Non-Primary Care Provider (PCP)											
Ednie Michael Kevin	Practitioner - Non-Primary Care Provider (PCP)											
Clausi Erin Kathleen	Practitioner - Non-Primary Care Provider (PCP)											
Lewis Heather	Practitioner - Non-Primary Care Provider (PCP)											
Sheehan Angela M	Practitioner - Non-Primary Care Provider (PCP)											
Colditz Vernon W	Practitioner - Non-Primary Care Provider (PCP)											
Gardner Jerry L	Practitioner - Non-Primary Care Provider (PCP)											
Wilson Allison Marie	Practitioner - Non-Primary Care Provider (PCP)											
Davis Alecia A Np	Practitioner - Non-Primary Care Provider (PCP)											
Kent Kenneth	Practitioner - Non-Primary Care Provider (PCP)											
Coyle Cassandra L	Practitioner - Non-Primary Care Provider (PCP)											
Bravo Enrico A	Practitioner - Non-Primary Care Provider (PCP)											

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Volo Samuel Cohen	Practitioner - Non-Primary Care Provider (PCP)											
Barsotti Christopher E	Practitioner - Non-Primary Care Provider (PCP)											
Abdullah Mishal	Practitioner - Non-Primary Care Provider (PCP)											
Iseman Christine Marie	Practitioner - Non-Primary Care Provider (PCP)											
Komissarova Maria A	Practitioner - Non-Primary Care Provider (PCP)											
Samson Brianna P	Practitioner - Non-Primary Care Provider (PCP)											
Redding Jack Eugene	Practitioner - Non-Primary Care Provider (PCP)											
Youssef James	Practitioner - Non-Primary Care Provider (PCP)											
Murphy Maureen	Practitioner - Non-Primary Care Provider (PCP)											
Mcshane Danine A	Practitioner - Non-Primary Care Provider (PCP)											
Slavin Laura N	Practitioner - Non-Primary Care Provider (PCP)											
Post David Robert	Practitioner - Non-Primary Care Provider (PCP)											
Duszak Richard	Practitioner - Non-Primary Care Provider (PCP)											
Edge Lizette	Practitioner - Non-Primary Care Provider (PCP)											
Gordon-Stacey Carrie	Practitioner - Non-Primary Care Provider (PCP)											
Mischler Jean R	Practitioner - Non-Primary Care Provider (PCP)											
Joseph Jalaja	Practitioner - Non-Primary Care Provider (PCP)											
Buckley Ryan C	Practitioner - Non-Primary Care Provider (PCP)											
Meagher Colin Patrick	Practitioner - Non-Primary Care Provider (PCP)											
Berkovich Betsy	Practitioner - Non-Primary Care Provider (PCP)											
Stulc Diana M	Practitioner - Non-Primary Care Provider (PCP)											
Carlson Joshua E	Practitioner - Non-Primary Care Provider (PCP)											
Didas Pa-C Colleen M	Practitioner - Non-Primary Care Provider (PCP)											
Bishop Lindsay J	Practitioner - Non-Primary Care Provider (PCP)											
Adhikari Christina Shrestha	Practitioner - Non-Primary Care Provider (PCP)											
Goel Hersh	Practitioner - Non-Primary Care Provider (PCP)											
Patel Anish	Practitioner - Non-Primary Care Provider (PCP)											
Wickert Kerry	Practitioner - Non-Primary Care Provider (PCP)											
Hinman Elisha Lynn	Practitioner - Non-Primary Care Provider (PCP)											
Harris Judy Ann	Practitioner - Non-Primary Care Provider (PCP)											
Jones Aimee L	Practitioner - Non-Primary Care Provider (PCP)											

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Ratelle Kimberly Joy	Practitioner - Non-Primary Care Provider (PCP)											
Quintero Elmer Luis	Practitioner - Non-Primary Care Provider (PCP)											
Leber Savanah Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Kay Kathleen	Practitioner - Non-Primary Care Provider (PCP)											
Kayi Pooja M	Practitioner - Non-Primary Care Provider (PCP)											
Price Chrystal	Practitioner - Non-Primary Care Provider (PCP)											
Germinder Elizabeth Nicole	Practitioner - Non-Primary Care Provider (PCP)											
Golis Dennis	Practitioner - Non-Primary Care Provider (PCP)											
Disanto Clare S	Practitioner - Non-Primary Care Provider (PCP)											
Ogden Rory Anne	Practitioner - Non-Primary Care Provider (PCP)											
Myhre David Alan	Practitioner - Non-Primary Care Provider (PCP)											
Cary David V	Practitioner - Non-Primary Care Provider (PCP)											
Marra Daniel	Practitioner - Non-Primary Care Provider (PCP)											
Cardinale Carmen	Practitioner - Non-Primary Care Provider (PCP)											
Kirkpatrick Yulia Alexandrovna	Practitioner - Non-Primary Care Provider (PCP)											
Patterson Jenna	Practitioner - Non-Primary Care Provider (PCP)											
Woodley Carlton Anthony	Practitioner - Non-Primary Care Provider (PCP)											
Kuehn Tracy Ann	Practitioner - Non-Primary Care Provider (PCP)											
Long Lynne C	Practitioner - Non-Primary Care Provider (PCP)											
Pickert Marcy Ann	Practitioner - Non-Primary Care Provider (PCP)											
Harris Laurie Ann	Practitioner - Non-Primary Care Provider (PCP)											
Ali Sami M	Practitioner - Non-Primary Care Provider (PCP)											
Almani Noel M	Practitioner - Non-Primary Care Provider (PCP)											
Gallacchi Dana	Practitioner - Non-Primary Care Provider (PCP)											
Jones Anthony C	Practitioner - Non-Primary Care Provider (PCP)											
Chanofsky Shannon	Practitioner - Non-Primary Care Provider (PCP)											
Zimmerman Jay S	Practitioner - Non-Primary Care Provider (PCP)											
Elma Elmer Jones Tadena	Practitioner - Non-Primary Care Provider (PCP)											
Ilowit Emily Katharine	Practitioner - Non-Primary Care Provider (PCP)											
Goff Meagan J	Practitioner - Non-Primary Care Provider (PCP)											
Bentley Tyrone	Practitioner - Non-Primary Care Provider (PCP)											

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Santoro Anna Marie	Practitioner - Non-Primary Care Provider (PCP)											
Sumter Ronald Herman	Practitioner - Non-Primary Care Provider (PCP)											
Gee Ashley Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Bederian Molly B	Practitioner - Non-Primary Care Provider (PCP)											
Hawkins Andrew Stewart	Practitioner - Non-Primary Care Provider (PCP)											
Ali-Hasan Samer Ahmad	Practitioner - Non-Primary Care Provider (PCP)											
Khan Saadat	Practitioner - Non-Primary Care Provider (PCP)											
Saville Ashley Elizabeth	Practitioner - Non-Primary Care Provider (PCP)											
Javaid Muhammad Ahsan	Practitioner - Non-Primary Care Provider (PCP)											
Malik Rizwan	Practitioner - Non-Primary Care Provider (PCP)											
Vaval Alain Raymond	Practitioner - Non-Primary Care Provider (PCP)											
Kaczor Michal	Practitioner - Non-Primary Care Provider (PCP)											
Sehgal Bhavna	Practitioner - Non-Primary Care Provider (PCP)											
Joyce Vanessa	Practitioner - Non-Primary Care Provider (PCP)											
Adeniji Aderonke Opeyemi	Practitioner - Non-Primary Care Provider (PCP)											
Osuna David	Practitioner - Non-Primary Care Provider (PCP)											
Orecki Zoe A	Practitioner - Non-Primary Care Provider (PCP)											
Demarest Susan Peng	Practitioner - Non-Primary Care Provider (PCP)											
Amirbekian Smbat	Practitioner - Non-Primary Care Provider (PCP)											
Mohsin Hammad	Practitioner - Non-Primary Care Provider (PCP)											
Oneil Trevor Nars	Practitioner - Non-Primary Care Provider (PCP)											
Hourmont Katherine	Practitioner - Non-Primary Care Provider (PCP)											
Nguyen-Chavez Killauda	Practitioner - Non-Primary Care Provider (PCP)											
Terwilliger Jessica	Practitioner - Non-Primary Care Provider (PCP)											
Shoesmith Amy	Practitioner - Non-Primary Care Provider (PCP)											
Lala Moinakhtar	Practitioner - Non-Primary Care Provider (PCP)											
Mathew Salil	Practitioner - Non-Primary Care Provider (PCP)											
Aye Aung	Practitioner - Non-Primary Care Provider (PCP)											
Bekan-Homawoo, Brigitte Md	Practitioner - Non-Primary Care Provider (PCP)											
Nazar, Alina Md	Practitioner - Non-Primary Care Provider (PCP)											
Hicks, Maria Ot	Practitioner - Non-Primary Care Provider (PCP)											

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Gardner, Sarah Pt	Practitioner - Non-Primary Care Provider (PCP)											
Hadley, Samantha Dpt	Practitioner - Non-Primary Care Provider (PCP)											
Ihsan, Muhammad Md	Practitioner - Non-Primary Care Provider (PCP)											
Miller, Stephanie Lmhc	Practitioner - Non-Primary Care Provider (PCP)											
Potter, Christine Mae	Practitioner - Non-Primary Care Provider (PCP)											
Tucker Cheryl S	Practitioner - Non-Primary Care Provider (PCP)											
Espinoza Liz Ms.	Practitioner - Non-Primary Care Provider (PCP)											
Fury Lauren A	Practitioner - Non-Primary Care Provider (PCP)											
Sherman Stephanie	Practitioner - Non-Primary Care Provider (PCP)											
Vadarevu Vijaya Deepthi	Practitioner - Non-Primary Care Provider (PCP)											
Slavkov Rumen	Practitioner - Non-Primary Care Provider (PCP)											
Seguinot Elizabeth Ms.	Practitioner - Non-Primary Care Provider (PCP)											
Rabadi Philip L	Practitioner - Non-Primary Care Provider (PCP)											
Preston, Terri	Practitioner - Non-Primary Care Provider (PCP)											
Murray, Susan	Practitioner - Non-Primary Care Provider (PCP)											
Mazzaferro, Sarah Pa	Practitioner - Non-Primary Care Provider (PCP)											
Nelson Thao T	Practitioner - Non-Primary Care Provider (PCP)											
Liu Dan	Practitioner - Non-Primary Care Provider (PCP)											
Giokas George John Md	Practitioner - Non-Primary Care Provider (PCP)											
Feinberg Zachary Allan	Practitioner - Non-Primary Care Provider (PCP)											
Mcbean, Dacia Mhc	Practitioner - Non-Primary Care Provider (PCP)											
Rothermel Helen P	Practitioner - Non-Primary Care Provider (PCP)											
Miranda Gelpi, Arturo Md	Practitioner - Non-Primary Care Provider (PCP)											
Anderson, Mary Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Carlson Audrey Ms.	Practitioner - Non-Primary Care Provider (PCP)											
Folek Jessica	Practitioner - Non-Primary Care Provider (PCP)											
Beatrice Polynice, Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Peck, Kristen Michelle	Practitioner - Non-Primary Care Provider (PCP)											
Weber Jordana	Practitioner - Non-Primary Care Provider (PCP)											
231459337mcosker Jennifer	Practitioner - Non-Primary Care Provider (PCP)											
Edick, Robin Rn	Practitioner - Non-Primary Care Provider (PCP)											

