



Project 2.a.i: Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 12/31/16

Deliverable: A clear strategic plan is in place which includes, at a minimum:

- **Definition of the Health Home At-Risk Intervention Program**
- **Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs.**

Documentation Needed:

1. **List of network providers**
2. **Updated list of network providers as changes occur.**
3. **List/inventory of agreements amongst providers in the IDS as it is defined in milestone requirement.**

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Milestone 2: Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.

DUE DATE: 3/31/17

Deliverable: PPS produces a list of participating HHs and ACOs.

Documentation Needed:

1. Updated list of participating HH comprising name, license #, start/end date of contract, full address, etc. The information must be provided in excel spreadsheet format.
2. Inventory of agreements with participating HHs and ACOs as it is defined in milestone requirement.
3. The evidence should include periodic meetings with schedules, agendas, meeting minutes, sign-in sheets, email conversations, etc.

Deliverable: Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.

Documentation Needed:

1. Periodic progress reports on implementation that demonstrates a path to evolve HH or ACO into IDS.

Deliverable: Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.

Documentation Needed:



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1. Inventory of meeting schedules, meeting agendas, meeting minutes, and list of attendees at meeting pertaining to the development of collaborative care practices and integrated service delivery.

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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.

DUE DATE: 3/31/17

Deliverable: Clinically Interoperable System is in place for all participating providers.

Documentation Needed:

1. HIE Systems demonstrating Clinical Interoperability across all providers.
2. Process workflows demonstrating how Clinical Interoperability Systems shares data across all participating providers, including responsible parties at every stage.

Deliverable: PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.

Documentation Needed:

1. Process flow diagrams demonstrating IDS processes.

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Continued: 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.

Deliverable: PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.

Documentation Needed:

1. Provide standard contract or agreement between network partners which demonstrates a requirement for tracking care outside of hospitals.
2. Sample reports which demonstrate a process for tracking care outside of hospitals, for example a registry which shows appointments following discharge from hospital. Report should reflect hospital and nonhospital providers.
3. Evidence of discharge plans uploaded into EHR.
4. Other sources demonstrating implementation of the system.

Deliverable: PPS trains staff on IDS protocols and processes

Documentation Needed:

1. List/inventory of training materials developed to train PPS staff on IDS protocols and processes.
2. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.

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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.

DUE DATE: 3/31/18

Deliverable: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements

Documentation Needed:

1. List/inventory of participation agreement with Qualified Entities as of project requirement.
2. Evidence of electronic information exchange of patient information within PPS network.
3. Evidence of secure email transactions using national standards, e.g. DIRECT. Evidence should include screenshot of email between multiple parties demonstrating encryption.

Deliverable: PPS uses alerts and secure messaging functionality.

Documentation Needed:

1. Documentation supporting the certification of the EHR system from a national certification entity.
2. Screenshots or other evidence of use of alerts and secure messaging.
3. List/inventory of staff training materials developed for this project.
4. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.

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NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/18

Deliverable: Documentation to be Provided Upon Requirement Completion by PPS

Documentation Needed:

1. CMS, NYS or EHR meaningful use certification.

Deliverable: Documentation to be Provided Upon Requirement Completion by PPS

Documentation Needed:

1. List of participating physicians/practitioners comprising name, license #, start/end date of contract, type of provider, full address, etc.
The information must be provided in excel spreadsheet format.
2. None required at metric completion unless chosen in random sample as described above.

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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.

DUE DATE: 3/31/18

Deliverable: PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

1. Sample patient registries showing functionality across multiple providers in PPS network.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

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Milestone 7: Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.

DUE DATE: 3/31/18

Deliverable: Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.

Documentation Needed:

1. Status reporting of recruitment of PCPs, particularly in high-need areas.
2. CAHPS documentations such as surveys demonstrating that patients have better access to primary care services.

Deliverable: All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.

Documentation Needed:

1. List of participating physicians/practitioners comprising name, license #, start/end date of contract, type of provider, full address, etc.
The information must be provided in excel spreadsheet format.
2. None required at metric completion unless chosen in random sample as described above.

Deliverable: EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)

Documentation Needed:

1. CMS, NYS or EHR meaningful use certification.

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Milestone 8: Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.

DUE DATE: 3/31/17

Deliverable: Medicaid Managed Care contract(s) are in place that include value-based payments.

Documentation Needed:

1. List/inventory of contracts with participating MCOs as it is defined in milestone requirement.
2. Report demonstrating percentage of total provider Medicaid reimbursement using value-based payments.