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Cheon-Schingo Hee-Joo Md	Practitioner - Non-Primary Care Provider (PCP)											
Henderson, Deborah	Practitioner - Non-Primary Care Provider (PCP)											
Hotvet, Kristin Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Famiglietti, Laura	Practitioner - Non-Primary Care Provider (PCP)											
Payano, Mercedes Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Hillabrandt, Barbara	Practitioner - Non-Primary Care Provider (PCP)											
Tripp, Laura	Practitioner - Non-Primary Care Provider (PCP)											
Forster-Green, Jennifer Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Oliver, Melissa	Practitioner - Non-Primary Care Provider (PCP)											
Barnett, William K	Practitioner - Non-Primary Care Provider (PCP)											
Irish Lisbeth M	Practitioner - Non-Primary Care Provider (PCP)											
Wyman, Elizabeth Rd	Practitioner - Non-Primary Care Provider (PCP)											
Snyder, Carolyn	Practitioner - Non-Primary Care Provider (PCP)											
Hollenbeck, Erin	Practitioner - Non-Primary Care Provider (PCP)											
Cheon-Lee Elaine H-Y Md	Practitioner - Non-Primary Care Provider (PCP)											
Conley, Soyna Pa	Practitioner - Non-Primary Care Provider (PCP)											
Thorpe, Heather Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Werner, Nancy Pa	Practitioner - Non-Primary Care Provider (PCP)											
Patel Kinjal	Practitioner - Non-Primary Care Provider (PCP)											
Barhydt, Echi Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
O'Brien, Dan Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Mcneilly Jennifer	Practitioner - Non-Primary Care Provider (PCP)											
Simone B Piraino Md	Practitioner - Non-Primary Care Provider (PCP)											
Luyun Ronnie Franco	Practitioner - Non-Primary Care Provider (PCP)											
Chilingaryan, Mikhail Md	Practitioner - Non-Primary Care Provider (PCP)											
Orr, Scott Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Vincent Sheema T	Practitioner - Non-Primary Care Provider (PCP)											
Milham, Carrie Anne Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Putman, Mary	Practitioner - Non-Primary Care Provider (PCP)											
Wolfkiel Nicole	Practitioner - Non-Primary Care Provider (PCP)											
Davis, Gary	Practitioner - Non-Primary Care Provider (PCP)											

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Harper, Laurie	Practitioner - Non-Primary Care Provider (PCP)											
Utter Lauren	Practitioner - Non-Primary Care Provider (PCP)											
Blanchard Raymond Mr.	Practitioner - Non-Primary Care Provider (PCP)											
Morgan John	Practitioner - Non-Primary Care Provider (PCP)											
Shams, Jemshaid Pa	Practitioner - Non-Primary Care Provider (PCP)											
Colby, Jake Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Willoughby Stephanie	Practitioner - Non-Primary Care Provider (PCP)											
Canning, Abba Pa	Practitioner - Non-Primary Care Provider (PCP)											
Surprenant, Robert Pa	Practitioner - Non-Primary Care Provider (PCP)											
Herrick, Paulette	Practitioner - Non-Primary Care Provider (PCP)											
Malone, Beth Lmhc	Practitioner - Non-Primary Care Provider (PCP)											
Sutton, Paula	Practitioner - Non-Primary Care Provider (PCP)											
Moore, Thomas Jr.	Practitioner - Non-Primary Care Provider (PCP)											
Antoniewicz Marcella K	Practitioner - Non-Primary Care Provider (PCP)											
Oby, Stephen Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Sutherland, Padmaksi Cnm	Practitioner - Non-Primary Care Provider (PCP)											
Keeley Lauren	Practitioner - Non-Primary Care Provider (PCP)											
Libruk Morgan Ashlee	Practitioner - Non-Primary Care Provider (PCP)											
Perezalonso Luis	Practitioner - Non-Primary Care Provider (PCP)											
Holm, Ben Pa	Practitioner - Non-Primary Care Provider (PCP)											
Wang, Cynthia Lmhc	Practitioner - Non-Primary Care Provider (PCP)											
Melendez, Maureen Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Heiser Linda Mrs.	Practitioner - Non-Primary Care Provider (PCP)											
Fisher Jennifer Ms.	Practitioner - Non-Primary Care Provider (PCP)											
Mcdonald Nancy A	Practitioner - Non-Primary Care Provider (PCP)											
Moon Esther M Md	Practitioner - Non-Primary Care Provider (PCP)											
Le, Chris Lmhc	Practitioner - Non-Primary Care Provider (PCP)											
Spencer, Terry	Practitioner - Non-Primary Care Provider (PCP)											
Leone, Tracey Rn	Practitioner - Non-Primary Care Provider (PCP)											
Pouliot Steffani	Practitioner - Non-Primary Care Provider (PCP)											
Blanc Nathalie	Practitioner - Non-Primary Care Provider (PCP)											

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Sferruzza, Cynthia Lcsw	Practitioner - Non-Primary Care Provider (PCP)											
Miller Shelly Mrs.	Practitioner - Non-Primary Care Provider (PCP)											
Boris, Lindsay	Practitioner - Non-Primary Care Provider (PCP)											
Pesek Sarah	Practitioner - Non-Primary Care Provider (PCP)											
Malinowski Diana	Practitioner - Non-Primary Care Provider (PCP)											
Flanagan Christie Ellen	Practitioner - Non-Primary Care Provider (PCP)											
Jenks Melissa	Practitioner - Non-Primary Care Provider (PCP)											
Mcclelland, Sandra	Practitioner - Non-Primary Care Provider (PCP)											
Denniston Kyle	Practitioner - Non-Primary Care Provider (PCP)											
Dargush, Holly Lcsw-R	Practitioner - Non-Primary Care Provider (PCP)											
Pettit Taylor Lynde	Practitioner - Non-Primary Care Provider (PCP)											
Paige Racheal Michele	Practitioner - Non-Primary Care Provider (PCP)											
Lundgren Brandon Michael	Practitioner - Non-Primary Care Provider (PCP)											
Wellington, Mary Ann	Practitioner - Non-Primary Care Provider (PCP)											
Mccoy, Robert	Practitioner - Non-Primary Care Provider (PCP)											
Sanders Christina Marie	Practitioner - Non-Primary Care Provider (PCP)											
Scunziano, Cynthia	Practitioner - Non-Primary Care Provider (PCP)											
Kanumuri Prathima	Practitioner - Non-Primary Care Provider (PCP)											
Gray Christine	Practitioner - Non-Primary Care Provider (PCP)											
Parker, Megan Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Godfrey Daniel	Practitioner - Non-Primary Care Provider (PCP)											
Betts, Maia Lcsw-R	Practitioner - Non-Primary Care Provider (PCP)											
Siegard, Steve Lcsw-R	Practitioner - Non-Primary Care Provider (PCP)											
Dimuro Jennifer	Practitioner - Non-Primary Care Provider (PCP)											
Reuse, Bonnie	Practitioner - Non-Primary Care Provider (PCP)											
Malachowski, Caroline	Practitioner - Non-Primary Care Provider (PCP)											
Saracino, Gail	Practitioner - Non-Primary Care Provider (PCP)											
Malieckal Deepa Alicia	Practitioner - Non-Primary Care Provider (PCP)											
Carlsen, Deb Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Blakeslee, Michelle	Practitioner - Non-Primary Care Provider (PCP)											
Lipson, Beth, Lmsw	Practitioner - Non-Primary Care Provider (PCP)											

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Diramio, Amy Lcsw-R	Practitioner - Non-Primary Care Provider (PCP)											
Kalavazoff Nadine	Practitioner - Non-Primary Care Provider (PCP)											
Campito Emily	Practitioner - Non-Primary Care Provider (PCP)											
Garcia, Rachel Md	Practitioner - Non-Primary Care Provider (PCP)											
Deninno, Victoria	Practitioner - Non-Primary Care Provider (PCP)											
Burrell Keisha Kay	Practitioner - Non-Primary Care Provider (PCP)											
Riley Marin Ms.	Practitioner - Non-Primary Care Provider (PCP)											
Gordon Seth	Practitioner - Non-Primary Care Provider (PCP)											
Bergen, Donna	Practitioner - Non-Primary Care Provider (PCP)											
Ortlieb, Michelle L	Practitioner - Non-Primary Care Provider (PCP)											
Tiesi, Dayna Lmsw	Practitioner - Non-Primary Care Provider (PCP)											
Price, Emily Jane	Practitioner - Non-Primary Care Provider (PCP)											
Aison Johnson Sarah	Practitioner - Non-Primary Care Provider (PCP)											
Hallow Leah	Practitioner - Non-Primary Care Provider (PCP)											
Weiler Cindy M	Practitioner - Non-Primary Care Provider (PCP)											
Bergin, John Pa	Practitioner - Non-Primary Care Provider (PCP)											
Kim Eun Ha	Practitioner - Non-Primary Care Provider (PCP)											
Gottesman Dina	Practitioner - Non-Primary Care Provider (PCP)											
Tsao Beatrice Hseuh-Shi Md	Practitioner - Non-Primary Care Provider (PCP)											
Dingman, Jamie	Practitioner - Non-Primary Care Provider (PCP)											
Samaritan Hospital	Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Albany Memorial Hospital	Hospital											
Seton Health System	Hospital											
Sunnyview Hosp	Hospital											
St Marys Hosp Amsterdam	Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ellis Hospital	Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
St Peters Hospital Albany	Hospital											
Burdett Care Center	Hospital											
Teppo Deborah Lynn Lcsw	Clinic											
Unity House Of Troy Mh	Clinic											
Samaritan Hospital	Clinic								✓			✓

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Albany Memorial Hospital	Clinic											
St Peters Surgery & Endoscopy	Clinic											
New Dimensions In Health Care	Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Seton Health System	Clinic											
Fulton Co Phns Psshsp	Clinic											
Schenectady Cnty Public Hlth	Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Schenectady Family Health Ser	Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Com Hlth Ctr Of Smh & Nlh Inc	Clinic			✓	✓				✓	✓		
Rensselaer County Doh	Clinic											
Planned Pthd Mohawk Hudson	Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Albany County Health Dept	Clinic											
Ucp Assn Of The Capital Dist	Clinic		✓	✓			✓			✓		
Whitney M Young Health Center	Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Montgomery Cty Public Hlth De	Clinic											
Sunnyview Hosp	Clinic											
St Marys Hosp Amsterdam	Clinic								✓	✓		✓
Ellis Hospital	Clinic								✓	✓		✓
St Peters Hospital Albany	Clinic											
Upper Hudson Planned Parent	Clinic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pp Of Mid-Hudson Valley Inc	Clinic											
Ridge Health Services Inc	Clinic											
Burdett Care Center	Clinic											
Parsons Child And Family Ctr	Clinic											
Koinonia Primary Care Inc	Clinic											
Omrdd/Support-Link Inc Cd	Case Management / Health Home											
Unity House Of Troy Mh	Case Management / Health Home											
Samaritan Hospital	Case Management / Health Home	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Albany Cnty Dept/Child Y&F Mh	Case Management / Health Home											
Fulton Cnty Public Hlth Ei	Case Management / Health Home											
Omrdd/Cath Charities Dds-Ta	Case Management / Health Home											
Omrdd/Wildwood Programs-Cd	Case Management / Health Home											

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Omrdd/Saratoga County Arc	Case Management / Health Home											
Omrdd/Warren/Washington Arc	Case Management / Health Home											
Omrdd/Living Resources Corp	Case Management / Health Home											
Liberty/Montgmry Arc-Cd	Case Management / Health Home											
Omrdd/Cath Charities Dds-Cd	Case Management / Health Home											
Clearview Center Mh	Case Management / Health Home											
Catholic Charities/Albany Ai	Case Management / Health Home											
Aids Council Of Neny Ai	Case Management / Health Home		✓	✓	✓	✓				✓		
Rehabilitation Supp Svcs C	Case Management / Health Home			✓								
Transitional Svcs Assoc Inc	Case Management / Health Home											
Schenectady County Pub Hlth	Case Management / Health Home											
Ellis Hospital Mh	Case Management / Health Home											
Albany County Mh	Case Management / Health Home											
Rensselaer Cnty Unified Mh	Case Management / Health Home											
St Marys Hsp At Amsterdam Mh	Case Management / Health Home											
Office Mental Health Mh	Case Management / Health Home											
Mvp Health Plan, Inc	Case Management / Health Home											
Visiting Nurs Svc/Schtd & Sar Cnty	Case Management / Health Home				✓							
St Marys Hosp Amsterdam	Case Management / Health Home	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Opwdd/Support Link Msc Sunmount	Case Management / Health Home											
Parsons Child And Family Ctr	Case Management / Health Home											
Vener Jennifer	Mental Health											
Goodemote Melissa	Mental Health											
Swaminathan Jyoti	Mental Health											
Torregrossa Martha	Mental Health											
Gellert Jane Carla Phd	Mental Health											
Ahmad Yousuf	Mental Health											
Gadalla Makar Gadalla Md	Mental Health											
Talwar Indu	Mental Health											
Krishnappa Kachigere Siddegowda Md	Mental Health											
Unity House Of Troy Mh	Mental Health											

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Weidner Kristine	Mental Health											
Knauer William	Mental Health											
Rossetti David	Mental Health											
Mohawk Opportunities Inc	Mental Health											
William Arshad	Mental Health											
Langer Bharat	Mental Health											
Chaudry Shahina K Lcsw	Mental Health											
Northeast Parent Child Societ	Mental Health											
Nadal Laurie Lambert	Mental Health											
Galea Patricia	Mental Health											
Samaritan Hospital	Mental Health						✓	✓				
Albany Cnty Dept Child Family	Mental Health											
Ciarmiello Sue	Mental Health											
Marballi Pradeep D Md	Mental Health											
Gabay Michelle	Mental Health											
Mittal Peeyush Md	Mental Health											
Villacorta-Pasco Jacqueline F	Mental Health											
Slavkov Rumen	Mental Health											
Gregg Michael	Mental Health											
Burke Jessica Narr Phd	Mental Health											
Pericak Arlene	Mental Health											
Albany County Comm Svs Board	Mental Health											
Allen Christine	Mental Health											
Duncan Ethel B	Mental Health											
Dorflinger Joseph Lcsw	Mental Health											
St Marys Hosp At Amsterdam	Mental Health											
Smith-Booth Brenda Karen	Mental Health											
Klim Kathleen	Mental Health											
Rothermel Helen P	Mental Health											
Toole Nancy E Lcsw	Mental Health											
Soscia Gina Lcsw	Mental Health											

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Peters Robert Lcsw	Mental Health											
Morris Adrian Anthony Md	Mental Health											
Olkowski Piotr K Md	Mental Health											
Burky Christophe	Mental Health											
Bourke Diane A Md	Mental Health											
Aronson Cynthia L Csw	Mental Health											
Wolner Ron K	Mental Health											
Tucker Cheryl S	Mental Health											
Root Jeffrey R	Mental Health											
Roldan Ernesto	Mental Health											
Nordhauser Micaela Urbano	Mental Health											
Malerba Robert Fortune Ii	Mental Health											
Lavigne Gregory L Md	Mental Health											
Jajoor Nagaraj O	Mental Health											
Butz Jr. Robert A	Mental Health											
Van Bellingham Heidi Md	Mental Health											
Dhingra Arun K Md	Mental Health											
Clearview Center Mh	Mental Health											
Fulton County Arc	Mental Health											
Rtf Hs Of The Good Shepherd	Mental Health											
Niedzwiadek Walter Md	Mental Health											
Workshop Inc, The	Mental Health											
Rappaport Steven S Md	Mental Health											
Lasalle School Inc	Mental Health											
The Family Counseling Ctr	Mental Health	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mehta Pankaj Md	Mental Health											
Rehabilitation Supp Svcs C	Mental Health											
Transitional Svcs Assoc Inc	Mental Health											
Lexington Com Serv Inc	Mental Health											
Fulton Freindship House Inc	Mental Health											
Catholic Fam Comm Ser Fulton	Mental Health											

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Nijjar Gurkirpal S Md	Mental Health											
Woodhouse Richard Phd	Mental Health											
Lexington Community Svcs Inc	Mental Health											
Saran Brij Mohan Md	Mental Health											
Ninan Oommen Md	Mental Health											
Saratoga Cnty Comm Srvs Brd	Mental Health											
Albany Cnty Community Svc Bd	Mental Health											
Rensselaer Cnty Dept Mntl Hlt	Mental Health	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Menzel Charles H Md	Mental Health											
St Marys Hosp Amsterdam	Mental Health						✓					
Ellis Hospital	Mental Health						✓	✓				
Nicholson John M W Md	Mental Health											
Hare Raymond	Mental Health											
Samenfeld-Specht James	Mental Health											
Heather L Juby	Mental Health											
Schwartz M Miles	Mental Health											
Gay Olumuyiwa	Mental Health											
Welansa Asrat	Mental Health											
Sandra L Foster	Mental Health											
Ellis Hospital	Mental Health											
Iseman Elizabeth Dinnel	Mental Health											
Brunelle Trudy	Mental Health											
Knight William	Mental Health											
Greene Jill	Mental Health											
Murry Natalie	Mental Health											
Kulzer Daniel	Mental Health											
Rehabilitation Support Services Inc	Mental Health											
Black Erica	Mental Health											
Mha Fulton And Montgomery Co	Mental Health											
Parsons Child And Family Ctr	Mental Health											
Matima Mabatho Lucia	Mental Health											

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Zack Yelena S	Mental Health											
Mamot Baker Margaret	Mental Health											
Van Anda Beryle Lee	Mental Health											
Hostig Kimberly	Mental Health											
Andre Rachel Mary	Mental Health											
Shapiro Lois A	Mental Health											
Truax Marian B	Mental Health											
Hinch Phrances Blay	Mental Health											
Howard Melanie Daryl	Mental Health											
Rafiq Faisal Muhammad	Mental Health											
Van Deusen Heidi Harlow	Mental Health											
Lowry Timothy P	Mental Health											
Gray Wendy Jo	Mental Health											
Lewis Heather	Mental Health											
Sheehan Angela M	Mental Health											
Colditz Vernon W	Mental Health											
Berkovich Betsy	Mental Health											
Didas Pa-C Colleen M	Mental Health											
Quintero Elmer Luis	Mental Health											
Chanofsky Shannon	Mental Health											
Bentley Tyrone	Mental Health											
Osuna David	Mental Health											
Mohsin Hammad	Mental Health											
Fury Lauren A	Mental Health											
Hallow Leah	Mental Health											
Kim Eun Ha	Mental Health											
Hotvet Kristin Nicole	Mental Health											
Willoughby Stephanie	Mental Health											
Pearl Street Counseling Cente	Substance Abuse											
Equinox Inc	Substance Abuse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Senior Hope Counseling Inc	Substance Abuse											

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Seton Health System	Substance Abuse											
Child & Fam Guid Ctr Adict Sv	Substance Abuse											
Lasalle School Inc	Substance Abuse											
St Lawrence Addiction Trt Ctr	Substance Abuse											
Conifer Park	Substance Abuse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hope House, Inc.	Substance Abuse											
820 River Street Inc.	Substance Abuse											
Addictions Care Ctr Of Albany	Substance Abuse											
Depaul Addiction Services Inc	Substance Abuse											
Hudson-Mohawk Recovery Ctr,In	Substance Abuse						✓					
Saratoga Cnty Comm Srvs Brd	Substance Abuse											
Alcoholism Council Schen Cnty	Substance Abuse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Albany Cnty Community Svc Bd	Substance Abuse											
Whitney M Young Health Center	Substance Abuse											
St Marys Hosp Amsterdam	Substance Abuse							✓				
St Peters Hospital Albany	Substance Abuse											
Belvedere Health Services Llc	Substance Abuse											
Schuyler Ridge Rhcf Adhc	Nursing Home											
Our Lady Of Mercy Life Ctr	Nursing Home											
Eddy Heritage House Nursing C	Nursing Home											
Whittier Rehab & Skilled Nrs Ctr	Nursing Home											
Ellis Residential & Rehab Ctr	Nursing Home											
Eddy Cohoes Rehabilitation Ce	Nursing Home											
St Johnsville Reh & Nrs Ctr	Nursing Home											
Daughters Of Sarah Non Occ	Nursing Home											
James A Eddy Mem Geri Ctr Snf	Nursing Home											
Kingsway Arms Nursing Ctr Snf	Nursing Home											
Baptist Hlth Nrs & Rehab Cnt	Nursing Home											
Glendale Home Schen Snf Co	Nursing Home											
Van Rensselaer Manor Snf	Nursing Home											
Hoosick Falls Health Center	Nursing Home											

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The Springs Nursing & Reh Ctr	Nursing Home											
Avenue Nursing & Rehab Ctr Sn	Nursing Home											
St Margarets Center	Nursing Home											
Teresian House Nrsg Hm Co Inc	Nursing Home											
Catskill Crossings	Nursing Home											
Evergreen Commons Snf	Nursing Home											
Glens Falls Crossings	Nursing Home											
St Peters Nursing & Rehab Center	Nursing Home											
Albany County Nursing Home	Nursing Home											
Wilkinson Residential Health Care F	Nursing Home											
Rosewood Rehabilitation & Nrs Ctr	Nursing Home											
Eddy Village Green At Beverwyck	Nursing Home											
Fulton Center Rehabilitation & Heal	Nursing Home											
River Ridge Operating Llc	Nursing Home											
Evergreen Commons Rehab & Nursing C	Nursing Home											
Price Chopper Operating Co Inc	Pharmacy											
Golub Corpration,The #196	Pharmacy											
Golub Corporation The #191	Pharmacy											
Golub Corporation The	Pharmacy											
Golub Corporation The	Pharmacy											
Price Chopper Operating Co In	Pharmacy											
Golub Corporation The	Pharmacy											
Golub Corporation The	Pharmacy											
Golub Corporation The #003	Pharmacy											
Empire Home Infusion Svc Inc	Pharmacy											
Golub Corporation	Pharmacy											
Golub Corporation The	Pharmacy											
Seton Health System	Pharmacy											
Golub Corporation	Pharmacy											
Golub Corporation	Pharmacy											
Golub Corporation	Pharmacy											

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Golub Corporation The	Pharmacy											
The Golub Corporation Price C	Pharmacy											
Watervliet Pharmacy Inc	Pharmacy											
Planned Pthd Mohawk Hudson	Pharmacy											
Ellis Hospital	Pharmacy											
St Peters Hospital Albany	Pharmacy											
Golub Corporation	Pharmacy											
Golub Corporation	Pharmacy											
Mountain Valley Hospice	Hospice	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Community Hospice Inc	Hospice											
St Peters Hospital Albany	Hospice											
1199 Seiu United Health Care Workers East	Community Based Organizations											
820 River Street Supportive Living	Community Based Organizations											
Altamont Pediatrics And Internal Medicine	Community Based Organizations											
Baptist Health Enriched Housing Program Inc	Community Based Organizations											
Braverman-Panza Medical Group	Community Based Organizations											
Broadalbin Perth School	Community Based Organizations											
Bulmer, Fred Social Work Assistant	Community Based Organizations											
Caggiano, Mary Peer Specialist	Community Based Organizations											
Capital District Community Gardens	Community Based Organizations											
Capital District Ymca	Community Based Organizations											
Capital Region Asthma Coalition	Community Based Organizations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Capital Region Family Health Care	Community Based Organizations											
Catholic Charities Housing	Community Based Organizations											
Catholic Charities Of Saratoga Warren Washington	Community Based Organizations											
Catholic Charities Of The Diocese Of Albany	Community Based Organizations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Catholic Charities Senior & Caregiver Support Services	Community Based Organizations											
Catholic Charities Tri-County Services- Catholic Charities Diocese Of Albany	Community Based Organizations											
Cdphp	Community Based Organizations											
Center For Remote Medical Management	Community Based Organizations											
Children'S Health Home Of Upstate New York	Community Based Organizations											

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Clark, Daniel Rehab Assistant	Community Based Organizations											
Clifton Park Family Practice Group	Community Based Organizations											
Clifton Park Pediatrics Center	Community Based Organizations											
Commission On Economic Opportunity For The Greater Capital Region	Community Based Organizations											
Community Care Givers Inc.	Community Based Organizations											
Community Care Physicians	Community Based Organizations											
Compeer, Inc.	Community Based Organizations											
Cornell Cooperative Extension Albany County	Community Based Organizations											
Depaul Housing Management	Community Based Organizations											
Devereux, Elizabeth Np	Community Based Organizations											
Elderplan - Homefirst	Community Based Organizations											
Family Medical Group	Community Based Organizations											
Family Support Services	Community Based Organizations											
Florio, Kaarn, Mhc	Community Based Organizations											
Fulton County Office For The Aging	Community Based Organizations											
Fulton Friendship	Community Based Organizations											
Gloversville School	Community Based Organizations											
Hannaford Bros Co. Subsidiary Of Delhaize Americ	Community Based Organizations											
Health Stream Medical Associates	Community Based Organizations											
Healthy Capital District Initiative	Community Based Organizations					✓			✓			
Here'S Cookin At You	Community Based Organizations											
Hfm Prevention Council	Community Based Organizations											
Hixny	Community Based Organizations											
Home Visiting Physicians	Community Based Organizations											
Hope House Inc	Community Based Organizations											
Institute For Health System Evaluation	Community Based Organizations											
Interfaith Partnership For The Homeless	Community Based Organizations				✓							
Internal Medicine Associates	Community Based Organizations											
Jaydene, Albert Lcsw-R	Community Based Organizations											
Kadyszewski, Barbara Lcsw	Community Based Organizations											
Latham Primary Care Associates	Community Based Organizations											