Milestone 9: Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.

DUE DATE: 3/31/17

Deliverable: PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.

Documentation Needed:

1. Inventory of meeting schedules, meeting agendas, meeting minutes, and list of attendees at meetings with MCOs to discuss utilization trends, performance issues and payment reform.
2. Process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership.

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Milestone 10: Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.

DUE DATE: 3/31/18

Deliverable: PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation.

Documentation Needed:

1. Policies and procedures that provide details of the provider compensation according to patient outcomes. The compensation model must demonstrate how the compensation will be affected according to patient outcomes. The VBP growth plan and compensation model should contain consultant recommendations.

Deliverable: Providers receive incentive-based compensation consistent with DSRIP goals and objectives.

Documentation Needed:

1. Provide standard contract or agreement between network partners which demonstrates a requirement for providers to receive incentive-based compensation.
2. Report showing which network providers are receiving incentive-based compensation.
3. Process implemented by PPS to complete reconciliation of payments under incentive-based models and resulting payment reconciliation documentation.
4. Other sources demonstrating implementation of the compensation and performance management system.

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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.

DUE DATE: 3/31/16

Deliverable: Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.

Documentation Needed:

1. List/inventory of community-based organizations utilized in IDS for outreach and navigation activities.
2. Provide job postings to demonstrate active hiring and list of community-based health workers hired at milestone completion.
3. List of executed co-location agreements between community health workers and CBOs.
4. Job description of the community health workers utilized for outreach and navigation activities.
5. List/inventory of patients who are engaged with community health worker.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 1: Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.

DUE DATE: 3/31/17

Deliverable: A clear strategic plan is in place which includes, at a minimum:

- **Definition of the Health Home At-Risk Intervention Program**
- **Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs.**

Documentation Needed:

1. **Complete strategic plan, which must define the Health Home At-Risk Intervention Program and comprehensive care management plan, including the roles of PCMH/APC PCPs and HHs**
2. **Periodic progress reports on implementation that demonstrate a path to development of the Health Home At-Risk Intervention Program.**

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 2: Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and/or Advanced Primary Care accreditation by Demonstration Year (DY) 3

DUE DATE: 3/31/18

Deliverable: All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.

Documentation Needed:

1. List of participating physicians/practitioners comprising
 - a. name,
 - b. license #,
 - c. start/end date of contract,
 - d. type of provider,
 - e. full address, etc.

The information must be provided in excel spreadsheet format.

NOTE: The IA will ask for a random sample of physicians from the list provided and request certification documents for the selected physicians

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 3: Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up

DUE DATE: 3/31/18

Deliverable: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.

Documentation Needed:

1. List/inventory of participation agreement with Qualified Entities as detailed in project requirement
2. Evidence of electronic information exchange of patient information within PPS network.
3. Evidence of secure email transactions using national standards, e.g. DIRECT. Evidence should include screenshot of email between multiple parties demonstrating encryption.

Deliverable: PPS uses alerts and secure messaging functionality.

Documentation Needed:

1. Documentation supporting the certification of the EHR system from a national certification entity.
2. Screenshots or other evidence of use of alerts and secure messaging.
3. List/inventory of staff training materials developed for this project.
4. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.



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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 4: : Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.

DUE DATE: 3/31/18

Deliverable: EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).

Documentation Needed:

1. CMS, NYS or EHR meaningful use certification.

Deliverable: PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.

Documentation Needed:

1. List/inventory of providers who have achieved NCQA 2014 Level 3 PCMH standards and/or APCM.

Milestone 5: Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.

DUE DATE: 3/31/18

Deliverable: PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.



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Documentation Needed:

1. Sample patient registries showing functionality across multiple providers in PPS network.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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

DUE DATE: 3/31/18

Deliverable: Procedures to engage at-risk patients with care management plan instituted

Documentation Needed:

1. Process workflows demonstrating how the comprehensive care management plan engaged patients in care and reduces patient risk factors.
2. List/inventory of training materials developed for this project.
3. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.
4. Sample care management plans which demonstrate how each patient is engaged in care and reduces patient risk factors.
5. Documentation which demonstrates how the PPS engages at-risk patients.
6. List/inventory of number of patients engaged with care management plan.

Milestone 7: Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.

DUE DATE: 3/31/17

Deliverable: Each identified PCP establish partnerships with the local Health Home for care management services.