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Lauchman, Vidyawatie Rn	Community Based Organizations											
Long, Molly Pa	Community Based Organizations											
Mance, Alicia, Lmsw	Community Based Organizations											
Mental Health Association In Nys	Community Based Organizations											
Montes, Irinia Pa	Community Based Organizations											
Mvp Health Care	Community Based Organizations											
National Association Of Social Workers - Nys	Community Based Organizations											
New Paltz Family Medicine	Community Based Organizations											
Ny Start Services	Community Based Organizations											
Nysarc, Inc Saratoga County Chapter/Saratoga Bridges D.B.A.	Community Based Organizations											
Nysna	Community Based Organizations											
Ockhenholt, Karen Anne Rn	Community Based Organizations											
Office For The Aging, Montgomery County	Community Based Organizations											
Peter Young Dss/Parole Shelter	Community Based Organizations											
Price Chopper Pharmacies	Community Based Organizations											
Rehabilitation Support Services (Albany Supported Housing Apartment Program)	Community Based Organizations											
Rehabilitation Support Services (Compeer)	Community Based Organizations											
Rehabilitation Support Services (Enhanced Supported Housing Apartment Program)	Community Based Organizations											
Rehabilitation Support Services (Schenectady Supported Housing Apartment Program)	Community Based Organizations											
Reistetter, Francine Lcsw	Community Based Organizations											
Right At Home Albany	Community Based Organizations											
Saratoga Center For The Family	Community Based Organizations											
Saratoga Family Practice	Community Based Organizations											
Schaghticoke Family Health Center	Community Based Organizations											
Schenectady Community Action Program	Community Based Organizations		✓									
Schenectady County Office Of Community Services	Community Based Organizations											
Schenectady County Public Library	Community Based Organizations											
Schuyler Inn	Community Based Organizations											
Second Chance Opportunities, Inc.	Community Based Organizations											

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Senior Services Of Albany	Community Based Organizations			✓								
Seton Health Pediatrics	Community Based Organizations											
Silburn, Daphne Mhta	Community Based Organizations											
St. Joseph'S Supportive Living	Community Based Organizations											
St. Paul'S Center	Community Based Organizations											
St. Peter'S Health Partners Medical Associates	Community Based Organizations											
Stillwater Family Health Center	Community Based Organizations											
The Alcohol And Substance Abuse Prevention Council, Inc.	Community Based Organizations											
The Altamont Program	Community Based Organizations											
The Next Step Inc.	Community Based Organizations											
The Workshop Dba Northeast Career Planning	Community Based Organizations											
Troy Community Residence	Community Based Organizations											
Troy Internal Medicine	Community Based Organizations											
Troy Rehabilitation And Improvement Program, Inc.	Community Based Organizations											
Unite Family Support Services, Llc	Community Based Organizations											
United Way Of The Greater Capital Region	Community Based Organizations		✓	✓					✓			
Vega, Lysandra Lmsw	Community Based Organizations											
Visions Of Hope At Village Of Colonie Outreach	Community Based Organizations											
Wildwood Programs - Respite	Community Based Organizations											
Wiley, Kaitlyn Lmsw	Community Based Organizations											
Winters, Brooke. Lmsw	Community Based Organizations											
Derenzo Timothy	All Other											
Tessler Patric	All Other											
Five Corners Family Practice	All Other											
Coelho L C	All Other											
Tera N Hetrick-Platte Md	All Other											
Colleen M Gassett Anp-C	All Other											
Finnegan Michael James	All Other											
Schneider Nicole Marie	All Other											
Uzzilia Jeffrey	All Other											
Oneill Rita Monica	All Other											

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Sullenberger Lance Eugene	All Other											
Kirsten K Cestaro Md	All Other											
Mayer & Cope Family Practice Llp	All Other											
Support Link Inc Nhtd	All Other											
Dykstra Todd Bryan Rpa	All Other											
Stetzer Lee	All Other											
Gregory John Tillou	All Other											
Nair Amita N Md	All Other											
Martorana Sebastian Vincent	All Other											
Craig Maier	All Other											
Elguero Carlos	All Other											
Lee Rosemary K Rpa	All Other											
Tariq Sayed	All Other											
Mahar Katherine Ellen	All Other											
Hazimeh Yusef Md	All Other											
Teppo Deborah Lynn Lcsw	All Other											
Madala Padmaja Md	All Other											
Amsden Tracy Rpa	All Other											
Field Gregory Md	All Other											
Christie Linda J Md	All Other											
Graham Claudia Ann	All Other											
Cummings Walter D Do	All Other											
Mathew Thomas Md	All Other											
Hong C Shelley Cnm	All Other											
Varghese Noel Md	All Other											
Living Resources H C Ag Tbi	All Other											
Kuo Ramsay	All Other											
Betit Alan	All Other											
Ciccarelli Michael F Do	All Other											
Balles Linda Cnm	All Other											
Lahtinen-Aley Kristina Marie Md	All Other											

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Smitas Catherine Malone Md	All Other											
Foye-Petrillo Melissa Do	All Other											
Smith Marsha	All Other											
Filippone John D Md	All Other											
Cooke Kristin	All Other											
Habib Nazia Md	All Other											
Salas Stephanie Ann Md	All Other											
Gasson Christian Anthony Md	All Other											
Raveendranath Brooke A	All Other											
Beauchamp Cara E Rpa	All Other											
Bleser Karen Md	All Other											
Marshall Jonah Scott Md	All Other											
Vasquez Deborah A Md	All Other											
Verpile Kendy Md	All Other											
Shahata Hani L Md	All Other											
Wasniewski Holly L Md	All Other											
Sundaram Shobharani Chitra Md	All Other											
Unity House Of Troy Mh	All Other											
Mckinney Sue Peterson Rpa	All Other											
Argubano Renee Arruira Md	All Other											
Bloss Christopher A Md	All Other											
Berg Jonathan B Md	All Other											
Osborn Kyle Thomas Md	All Other											
Sheridan Brian Md	All Other											
Morgan Ayman Md	All Other											
Memon Nazir Ahmed	All Other											
Heckman Jason Todd Md	All Other											
Rodden Mary Np	All Other											
Cunningham Christine	All Other											
Panemanglore Vishnudas	All Other											
Hobbs Patricia	All Other											

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Vandepol-Rimash Maria	All Other											
Burke Michael Kevin Md	All Other											
Callaghan Olin Rpa	All Other											
Petrillo John M Md	All Other											
Abriel Linda Marie Np	All Other											
Healy Kirsten O Md	All Other											
Petridis Deborah	All Other											
Pearl Street Counseling Cente	All Other											
Roglieri Joseph Marc Do	All Other											
Broderick Bethany Md	All Other											
Kaw Pamela Md	All Other											
Madden Jeena Md	All Other											
Saxena Shravan	All Other											
Cruz Alan Md	All Other											
Bang Christopher S Do	All Other											
Kucij Lyn Irene Rpa	All Other											
Stetzer Rebecca	All Other											
Yarra Srinadh Md	All Other											
All Metro Home Care Services Of New	All Other											
Winchester Susan B Np	All Other											
Hildreth Deborah A Rpa	All Other											
Living Resources Corp Day	All Other											
The Workshop Inc Hcbs Day	All Other											
Rao Mohan Cn Md	All Other											
Fulton Cnty Arc Day	All Other											
Saunders Jessica Ann Md	All Other											
Catholic Char Dds Day	All Other											
Steckley Renee E Rpa	All Other											
Hassan Syed Riaz Ul Md	All Other											
Pathirana Priyangika Atanikitha Md	All Other											
Pawlinga Christophe	All Other											

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Participating in Projects												
Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Michelena Karen X	All Other											
Schwam Ariel Sergio Md	All Other											
Ludwig Samantha Md	All Other											
Leonidas Leonard Al Md	All Other											
Bernad Jason Edward Md	All Other											
Gomez Francisco Javier Md	All Other											
Mcdonough Joanne Md	All Other											
Comley Sood Shannon Md	All Other											
Dalzell Melissa J Md	All Other											
Sidhu Sonya Mahijit Md	All Other											
Wang Robert Shih-Ning Md	All Other											
Carlson Aimee Isabelle	All Other											
Palmer Michelle N	All Other											
Tenhulzen Amanda B	All Other											
O'Meara-Zimmer Kimberly J Np	All Other											
Compa Kristen Leigh Md	All Other											
Moon Esther M Md	All Other											
Cook Cynthia L	All Other											
Hickey Lynn Leitner Md	All Other											
Samaritan Hospital	All Other	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Phang Robert S Md	All Other											
Albany Memorial Hospital	All Other											
Irani Danesh S Rpa	All Other											
Horn Elizabeth C	All Other											
Etienne Mineke Enola Md	All Other											
D'Avella Wendy K	All Other											
Mcgaffin Christina E	All Other											
Barats Lev Leonidovich Md	All Other											
Prime Care Physicians Pllc	All Other											
Kim Jai Md	All Other											
Lehr David Md	All Other											

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Zamer Joshua D Md	All Other											
Pan Phillip Md	All Other											
Catholic Charities Dds Rsp	All Other											
Gildersleeve Rebecca Ann Md	All Other											
Woodruff Barbara A Rpa	All Other											
Campagna Kristine J Do	All Other											
Mazzei-Klokiw Renata N Md	All Other											
Living Resources Corp Rsp	All Other											
Fulton Co Chap Nysarc Rsp	All Other											
Berman Jessica Dembitz Md	All Other											
Equinox Inc	All Other											
Lucchesi Allison Ruff Md	All Other											
Martin Kristen Hedger Md	All Other											
Mance Joan M	All Other											
Greenblatt Carol Lynn Do	All Other											
Spindler John B Rpa	All Other											
Tolentino Rommel M Md	All Other											
Deserre Steven Francis Cnm	All Other											
Hettrich Amy L Rpa	All Other											
Riede Barbara	All Other											
Schuman Peter	All Other											
Lindow Matthew	All Other											
Pellerin Gene R Jr Do	All Other											
Johnson-Della Sala Cheryl	All Other											
Wood Bret James Do	All Other											
Brown Jean	All Other											
Aragona Sharon L	All Other											
Stoecklin William	All Other											
Venditti Thomas H Rpa	All Other											
Lynch Kevin W	All Other											
Sherman Sherry D	All Other											

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Reilly Marcelle J Do	All Other											
Lathers Susan E	All Other											
Yadegari-Lewis Nasrene Md	All Other											
Haldeman Iii Richard J	All Other											
Platis Pamela Anne	All Other											
Mcgrann Ellen Mary Rpa	All Other											
Doherty-Wells Karen A	All Other											
Leroy Martha A	All Other											
Mcdermott Patrick F Rpa	All Other											
Glick Cheryl M	All Other											
Tenenbaum Diane Cantor Md	All Other											
Benjamin Anthony P Md	All Other											
Daas Mamoon	All Other											
Murray Sherrie L	All Other											
Gregg Michael	All Other											
Bogdanov Assen Petrov Md	All Other											
Fulton Co Arc Nd 8	All Other											
Kim Regina Y Md	All Other											
Coleman Kenneth Md	All Other											
Cleveland Byrd Md	All Other											
Kamerling Lisa Benay Md	All Other											
Stiller Jamie M	All Other											
Schaefer Donna J	All Other											
Naumowicz Edward T	All Other											
Gurrala Geetha Md	All Other											
Cleney Holly K Md	All Other											
Montalto Nicholas J Jr Md	All Other											
Miles Matthew James Md	All Other											
Heffernan Donna Marie Md	All Other											
Forman Peter Howard Md	All Other											
Priola Margaret E	All Other											