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Documentation Needed:

1. Documentation of the policies and procedures surrounding information-sharing and the establishment of partnerships with local HH for care management.
2. List/inventory providing the number of patients provided care management services.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 8: Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).

DUE DATE: 3/31/17

Deliverable: PPS has established partnerships to medical, behavioral health, and social services.

Documentation Needed:

1. Documentation of the policies and procedures surrounding information-sharing and the establishment of partnerships with local HH for care management.
2. List/inventory providing the number of patients provided care management services.
3. List/inventory of agreements with partner providers and agencies as it is defined in milestone requirement.
4. Documentation which describes care coordination processes and services.
5. Documentation of the policies and procedures related to the clinical team's group decision-making.

Deliverable: PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.

Documentation Needed:

1. Documentation supporting the certification of the EHR system from a national certification entity.
2. Documentation of protocols for use of EHR vendor referral documentation.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 9: Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

DUE DATE: 3/31/17

Deliverable: PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.

Documentation Needed:

1. Documentation of policy surrounding evidence-based guidelines and the sources of the guidelines used.
2. Documentation demonstrating the process and workflow and the responsible resources used at each stage.
3. List/inventory of training materials developed for this project.
4. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.
5. Documentation detailing how the evidence-based protocols were developed
6. List/inventory of training materials developed for this project.

Deliverable: Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.

Documentation Needed:

1. Inventory of meeting schedules, meeting agendas, meeting minutes, and list of attendees at meeting pertaining to development of collaborative evidence-based standards of care including medication management and care engagement process.

Deliverable: PPS has included social services agencies in development of risk reduction and care practice guidelines.

Documentation Needed:



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1. Inventory of meeting schedules, meeting agendas, meeting minutes, and list of attendees at meeting pertaining to development of risk reduction and care practice guidelines.
2. Inventory of agreements with participating social service agencies as it is defined in milestone requirement.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 1: Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.

DUE DATE: 3/31/19

Deliverable: A strategic plan is in place which includes, at a minimum:

- **Definition of services to be provided in medical village and justification based on CNA.**
- **Plan for transition of inpatient capacity.**
- **Description of process to engage community stakeholders.**
- **Description of any required capital improvements and physical location of the medical village.**
- **Plan for marketing and promotion of the medical village and consumer education regarding access to medical village services.**

Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.

Documentation Needed:

1. Complete strategic plan which must describe the plan to convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.
2. Periodic progress reports on implementation that demonstrate a path to development of the outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.
3. List/inventory of meeting minutes, attendees and organizations represented.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 2: Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or “staffed” beds.

DUE DATE: 3/31/17

Deliverable: PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.

Documentation Needed:

1. Certificate of Need (CON) for bed reduction.
2. Detailed bed reduction timeline.
3. Baseline must be set for bed capacity. The PPS must submit procedure utilized to set baseline bed capacity, such as community need assessment.
4. Periodic progress reports documenting bed reduction with detailed timeline.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 3: Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state- determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.

DUE DATE: 3/31/18

Deliverable: All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.

Linked to: Helene Kopal

Documentation Needed:

1. List of participating physicians/practitioners comprising name, license #, start/end date of contract, type of provider, full address, etc. The information must be provided in excel spreadsheet format.
 2. None required at Deliverable completion unless chosen in random sample as described above.
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Milestone 4: Ensure that all safety net providers participating in Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.

DUE DATE: 3/31/18

Deliverable: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.

Linked to: Helene Kopal

Documentation Needed:

1. List/inventory of participation agreement with Qualified Entities as detailed in project requirement.



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2. Evidence of electronic information exchange of patient information within PPS network.
3. Evidence of secure email transactions using national standards, e.g. DIRECT. Evidence should include screenshot of email between multiple parties demonstrating encryption.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 5: Use EHRs and other technical platforms to track all patients engaged in the project.

DUE DATE: 3/31/17

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

1. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

Milestone 6: Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2.

DUE DATE: 3/31/18

Deliverable: EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).

Linked to: Helene Kopal

Documentation Needed:

1. CMS, NYS or EHR meaningful use certification.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 7: Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.

DUE DATE: 3/31/17

Deliverable: Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.).

Documentation Needed:

1. Detailed plan for migration of any services to different setting or location due to infrastructure changes.
2. Documentation that demonstrates that the migration of services is supported up by community needs assessment.
3. Documentation of the migration plan described above should include details regarding the frequency of updates.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/17

Deliverable: Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.