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Pandya Tejas Ramesh Dpm	All Other											
Butler Renita Danette Md	All Other											
Kondo Kathleen	All Other											
Corcoran Vincent A Md	All Other											
Ismail Mahmoud Ismail Md	All Other											
Joy Robert A Md	All Other											
Fulton Cnty Arc Hcbs 6	All Other											
Lynch William P Rpa	All Other											
Kim Alice Y Md	All Other											
Bashant John Michael Md	All Other											
Yunker Cathy	All Other											
Berkery Leah Rebecca Md	All Other											
Phelan Carol Beberwyk	All Other											
Nicholson Timothy Joseph	All Other											
Syta Cheryl Lynn	All Other											
Carlin Christophe S	All Other											
Dluge-Aungst Dawn B Rpa	All Other											
Wheeler Tammy H	All Other											
Sgarlata Donna L	All Other											
Hosterman Kandy L	All Other											
Roske Julia H Rpa	All Other											
Conard Joanna L	All Other											
Dorney Patricia Mary Md	All Other											
St Peters Hospital	All Other											
Angert Victoria	All Other											
Zampier Alison A	All Other											
Yamin Mary Christine	All Other											
Warner Deborah P	All Other											
Rabbin Linda S	All Other											
Olszewski Peter	All Other											
O'Loughlin Suzanne	All Other											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Matties Regina K	All Other											
Gendron Kim Retell	All Other											
Lasker Susan	All Other											
Janowski Darcy A	All Other											
Hill Barbara	All Other											
Griffin Margaret Anne	All Other											
Gabriel Nancy	All Other											
Duncan-Bornt Cynthia	All Other											
Decker Georgia M	All Other											
Chank Shelly M	All Other											
Gara Maureen	All Other											
Brown Linda S Cnm	All Other											
Fairbank Matthew K Rpa	All Other											
Hyde Natalie Ann	All Other											
Goldberg Craig R Md	All Other											
Hirt Deborah	All Other											
Kayayan Ara Md	All Other											
Salanger Stephanie A Rpa	All Other											
Singh Chanderdeep Md	All Other											
Bishop Gregory C Md	All Other											
Navarro Brian Scott Md	All Other											
Luke Lynne Laura	All Other											
Murray Brian P	All Other											
Bae Jina Md	All Other											
Chan Cindy Hoying Md	All Other											
Peregrim Kimberly A Do	All Other											
Senior Hope Counseling Inc	All Other											
Mantello Melinda A Md	All Other											
Chakraborty Ranen Kumar Md	All Other											
Jacon Mary Grace	All Other											
Smith Karen R	All Other											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Fabre Lynn D	All Other											
Santoro Carol Rinko Md	All Other											
Seaman Tami Md	All Other											
Coates Andrew Donnally Md	All Other											
Greenblatt Michael J Md	All Other											
Living Resources Corp Spt	All Other											
Living Resources Corp Spv	All Other											
Fulton Co Chapter Nysarc Spt	All Other											
Kasarda Karen Marie Rpa	All Other											
Larner Virginia Blake Rpa	All Other											
Catholic Charities Dds Spv	All Other											
Knapp Robin Gail Cnm	All Other											
Basavaraju Nerlige G	All Other											
Denovio Bradley M Rpac	All Other											
Campbell Kathleen Kissane Rpa	All Other											
Mcgarry Karen A Rpa	All Other											
Catholic Char Dds Hcbs 15	All Other											
Nardin Gary Steven Rpa	All Other											
Halpert Jonathan S Md	All Other											
Petraccione Lisa F Rpa	All Other											
Living Resources Corp Hcbs 6	All Other											
Braungart Carol Fritz	All Other											
Stein Rhonda Danielle Md	All Other											
Ens Health Care Services Llc	All Other											
Dempsey Stephen J Md	All Other											
Eaton Carolyn A Md	All Other											
Silvernail Donna L Pa	All Other											
Dooley Kevin M Md	All Other											
Puthuparampil Beulah J Md	All Other											
Brennan-Jordan Nancy	All Other											
Conway Lillian Marie	All Other											

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Gradner Jill A Md	All Other											
Watson Dottie L Md	All Other											
Catholic Char Dds Hcbs 14	All Other											
Capitalcare Medical Group Llc	All Other											
St Marys Hosp At Amsterdam	All Other	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Living Resources Hm Care Ag	All Other											
Fulton Co Chapter Nys Arc Smp	All Other											
Renss Co Chap Nysarc Smp	All Other											
The Workshop Inc Smp	All Other											
Warren Washington Arc Smp	All Other											
Living Resources Corp Smp	All Other											
Rehman Hafeez U Md	All Other											
Lemons Lorraine S Do	All Other											
Wise Birute Marija Md	All Other											
Petitti Nicola Md	All Other											
Carrelle Raymond J Md	All Other											
Ryan Sean Patrick Md	All Other											
Ojukwu Ifeoma Clarissa Md	All Other											
Karatnycky Adrian Paul Md	All Other											
Belvedere Enterprises Llc Tbi	All Other											
Usow Mark H Md	All Other											
Nichols Joel Lawrence Dpm	All Other											
Hunter Philip Raymond Md	All Other											
Price Darin Michael Md	All Other											
Catholic Char Dds Hcbs 13	All Other											
Shulof Jennifer Amy	All Other											
Palmieri Suzanne Do	All Other											
Living Resources Corp Hcbs 5	All Other											
Boka Suzanna P Md	All Other											
Murphy Eileen	All Other											
Prieto Alfonso Francisco Jose	All Other											

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Aitken Geri Lynn Do	All Other											
Sherwood David Edward Md	All Other											
Gupta Saaket Md	All Other											
Jorgensen Stephanie E Md	All Other											
Cunningham Matthew Md	All Other											
Dyer-Martin Mary Kyle Do	All Other											
Mcconnell Theresa Marie	All Other											
Pallis Evangelos N Md	All Other											
Living Res Certified Hha	All Other											
Hoffman Darlene Joan	All Other											
Tonneau Benoit Md	All Other											
Petersen Lauris	All Other											
Etzkorn Emily Md	All Other											
Reyes Juanito Antonio S Md	All Other											
Mead Daniel H Pa	All Other											
Mayott Catherine Kreyer	All Other											
Denno Matthew L Md	All Other											
Brueggemann Christina Mchugh	All Other											
St Peters Licensed Home Care	All Other											
Amirbekian Satik Md	All Other											
Zimring Debra Carol Md	All Other											
Gaston Shenelle R Md	All Other											
Pesquera Maria Margarita Md	All Other											
Kaplan Irina Inna Md	All Other											
Ashley Christopher Charles Md	All Other											
Mcpadden Marion C Cnm	All Other											
Weitz Steven H Md	All Other											
Adonai Chisara Md	All Other											
Kowal William J Md	All Other											
Collen Kimberly A Rpa	All Other											
Evans Stephanie B Md	All Other											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Nardacci Elizabeth Anne	All Other											
Cavoli Salvatore Richard	All Other											
Chinyere Ofonagoro Physician Pllc	All Other											
Schaeffer Michael Eric Md	All Other											
Sam Olai V Md	All Other											
Holcomb Margaret Isabelle Cnm	All Other											
Murphy Christine M Md	All Other											
Delaparte Marie Patricia	All Other											
Gomez-Di Cesare Caroline M Md	All Other											
Mccabe Megan	All Other											
Cultrara Katherine Tanner	All Other											
Carmody Janet Mary	All Other											
Gay Margaret Anne	All Other											
Manzoor Sikander Md	All Other											
Gandham Vijaya L Md	All Other											
Platzman Michael Do	All Other											
Mccormack Thomas M Md	All Other											
Baker Kenneth J Md	All Other											
Axford James P Jr Md	All Other											
Ross Donald Md	All Other											
Levine Carolyn Robbins	All Other											
Drzymalski Zofia Wanda Md	All Other											
Gregorian Antonio Md	All Other											
Dincer Yusuf M Md	All Other											
Banson Martin L Md	All Other											
Hajar Marilyn	All Other											
Stracke Lothar	All Other											
Donohue Robert	All Other											
Fera Frank	All Other											
Vinsel Paul J	All Other											
Bala Virinchi	All Other											

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Merriman Joann	All Other											
Schuyler Ridge Rhcf Adhc	All Other											
Gebhard Paul E Jr Md	All Other											
Block-Galarza Jessie A Md	All Other											
Wilson James Henry Md	All Other											
Cicchino Dennis	All Other											
Casals Gail Jordan	All Other											
Czerwinski Maria H Md	All Other											
Caton Alice	All Other											
Cafiero Madeline R	All Other											
Living Resource Corp Tbi	All Other											
Smith Jane Patterson	All Other											
Goyer Richard Paul Jr Md	All Other											
Grabovetsky Mikhail Md	All Other											
Wenacur Russell Md	All Other											
Kondo Nicholas Ivan	All Other											
Maloney Cynthia M	All Other											
Santos Kristen A Do	All Other											
Rapoport Robert J Md	All Other											
Laregina Victor G Md	All Other											
Letteriello Denise Do	All Other											
Fatone Christopher T Md	All Other											
Graney Sheela Md	All Other											
Kopff Heather S Do	All Other											
Azad Abul Kazam Md	All Other											
Kessler Robert Blake Md	All Other											
Cheon-Lee Elaine H-Y Md	All Other											
Cirenza Emanuel Nicholas Md	All Other											
Bidot Ramon Md	All Other											
Liberty/Montgomery Arc Hcbs 2	All Other						✓			✓		
Adetona Adetutu Basirat Md	All Other											

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Rogge Scott W Md	All Other											
Kraev Igor Alexander Md	All Other											
Taccad-Reyes Sandra Carlos Md	All Other											
Albert Kevin Constantine Md	All Other											
Chang Theodore Tuan Md	All Other											
Sinchak Joseph Richard Md	All Other											
Pica Laura E Md	All Other											
Parikh Nita S	All Other											
Liljeberg Peter M Md	All Other											
Kostun William A Md	All Other											
Jajoor Nagaraj O	All Other											
Clements Philip C	All Other											
Catalano Kathleen M Do	All Other											
Caruso Lori A	All Other											
Empire Home Infusion Svc Inc	All Other											
Effendi Tahir	All Other											
Rapisarda Sergio Vito Md	All Other											
Ali Shehzad	All Other											
Brasch Mary L Md	All Other											
Cheon-Schingo Hee-Joo Md	All Other											
Pizarro Glenn Md	All Other											
Hawthorne Jami M	All Other											
Tsao Beatrice Hseuh-Shi Md	All Other											
Barkowski Nancy Ann C Md	All Other											
Millett Jeanne Marie	All Other											
Dimova Aneta Kosta Md	All Other											
Diaz Miguel Remigio Md	All Other											
Sirico Theresa A Do	All Other											
Cotugno Steffani Do	All Other											
New Dimensions In Health Care	All Other											
Chava Prabhakar Rao Md	All Other											

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Herrmannsdoerfer Axel J Md	All Other											
Kufs William Michael Md	All Other											
Reddy Sarada Modugu Md	All Other											
Anyaegbunam William I Md	All Other											
Diana Mary G Md	All Other											
Roche Sean Patrick Md	All Other											
Swicker Stefan Andrew Md	All Other											
Pramenko John M Md	All Other											
Cavanna Angela C Do	All Other											
Obrien Michael J Md	All Other											
Sung Steve C Md	All Other											
Baghel Ashok Md	All Other											
Raphael Hong Thi-Le Md	All Other											
Yousuf Asim Md	All Other											
Farooq Joseph Md	All Other											
Seton Health System	All Other											
Benoit Marcel M Md	All Other											
Cah Unified Services	All Other											
Shuman Barry A Md	All Other											
Gregory Elizabeth Marie Md	All Other											
Syed Zainul-Abideen Md	All Other											
Almonte Oscar Foz Md	All Other											
Sipperly Stephen F Do	All Other											
Ortiz Gerald James Md	All Other											
Schenectady Co Chap Nys Arc	All Other											
Fulton County Arc	All Other											
Fulton County Arc Tbi	All Other											
Catholic Charities Tbi	All Other											
Seton Health System	All Other											
Sosa-Suarez Guillermo Eduardo	All Other											
Black Joy Merry Rpa	All Other											

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Elliott Rebecca Lynne Md	All Other											
Child & Fam Guid Ctr Adict Sv	All Other											
Woods Margaret Mary Md	All Other											
Martinelli Michael J Md	All Other											
Friscia Marisa Md	All Other											
Bevilacqua Lisa Rose Md	All Other											
Tuttle Donna Md	All Other											
Merritt Patricia Md	All Other											
Fulton County Arc Hcbs	All Other											
Seyburn David F Md	All Other											
Osborn Mark Edward Md	All Other											
Cospito Peter D Md	All Other											
Walsh Amy Md	All Other											
Ianniello Louis Md	All Other											
Fusella Joseph Ii Do	All Other											
Gaylord James Md	All Other											
Strizich Gregory Md	All Other											
Ratner Lee Mark Md	All Other											
Bapat Aruna V Md	All Other											
Yee Lily Fong Cho Md	All Other											
Lasalle School Inc	All Other											
Gardner Jeffrey Louis Md	All Other											
Justa Shelley Md	All Other											
Fulton Co Phns Psshsp	All Other											
Conifer Park	All Other											
Our Lady Of Mercy Life Ctr	All Other											
Clark Richard A	All Other											
Lee Arthur Farren Md Pc	All Other											
Schenectady Csd	All Other											
Pezzulo John Phillip Md	All Other											
Schnakenberg Eric C Md	All Other											

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Jolie Patricia Lynn Md	All Other											
Balsamo Steven Joseph Md	All Other											
Craig James Charles Iii Md	All Other											
Thorn Lisa Marie Md	All Other											
Ellis Hospital Lifeline	All Other											
Card Harold George Md	All Other											
Morris Barbara A Md	All Other											
Margono Franz Md	All Other											
Renauld Cynthia Rose Md	All Other											
Migden Hedy L	All Other											
Eddy Heritage House Nursing C	All Other											
Whittier Rehab & Skilled Nrs Ctr	All Other											
Viola Theresa Md	All Other											
Esper Daniel William Md	All Other											
Saxena Parul Md	All Other											
Vassolas George A Md	All Other											
Roccario Eric Stephen Md	All Other											
Peterson Charles Craig Md	All Other											
Carenet Medical Group Pc	All Other											
Dweck Laurie Jo	All Other											
Phillip James L Md	All Other											
Rebehn Keith Alan Md	All Other											
Shaker Pediatrics Pc C	All Other											
Patacsil Domiciano P Jr Md	All Other											
Biggers Ellen Marie Md	All Other											
Lemanski Paul Md	All Other											
Hope House, Inc.	All Other											
Gold Louis Harold Md	All Other											
Strumpf David A Md	All Other											
Bellin Joyce Lea Pa	All Other											
Bedford Sharon L Md	All Other											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Klausner Eric G Md	All Other											
Pascual Arsenio George Md	All Other											
Nijjar Gurkirpal S Md	All Other											
Arnold Hendrick Jr Md	All Other											
Dort Janice Beth	All Other											
David Jose M Jr Md	All Other											
Galati James Edward Dds	All Other											
Warszawa-Ambros Maryla A Md	All Other											
Campbell Robert J Md	All Other											
Skory David S Md	All Other											
Morin Michael P Md	All Other											
Sosnow Peter Lewis Md	All Other											
Schwartz Kenneth Md	All Other											
Murphy Suzanne Marie Md	All Other											
Hughes Patricia A Md	All Other											
Mirza Shahida Parveen Md	All Other											
Haber Eugene Curtis Md	All Other											
Cope Kevin Patrick Md	All Other											
Schenectady County Pub Hlth	All Other											
Kandath David D Md	All Other											
Schenectady Cnty Public Hlth	All Other											
Basso Deborah Md	All Other											
Salehi Freshteh Md	All Other											
Murphy Christopher J Md	All Other											
Herdzik Katherine Joan Md	All Other											
Catholic Charities Wellington	All Other											
Sapio Nancy C Md	All Other											
Nafziger Anne N Md	All Other											
Figge James J Md Mba	All Other											
Charland James M Md	All Other											
Dorsey Susan Serra Md	All Other											

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Participating in Projects												
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Rowley Richard F Md	All Other											
Savage Duncan E Md	All Other											
Turi Anthony R Md	All Other											
Zitwer Seth Darryl Md	All Other											
Barbarotto Paul David Md	All Other											
Marthy-Noonan Anne K Md	All Other											
Jordan Mark Md	All Other											
Rienzi Peter Anthony Md	All Other											
Sheridan Michael Martin Do	All Other											
Hughes Stephen Arnold Md	All Other											
Quarrier John V Md	All Other											
Fitz Grahame Wright Md	All Other											
Yan Richard	All Other											
Kronick Gary Archer Md	All Other											
Hoenzsch Ronald Ernest Md	All Other											
Duff Thomas Edward Jr Md	All Other											
Wong Winston C Md	All Other											
Kineke Stephen Francis Md	All Other											
Trout Charles A Md	All Other											
Quimby Robert R Md	All Other											
Talma Theodore E Md	All Other											
Spinelli Karen Ann Md	All Other											
Any-Time Home Care Inc	All Other											
Lovely Thomas John Md	All Other											
Ellis Residential & Rehab Ctr	All Other											
Eddy Cohoes Rehabilitation Ce	All Other											
820 River Street Inc.	All Other											
Abelseth Jill M Md	All Other											
Katz Michael Scott Md	All Other											
Visiting Nurses Homecare	All Other											
Marinello Anthony James Md	All Other											

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Tetreault William Robert Md	All Other											
Lecours Laura Yates Md	All Other											
St Johnsville Reh & Nrs Ctr	All Other											
Cohen Gary S Md	All Other											
Schenectady Family Health Ser	All Other											
Marmulstein Michael Md	All Other											
Daughters Of Sarah Non Occ	All Other											
Muller Reid Thomas Md	All Other											
Silk Yusuf Nuruddin Md	All Other											
Haas Douglas L Md	All Other											
Bodnar Judith D	All Other											
Klein Ronald Steven Md	All Other											
Manjunath Kallanna Md	All Other											
Kroopnick Kenneth Md	All Other											
Maggiore Peter Rocco Md	All Other											
Palat David S Md	All Other											
Braverman Panza Jill	All Other											
Cagino Anthony John Md	All Other											
Vachon Francois Marc Andre Md	All Other											
Nightingale Luke Mahlon Md	All Other											
Passaretti Zachary Hobart Md	All Other											
Johnston Mary Md	All Other											
Catholic Charities Warren Icf	All Other											
Pride Boone Janice Md	All Other											
Limeri Dean Joseph Md	All Other											
Coplin Bruce Evan Md	All Other											
Addictions Care Ctr Of Albany	All Other											
Parsley Lawrence J Md Jr	All Other											
Gunther Andrew George Md	All Other											
Stevens Arthur L Md	All Other											
Manor Denis P Md	All Other											

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Mishkin Jonathan Md	All Other											
Warner Robert Charles Jr Md	All Other											
Gelman Leonard M Md	All Other											
Neilley Henry Md	All Other											
Phillips Roland Turner Md	All Other											
Finn Daniel Joseph Md	All Other											
Goldberg Steven Marc Md	All Other											
Community Hospice Inc	All Other											
Castro Carlos A Md	All Other											
Parikh Dineshkant N	All Other											
Gardner Michael J Md	All Other											
Snitkoff Louis Md	All Other											
Parkes Robert J Md	All Other											
Troitino Anthony Md	All Other											
Mitnick Neil Craig Md	All Other											
Sunkin Arthur L Md	All Other											
Carrozza Joseph K Md	All Other											
Caulfield Patrick Francis Md	All Other											
Smith Steven P Md	All Other											
Jaffe Joshua Md	All Other											
Eddy Vna Twin Counties	All Other											
Zakariyya Hasan Md	All Other											
Warheit Andrew Md	All Other											
Hannan Edward Joseph Md	All Other											
Lexington Community Svcs Inc	All Other											
Grant Stephen A Md	All Other											
Bloomfield Naomi Terry Md	All Other											
Com Hlth Ctr Of Smh & Nlh Lth	All Other											
Fogel Alan Jeffrey Md	All Other											
Com Hlth Ctr Of Smh & Nlh Inc	All Other	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
James A Eddy Mem Geri Ctr Snf	All Other											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Cecil Russell N A Md	All Other											
Atkins Carl D Md	All Other											
Orsi Richard A Md	All Other											
Elacqua Mary S	All Other											
Perumal Kandasamychetty Md	All Other											
Rochet Michael A Md	All Other											
Braim Timothy E Od	All Other											
Gebert John Kevin Md	All Other											
Mayer William D Md	All Other											
Catholic Charities Serena Icf	All Other											
Sokol Harold Marc Md	All Other											
Knudsen Nancy Slezak Md	All Other											
Sonnekalb Michael P Md	All Other											
Spurgas Paul Edward Md	All Other											
Conlon Alan T Md	All Other											
Sturges Charles E Md	All Other											
Taylor Robert John Md	All Other											
Ellis David A Md	All Other											
Geehr Robert B Md	All Other											
Perazzelli Michael E Md	All Other											
Kumar Pashu Pati Md	All Other											
Sullivan Andrew Md	All Other											
Baran Andrij Ostap Dimitry Md	All Other											
Drislane Mary Ellen Md	All Other											
Vacca William M Md	All Other											
Gaffuri Paul E Md	All Other											
Ramaswami Ravi Md	All Other											
Desantis Jonathan M Md	All Other											
Cioffi James Michael Md	All Other											
Goddard Bryan L Md	All Other											
Weissberg Robert A Md	All Other											

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Provider Name	**Provider Category**	**2.a.i**	**2.b.iii**	**2.b.iv**	**2.b.viii**	**2.d.i**	**3.a.i**	**3.a.iv**	**3.d.ii**	**3.g.i**	**4.a.iii**	**4.b.i**
Lader Ellis Wayne Md	All Other											
Musto Ronald V Md	All Other											
Sattar Fouad A Md Pc	All Other											
Bruce Melody A Md	All Other											
Visiting Nurs Svc/Schtd & Sar Cnty	All Other											
Rosman Paul Martin Do	All Other											
Dunkerley Gary Robert Md	All Other											
Rios Zandra M Md	All Other											
Phelps David Millard Md	All Other											
Kolanchick Gary J Md	All Other											
Dworkin Paul Md	All Other											
Reiter Paul Michael Md	All Other											
Nebres Jose F Md	All Other											
Marar Hani G Md	All Other											
Depaul Addiction Services Inc	All Other											
Tomiak Henry P Jr Md	All Other											
Goel Veena	All Other											
Hudson-Mohawk Recovery Ctr,In	All Other											
Sgambati Stephen S Jr Md	All Other											
Marshall Robert Andrew Md	All Other											
Saratoga Cnty Comm Srvs Brd	All Other											
Nakao Michael Md	All Other											
Lindenberg Barry Scott Md	All Other											
Wolff Michael Leonard Md	All Other											
Bartoletti Albert L Md	All Other											
Huggins Eustace A Md	All Other											
Welch Michael C Md	All Other											
Strader Stephen Earl Md	All Other											
Alcoholism Council Schen Cnty	All Other											
Busino William A Jr Md	All Other											
Saperstone James D Md	All Other											

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Ford Bradley A Md	All Other											
Makarachi Ahad Md	All Other											
Patel Vina R Md	All Other											
Zornow David H Md	All Other											
Ghazi Moghadam M R Md	All Other											
Sulzman Charles Michael Md	All Other											
Baselice Marino Md	All Other											
Albany Cnty Community Svc Bd	All Other											
Fruiterman Roy Md	All Other											
Patil Nagaraja N Md	All Other											
Glasgow Constance Lenore Mdpc	All Other											
Irwin Robert W Md	All Other											
Engelstein Martin S Md	All Other											
Mesch John C Md	All Other											
Bruce David H Md	All Other											
Woods Norbert J Md	All Other											
Walders James D Md	All Other											
Zeltner Theodore Harold Md	All Other											
Rensselaer Cnty Dept Mntl Hlt	All Other											
Ismail Mohammed Md	All Other											
Agopovich Arsenio Md	All Other											
Rappazzo Mary Elizabeth Md	All Other											
Sin Zae Seol Pc Md	All Other											
Scher Michael Lee Md	All Other											
Fabregas Ramon Md	All Other											
Chen Jung Wen Md	All Other											
Saha Proshanta K Md	All Other											
Rao Govind C K Md	All Other											
Jain Rajinder Pc Md	All Other											
Perkins Jeffrey Md	All Other											
Hennessey William J Md Pc	All Other											