Documentation Needed:

1. Documentation of process and workflow demonstrating implementation of care transitions intervention model across corresponding providers as defined in project requirement, including responsible parties at every stage.
2. List/inventory of staff training materials developed for this project.
3. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/18

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

Documentation Needed:

1. List/inventory of payment agreements or MOU with Managed Care Plans as defined in milestone requirement.
2. Documentation of methodology and strategies including identification of responsible resources at each stage of the workflow to accomplish the project objective as defined in project requirement and Deliverable.
3. List/inventory of periodic self-audit reports and recommendations that demonstrate the PPS has engaged with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
4. List/inventory of written attestation or evidence of coordination of care transition strategies with Health Homes and the supportive housing site to accomplish the project objective as defined in project requirement and Deliverable.
5. Documentation of process and workflow demonstrating how post-discharge protocols are followed to implement care transition intervention model across all participating providers, including responsible parties at every stage.



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6. List/inventory of staff training materials developed for this project.
7. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 3: Ensure required social services participate in the project.

DUE DATE: 3/31/18

Deliverable: List/inventory of the required network social services, including medically tailored home food services, are provided in care transitions.

Documentation Needed:

1. List/inventory of the required network social services, including medically tailored home food services, are provided in care transitions.
2. Documentation of process and workflow demonstrating participation of social services in care transitions intervention model, including responsible parties at every stage.
3. List/inventory of written attestation or evidence of agreements with required social services as it is defined in project requirement and Deliverable.
4. List/inventory of periodic self-audit reports and recommendations that demonstrate the PPS is ensuring the required social services participate in this project.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/17

Deliverable: Policies and procedures are in place for early notification of planned discharges. PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.

Documentation Needed:

1. Documentation of early notification of planned discharge process and workflow including responsible resources at each stage.
2. List/inventory of training materials developed for this project.
3. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.
4. Provide standard contract or agreement demonstrating the PPS has a program that allows care managers access to visit patients in the hospital and provide care transition services and advisement as it is defined in project requirement and Deliverable.
5. Documentation which demonstrates that the system is designed to fulfill this project requirement.
6. Documentation demonstrating that the care manager has access to visit their patients in the hospital.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 5: Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.

DUE DATE: 3/31/17

Deliverable: 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.

Documentation Needed:

1. Documentation of process and workflow demonstrating how interoperable systems share data across all participating providers, including responsible parties at every stage.
2. List/inventory of staff training materials developed for this project.
3. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.
4. List/inventory of periodic self-audit reports and recommendations that demonstrate 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.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 6: Ensure that a 30-day transition of care period is established

DUE DATE: 3/31/17

Deliverable: Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.

Documentation Needed:

1. Documentation of the policies and procedures demonstrating the requirement that 30 day transition of care period is established, implemented, and utilized.

Milestone 7: Use EHRs and other technical platforms to track all patients engaged in the project.

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

DUE DATE: 3/31/17

Documentation Needed:



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1. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 1: Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.

DUE DATE: 3/31/19

Deliverable: Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.

Documentation Needed:

1. List/inventory of MOUs, letters, contracts, agreements and other documentation between the PPS and CBOs as defined in milestone requirement.
2. Quarterly report narrative demonstrating successful implementation of project requirements.

Milestone 2: Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

DUE DATE: 3/31/16

Documentation Needed:



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1. List/inventory of names and respective roles of team staff trained in PAM® or other patient activation methods.
2. List/inventory of training materials and trainers developed for this project.

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/17

Deliverable: Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.

Documentation Needed:

1. "Hot spot" map delineated by UI, NU, LU types.
2. Documentation of CBO outreach within appropriate "hot spot" areas.

Milestone 4: Survey the targeted population about healthcare needs in the PPS’ region.

Deliverable: Community engagement forums and other information-gathering mechanisms established and performed.

DUE DATE: 3/31/17

Documentation Needed:

1. List/inventory of community forums held detailing locations, agenda, and presenters.



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2. Documentation of surveys or other information-gathering techniques performed by the PPS to survey the targeted population about healthcare needs in the PPS' region.

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 5: Train providers located within “hot spots” on patient activation techniques, such as shared decision- making, measurements of health literacy, and cultural competency.

DUE DATE: 3/31/19

Deliverable: PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM® trainers".

Documentation Needed:

1. List/inventory of PPS providers trained in PAM®.
2. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), and the format of the training (in person or online).
3. List/inventory of training materials developed to train providers on patient activation techniques.

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.

4.

5.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/17

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.

Documentation Needed:

1. Documentation of the 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.
2. List/inventory of information-exchange agreements with PPS and MCO per the project requirement.