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Mitta Swatantra K Md	All Other											
Toll Richard B Md	All Other											
Bello Scott C Md	All Other											
Miller Nelson L Md	All Other											
Gort Dennis A Md	All Other											
Beer Yoram Md	All Other											
Kingsway Arms Nursing Ctr Snf	All Other											
Baptist Hlth Nrs & Rehab Cnt	All Other											
Glendale Home Schen Snf Co	All Other											
Van Rensselaer Manor Snf	All Other											
Vna Of Albany & Saratoga	All Other											
Rensselaer County Doh	All Other											
Planned Pthd Mohawk Hudson	All Other											
Albany County Health Dept	All Other											
Ucp Assn Of The Capital Dist	All Other											
Whitney M Young Health Center	All Other											
Montgomery Cty Public Hlth De	All Other											
Storm Fred Charles Md	All Other											
Bertram Michael C Md	All Other											
Rockwell David R Md	All Other											
Rimash Rorick T Md	All Other											
Rosenberg Stuart A Md	All Other											
Kosinski Norbert Dpm	All Other											
Odabashian Harry C Md	All Other											
Petersen William A Md	All Other											
Malone Anthony F Md	All Other											
Richman Charles H Md	All Other											
Lavigne Richard E Pc Md	All Other											
Leyhane James C Md	All Other											
Sunnyview Hosp	All Other											
Millora Angel B Md	All Other											

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Hoosick Falls Health Center	All Other											
The Springs Nursing & Reh Ctr	All Other											
St Marys Hosp Amsterdam	All Other											
Hardies Michael J Md	All Other											
Ellis Hospital	All Other	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
St Peters Hospital Albany	All Other											
Farrell Richard Md Jr	All Other											
Gross Eric J Md	All Other											
Avenue Nursing & Rehab Ctr Sn	All Other											
St Margarets Center	All Other											
Teresian House Nrsg Hm Co Inc	All Other											
Catskill Crossings	All Other											
Evergreen Commons Snf	All Other											
Glens Falls Crossings	All Other											
St Peters Nursing & Rehab Center	All Other											
Albany County Nursing Home	All Other											
Upper Hudson Planned Parent	All Other											
Ford Jockular B Pc Md	All Other											
Nicholson John M W Md	All Other											
Pp Of Mid-Hudson Valley Inc	All Other											
Rehman Syed	All Other											
Mack Brigid	All Other											
Marshall Ryan	All Other											
Sheehan Rebecca	All Other											
Gabree Samara	All Other											
Rosenbaum Elena	All Other											
Dollard Michael Anthony	All Other											
Gardner Nathan James Rpa	All Other											
Lopez Pablo	All Other											
Sullivan Jill	All Other											
Wachtmeister Erika Britt Md	All Other											

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Norton Neal David Jr Rpa	All Other											
Family And Child Services Schen Day	All Other	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Belvedere Enterprises Llc Nhtd	All Other											
Muthavarapu Satish	All Other											
Anisman Steven David	All Other											
Fulton Cnty Chap Nysarc Nhtd	All Other											
Vollmer Kelly J	All Other											
Rahman Abdul	All Other											
Kepner Heather Marie Np	All Other											
Wildwood Programs Inc Rec Rsp	All Other											
Family Medicine Of Mechanicville Pl	All Other											
Ellis Hospital	All Other											
Lawyer Sarah Alicia Np	All Other											
Bowdy Michele Marie Trela	All Other											
Locke Elizabeth Anne Md	All Other											
Wilkinson Residential Health Care F	All Other											
Eddy Lifeline	All Other											
Haque Anwar Mohammed Md	All Other											
Yen-Mancuso Sovonna Sintarea Rpa	All Other											
Afejuku-Adelaja Neema Roli Md	All Other											
Shelley M Gilbert	All Other											
Barcomb Timothy F	All Other											
Hogan Eileen Fox	All Other											
Catholic Charities Of Albany Ptl	All Other											
Dinkels Michael	All Other											
Ellis Hospital	All Other											
Fleck Barbara J	All Other											
Lisa E Preller	All Other											
Young Jamie Lynn	All Other											
Scarabino Karissa	All Other											
Cruz Faith	All Other											

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Hang Kyu Park	All Other											
Barry Kelli Ann	All Other											
Kim Susan Sunjung	All Other											
Nguyen Catherine Tuong Khanh Md	All Other											
Simone B Piraino Md	All Other											
Robinson Stacy P	All Other											
Fish Erica Ann	All Other											
Lahey Barbara Jean	All Other											
Adam Donald Stallmer	All Other											
Graziadei Allison Doyle	All Other											
Marks Elizabeth R Md	All Other											
Datt Chandradai	All Other											
Pachucki Kevin Christopher Rpa	All Other											
Keefer Jennifer Lynn	All Other											
Sapovits John D	All Other											
Parker Dawne Louise	All Other											
Brilliant Rachelle I	All Other											
Wait Allison Jamie	All Other											
Brignola Ellen Alicia	All Other											
Yannetti Kristin	All Other											
Mooney Timothy B	All Other											
Kanthal Marissa Loren	All Other											
Brown Sheryl	All Other											
Sarwer Wafia	All Other											
Pedreira Denia	All Other											
Ramanathan Nalini	All Other											
Gowdara Divakara Murthy Md	All Other											
Shoemaker Vanita	All Other											
Saha Manish	All Other											
Lifesong Inc Day/Ch	All Other											
Spencer Taylor	All Other											

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Koblenzer Jude A	All Other											
Shen Jian	All Other											
Wrzesinski Tamara Jennifer	All Other											
Saratoga County Chapter Nys Arc Inc	All Other											
Rosewood Rehabilitation & Nrs Ctr	All Other											
Piacentine Stephen Michael	All Other											
Wrzesinski Stephen Md	All Other											
Kerner Rene Lynn	All Other											
Eddy Village Green At Beverwyck	All Other											
Pacheco Joshua Michael	All Other											
Murtagh Colleen	All Other											
Rutter Ann	All Other											
Guptill Gloria G	All Other											
Barraclough Nancy L Np	All Other											
Dvorscak Amanda Jayne	All Other											
Mchugh Robert	All Other											
Irizarry Eddie	All Other											
Negandhi Ami Miten	All Other											
Cristalli Gaetano	All Other											
Keim Rebecca L	All Other											
Veino Melissa J	All Other											
Sculco Deborah A	All Other											
Preventive Diagnostics Inc	All Other											
Yager Janet	All Other											
Dibble Christophe	All Other											
Phoenix Jennifer	All Other											
Kachurek David P	All Other											
Paul S Walter	All Other											
Lauren T Siy	All Other											
Sandu Diana	All Other											
Besong Alice	All Other											

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Ridge Health Services Inc	All Other											
Young Linda	All Other											
Blanch Tanya Malka	All Other											
Shin Joong	All Other											
Brandow Ruth	All Other											
Matta Mandeep	All Other											
Burdett Care Center	All Other											
Clark Catherine Nielsen	All Other											
Lagace Samantha Lynne	All Other											
Antohi Petronela	All Other											
Stephanie Noyes	All Other											
Janssen Daniel James	All Other											
Stracke Carsten Paul Md	All Other											
Valerie Thomas	All Other											
Ward Theresa Marie	All Other											
Bobde Rajanish Manohar	All Other											
Krauss Beverley	All Other											
Wesselhoeft Karen Beth	All Other											
Rodriguez-Iglesias Realba	All Other											
Wintle Catherine Ann	All Other											
Amirbekian Vardan	All Other											
Parsons Child And Family Ctr	All Other											
Belvedere Health Services Llc	All Other											
Medina Christopher	All Other											
Mccrory Krisemily Anderson	All Other											
Cieszynski Veronica Eileen	All Other											
Kittle Richard Eric	All Other											
Mondelo Doreen Perez	All Other											
Catholic Charities Of Albany Inc Cs	All Other											
Montelone Kimberly Ann Np	All Other											
Catholic Charities Of Albany Inc Cs	All Other											

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Catholic Charities Of Albany Inc Cs	All Other											
Catholic Char/ Albany Inc Cssz05	All Other											
Karhan Beth Lauren	All Other											
Searfoss Linda A	All Other											
Catholic Char/Albany Inc Cssz02	All Other											
Cunningham Jane M	All Other											
Weiss Brian Paul	All Other											
Rashid Numan	All Other											
Cody Megan P	All Other											
Walled Douglas	All Other											
Jeannie Ngygen	All Other											
Valley Katie Jayne	All Other											
Wilkinson Sarah Jane	All Other											
Snyder Ilona	All Other											
Fulton Center Rehabilitation & Heal	All Other											
Duross Susan K	All Other											
Colman David Lawrence	All Other											
Su Xiao	All Other											
Dunne Laurie Anne	All Other											
Memmelaar Angela R	All Other											
Clark Kristina Marie	All Other											
Nemith Lindsay Mumford	All Other											
Dumrese Danielle Lee	All Other											
Tumuluri Srilaxmi	All Other											
Romero-Demontero Cristina	All Other											
Ditursi Mary Kathleen Williams	All Other											
Voloshinov Veronica	All Other											
Lipscomb Deanna M	All Other											
O'Connell Sherie M	All Other											
Mary Patricia Shierly	All Other											
Khan Khyber	All Other											

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Kennedy Karen Olsen	All Other											
Ronan Alisha Lynn	All Other											
Blatz Sarah J Pa	All Other											
Sajid Farah	All Other											
Dibble Colleen M	All Other											
Catholic Charities Of Albany Ics	All Other											
Lawson Jessica L	All Other											
Li Jianyu	All Other											
Jain Sanjeev	All Other											
Macaluso Christopher	All Other											
Gallagher Ellen E	All Other											
Vukovic Joseph Thomas	All Other											
Khiangte Zothanmawii	All Other											
Krass Jessica A	All Other											
Koinonia Primary Care Inc	All Other											
Schaefer Benjamin M	All Other											
Samuel Jency Thomas	All Other											
Morgan Lacey Elizabeth	All Other											
Hennessy Elisa	All Other											
Rizzuto Michael J	All Other											
Sick Megan Mackenzie	All Other											
Shaw Colleen Margaret	All Other											
Frasier Kasandra C	All Other											
Meghani Mustafain	All Other											
Bhoiwala Dipti	All Other											
Seguel Joseph Michael	All Other											
Mahon Hiromi Kimura	All Other											
Lieu Jason	All Other											
Vachon Cary Ian	All Other											
Akinyede Olufemi	All Other											
Rose Jennifer	All Other											

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Jacob Jackcy	All Other											
Salei Inesa	All Other											
Van Amburgh Marilyn	All Other											
Laurent Yvenalie	All Other											
Millea Kerry	All Other											
Kuwitzky Kaitlin S	All Other											
Gilbertson Dorothy	All Other											
Mary Annelle Collins	All Other											
Koh Daniel Yea Suk	All Other											
Durosier Garry	All Other											
Celestine Erica	All Other											
Dolinsky Steven H	All Other											
Rodriguez-Jaquez Carlos R	All Other											
Kestler Margaret	All Other											
Majeed Mahvash	All Other											
Tatagari Jayasree	All Other											
Aliggayu Darryl A	All Other											
Farrell Claudia Sales	All Other											
Galarza Richard A	All Other											
Henson Jennifer T	All Other											
Occhiogrosso Marie Anne	All Other											
Richard Thomas Cleary Jackson	All Other											
Bauer Richard Thomas Iii	All Other											
Turner Latasha M	All Other											
Chan York Sing	All Other											
Lagace Richard Edward	All Other											
Chauvin Rebecca L	All Other											
Sharp Meghan	All Other											
Chism-Fraine Lisamarie	All Other											
Quinn Barbara Hunter	All Other											
Nora Breen	All Other											

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Gardner Jerry L	All Other											
Wilson Allison Marie	All Other											
Sazon Tatiana	All Other											
Lammly Adam	All Other											
Volo Samuel Cohen	All Other											
Barsotti Christopher E	All Other											
Sheaffer Margaret A	All Other											
Iseman Christine Marie	All Other											
Komissarova Maria A	All Other											
Schneiderheinze Michelle L	All Other											
Samson Brianna P	All Other											
Mack Kristin Lake	All Other											
Redding Jack Eugene	All Other											
Karyn Marie Hughes	All Other											
Torre Jenny Ann	All Other											
Kohanski Dawn M	All Other											
Murphy Maureen	All Other											
Mcshane Danine A	All Other											
River Ridge Operating Llc	All Other											
Slavin Laura N	All Other											
Post David Robert	All Other											
Gordon-Stacey Carrie	All Other											
Joseph Jalaja	All Other											
Campito Emily	All Other											
Buckley Ryan C	All Other											
Upstate Physician Services Pc	All Other											
Meagher Colin Patrick	All Other											
Bossolini Marybeth M	All Other											
Carlson Joshua E	All Other											
Bishop Lindsay J	All Other											
Adhikari Christina Shrestha	All Other											

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Bindlish Shagun	All Other											
Wickert Kerry	All Other											
Delamater Jeffrey T	All Other											
Ratelle Kimberly Joy	All Other											
Yu Alice	All Other											
Germinder Elizabeth Nicole	All Other											
Golis Dennis	All Other											
Cary David V	All Other											
Cardinale Carmen	All Other											
Lundy Lauren	All Other											
Kirkpatrick Yulia Alexandrovna	All Other											
Kuehn Tracy Ann	All Other											
Harris Laurie Ann	All Other											
Gallacchi Dana	All Other											
Jones Anthony C	All Other											
Ilowit Emily Katharine	All Other											
Santoro Anna Marie	All Other											
Bederian Molly B	All Other											
Hawkins Andrew Stewart	All Other											
Burrell Keisha Kay	All Other											
Joyce Vanessa	All Other											
Demarest Susan Peng	All Other											
Amirbekian Smbat	All Other											
231459337mcosker Jennifer	All Other											
Shoesmith Amy	All Other											
Potratz Meagan A	All Other											
Malinowski Diana	All Other											
Nazar Alina	All Other											
Denniston Kyle	All Other											
Pettit Taylor Lynde	All Other											
Sutherland Padi	All Other											

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Espinoso Cristine Maria	All Other											
Ethier Gloria	All Other											
Folek Jessica	All Other											
Gottesman Dina	All Other											
Luyun Ronnie Franco	All Other											
Kasbekar Vishwala	All Other											
Sanders Christina Marie	All Other											
The Montgomery County Chapter Of Nysarc, Inc.	Uncategorized											
Nysarc, Inc Saratoga County Chapter/Saratoga Bridges D.B.A.	Uncategorized											
Fulton County Arc	Uncategorized											
Catholic Charities Disabilities Services Waiver	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 5	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 6	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 7	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 8	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 9	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 10	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 11	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 12	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 16	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 17	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 18	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 19	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 20	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 21	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 22	Uncategorized											
Catholic Charities Disabilities Services Waiver Nd 1	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 23	Uncategorized											
Catholic Charities Disabilities Services 1 Waiver Hcbs 24	Uncategorized											
Catholic Charities Disabilities Services Waiver Nd 2	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 25	Uncategorized											

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Catholic Charities Disabilities Services Waiver Hcbs 26	Uncategorized											
Catholic Charities Disabilities Services B2h	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 27	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 28	Uncategorized											
Wildwood Programs - Consolidated Support Services	Uncategorized											
Corelli, Altanah Rn, Cde, Rd	Uncategorized											
Mctiernan, Annette Mhc	Uncategorized											
Boyce, Jeremy Mhc	Uncategorized											
Gracia, Jessica	Uncategorized											
Irwin, Kelly Np	Uncategorized											
Rensselaer County Department Of Hea	Uncategorized											
Consumer Directed Choice, Inc	Uncategorized											
Nathan, Sacheen Md	Uncategorized											
Peck, Stacy	Uncategorized											
Home Health-Care Partners Corp	Uncategorized											
Coffaro, Leslie Rn	Uncategorized											
Deane, Sarah Lmhc	Uncategorized											
Johansson, Joyce Rn	Uncategorized											
Seton Internal Medicine	Uncategorized											
Ieronimo, Darlene Lmsw	Uncategorized											
Barry, Mark Pa	Uncategorized											
Jacquard, Ann Elizabeth	Uncategorized											
Guido, Rochelle, Lmhc	Uncategorized											
Culkin, Josephine Rn	Uncategorized											
Strong, Julie Mhc	Uncategorized											
Taylor, Marilyn Rae Lcsw	Uncategorized											
Lazaroff, Terrie Marie	Uncategorized											
Axelrod, Howard Phd	Uncategorized											
Baratto, Nora Lcsw	Uncategorized											
Hadland, Nancy Louise	Uncategorized											
Schenectady County Public Health Services - Children With Special Needs	Uncategorized											

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Delguidice, Margaret Ot	Uncategorized											
Ali Mirza	Uncategorized											
Powers, Pius Md	Uncategorized											
Belvedere Health Services	Uncategorized											
Kane, Kathleen	Uncategorized											
Pearl, Carol Ann	Uncategorized											
Mangan, Kevin Aud	Uncategorized											
Dunn, Nancy Mhc	Uncategorized											
Seidenberg, Jessica Phd	Uncategorized											
Wagner, Mark Licensed Phd	Uncategorized											
Buehler, Mark Lcsw	Uncategorized											
Resource Medical Services, Pc (D.B.A. Arcwell Medical)	Uncategorized											
Valente, Michelle Mhc	Uncategorized											
Bove, Maria Lcsw-R	Uncategorized											
Wiedemann, Heidi Lmsw	Uncategorized											
Alicia Mahler	Uncategorized											
Living Resources Home Care Agency Inc.	Uncategorized											
Family & Child Service Of Schenectady	Uncategorized											
Reed, Bashiyra Mhc	Uncategorized											
Bovee, Deborah Lcsw-R	Uncategorized											
Abrams, Lynn Marie	Uncategorized											
Rhodes, Angela Lmsw	Uncategorized											
Labarge, Rebecca Mhc	Uncategorized											
Schenectady Ambulance Service, Inc	Uncategorized											
Mcdonnell, Kathleen Pt	Uncategorized											
Trujillo, Allison Lcsw	Uncategorized											
Eddy Licensed Home Care Agency, Inc.	Uncategorized											
Dybas, Lauren Lmhc	Uncategorized											
Rosewood Rehabilitation & Nursing Center	Uncategorized											
Frey, Catherine Lmsw	Uncategorized											
Gallo, Kristina Dds	Uncategorized											

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Community Maternity Services	Uncategorized											
Linney, Ileen	Uncategorized											
Forker-Hester, Cynthia Lcsw-R	Uncategorized											
Trinity Alliance Of The Capital Region, Inc.	Uncategorized											
Pathways Nursing And Rehabilitation Center	Uncategorized											
Forefront Medical Services, Pllc	Uncategorized											
Compassion And Support.Org Tech Assistance Center	Uncategorized											
Colletti, Michael Lmsw	Uncategorized											
Vnsny Choice Mltc	Uncategorized											
Wilson, Amanda Lmhc	Uncategorized											
Riverside Medical Group	Uncategorized											
Whitaker, Karleen Mhc	Uncategorized											
South Troy Health And Urgent Care Center	Uncategorized											
Witenberg Fisher, Susan Phd	Uncategorized											
Ross Medical Corporation	Uncategorized											
Fiedler, Kaylee Pt	Uncategorized											
Independent Living Center Of The Hudson Valley, Inc.	Uncategorized											
O'Brien, Sara Lmsw	Uncategorized											
Saratoga County Maplewood Manor	Uncategorized											
Family And Child Service Of Schenectady, Inc.	Uncategorized											
Norris, John Pt	Uncategorized											
Sanderson, Sandra Pt	Uncategorized											
Capital District Internal Medicine	Uncategorized											
Jordan, Diane Lcsw	Uncategorized											
Kennedy, Danielle Mhc	Uncategorized											
Shibley, Jessica	Uncategorized											
Jewish Family Services Of Northeaster New York	Uncategorized											
Huss, Julie Np	Uncategorized											
Rhodes, Judy	Uncategorized											
Mccarthy, Karen Rn	Uncategorized											
Blaha, Beth	Uncategorized											

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Farzin Davachi	Uncategorized											
Samaha, Maria Lcsw	Uncategorized											
Hospitality House	Uncategorized											
Towne, Sadie Lmhc	Uncategorized											
Stacey Lloyd, Ma Crc	Uncategorized											
O'Connor Ethier, Jomarie Ot	Uncategorized											
Family And Child Service Of Schenectady, Inc.	Uncategorized											
Milkiewicz, Sue Ann Rn	Uncategorized											
Chesnut, Walda Lmsw	Uncategorized											
Catholic Charities Disabilities Services Waiver Hcbs 4	Uncategorized											
Family And Child Service Of Schenectady, Inc.	Uncategorized											
Schmidt, Jennifer Np	Uncategorized											
Peterson, Julie Rn	Uncategorized											
Concordia, Taylor Mhc	Uncategorized											
Krasniqi, Beth-Anne Pt	Uncategorized											
Ryan, James Pa	Uncategorized											
Community Maternity Services	Uncategorized											
Lafrenier, Audrey, Lcsw-R	Uncategorized											
Nepa, Elyse Mhc	Uncategorized											
Peryea, Michelle	Uncategorized											
Laport, Robin Lmhc	Uncategorized											
Eidelberg, David Md	Uncategorized											
Russitano, Maryann	Uncategorized											
Newhoff, Renee Lmsw	Uncategorized											
Polsinelli, Amy Lmsw	Uncategorized											
Restivo, Mildred Lcsw	Uncategorized											
Levine, Lisa Lcsw	Uncategorized											
Toye-Vego, Marcia Ot	Uncategorized											
D'Aversa, Suzanne Lcsw-R	Uncategorized											
Empire Home Infusion Inc D/B/A Northeast Medical Home Equipment	Uncategorized											
Parkland Ambulance Service, Inc.	Uncategorized											

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Ochoa, Jennifer	Uncategorized											
Community Maternity Services	Uncategorized											
Buhler, Erica Lmsw	Uncategorized											
Cohoes Family Care	Uncategorized											
Vna Homecare Options Llc	Uncategorized											
Dejoy, Karen Aud	Uncategorized											
Troy Medical Group Family Practice	Uncategorized											
Kee To Independent Growth, Inc.	Uncategorized											
Roes, Audrey Slp	Uncategorized											
Van Diver, Aaron	Uncategorized											
Samaritan Hospital Troy	Uncategorized											
Colonie Senior Service Centers, Inc./Bright Horizons	Uncategorized											
Bethesda House Of Schenectady, Inc.	Uncategorized		✓				✓					
David, Krista Mhc	Uncategorized											
Howes, Sarah Lmsw	Uncategorized											
Meemken, Karen Lcsw	Uncategorized											
Lowry, Anita Diane	Uncategorized											
Grimm, Erin Mhc	Uncategorized											
Hospitalist Healthcare Services, Pllc	Uncategorized											
Gilston, Mary Lcsw-R	Uncategorized											
Carmel, Melissa	Uncategorized											
Villano, Diane Rn	Uncategorized											
Miller, Mary Frances Slp	Uncategorized											
Halvorsen, Ingrid Rn	Uncategorized											
Home Helpers And Direct Link	Uncategorized											
Birdsell, Denise Slp	Uncategorized											
Coleman, Joren Lmsw	Uncategorized											
Walsh, Stephanie D.	Uncategorized											
Cool, Stacey	Uncategorized											
Zimmer, Marianne Fnp-C	Uncategorized											
U.S. Care Systems Inc.	Uncategorized											

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Trumbull, Sue-Ellen Mhc	Uncategorized											
Nawab, Andalib	Uncategorized											
Waterford Family Health	Uncategorized											
Passino, Nicole Mhc	Uncategorized											
Vliek, Melissa Lcsw	Uncategorized											

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