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 7: Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® 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.

DUE DATE: 3/31/19

Deliverable: For each PAM® activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).

Documentation Needed:

1. Documentation of the baseline, periodic and annual PAM® cohort reports and presentations as defined in the project requirement.

Milestone 8: Include beneficiaries in development team to promote preventive care.

DUE DATE: 3/31/17

Deliverable: Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.

Documentation Needed:

1. List/inventory of contributing patient members participating in program development and awareness efforts. Documentation should be consistent with Patient Engagement requirements (as articulated above).

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 9: Measure PAM® 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® survey and designate a PAM® 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® 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.

DUE DATE: 3/31/19

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.

CONTINUED: Milestone 9

Deliverable: Performance measurement reports established, including but not limited to:

- Number of patients screened, by engagement level.
- Number of clinicians trained in PAM® 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.

Documentation Needed:

1. Documentation of the performance measurement reports and presentations as defined in the Deliverable requirement above.
2. Annual report assessing individual member and the overall cohort's level of engagement.
3. Member engagement lists, by PAM® cohort as defined in the Deliverable requirement above

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 10: Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.

DUE DATE: 3/31/19

Deliverable: Volume of non-emergent visits for UI, NU, and LU populations increased.

Documentation Needed:

1. Documentation noting baseline non-emergent volume with periodic reports demonstrating increase in visits (specific to UI, NU, and LU patients).

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.

DUE DATE: 3/31/19

Deliverable: Community navigators identified and contracted.

Documentation Needed:

1. List/inventory of community navigator credentials (by designated area) detailing navigator names, location, and contact information.

Deliverable: Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.

Documentation Needed:

1. Provide an inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.
2. PPS must upload a document that articulates the inventory of training materials developed for this project.

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 12: Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.

DUE DATE: 3/31/17

Deliverable: Policies and procedures for customer service complaints and appeals developed.

Documentation Needed:

1. Documentation of the procedures and protocols developed for Medicaid recipients and project participants to report complaints and receive customer service, including appeals.

Milestone 13: Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.

DUE DATE: 3/31/17

Deliverable: List of community navigators formally trained in the PAM®. (Provider level requirement).

Documentation Needed:



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1. List/inventory of the community navigators formally trained in the PAM®, including the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy of training agenda materials, and team staff roles who will be engaged in patient activation.

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/19

Deliverable: Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.

Documentation Needed:

1. Documentation demonstrating navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.

Milestone 15: Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.

DUE DATE: 3/31/19

Deliverable: List of community navigators formally trained in the PAM®. (Provider level requirement).

Documentation Needed:

1. List/inventory of navigators trained by PPS about insurance options and healthcare resources available to UI, NU, and LU populations.]
2. List/inventory of the PPS trainers.

3. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), and the format of the training (in person or online).
4. PPS must upload a document that articulates the inventory of training materials developed for this project.

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.

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 16: Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.

DUE DATE: 3/31/19

Deliverable: Timely access for navigator when connecting members to services.

Documentation Needed:

1. Documentation of the policies and procedures regarding the ability of the intake and/or scheduling staff to receive navigator calls.
2. List/inventory of provider intake staff trained by the PPS.

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.

DUE DATE: 3/31/17

Deliverable: PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

1. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

3ai: Integration of Primary Care and Behavioral Health Services (Model 1)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 1: Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3

DUE DATE: 3/31/18

Deliverable: All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3

Documentation Needed:

1. List of participating physicians/practitioners comprising of:
 - a. name,
 - b. license #,
 - c. start/end date of contract,
 - d. type of provider,
 - e. full address, etc.

The information must be provided in excel spreadsheet format.

Deliverable: Behavioral health services are co-located within PCMH/APC practices and are available.

Documentation Needed

3. Comprehensive list of behavioral health practitioners and licensure performing services at PCMH and/or APCM sites.



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4. List of dates and hours when behavioral health services are available at PCMH and/or APCM sites for all sites. The information must be provided in excel spreadsheet format.

3ai: Integration of Primary Care and Behavioral Health Services (Model 1)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 2: Develop collaborative evidence-based standards of care including medication management and care engagement process.

DUE DATE: 3/31/17

Deliverable: Regularly scheduled formal meetings are held to develop collaborative care practices.

Documentation Needed:

1. Inventory of :
 - a. Meeting schedules OR
 - b. Meeting agendas OR
 - c. Meeting minutes OR
 - d. List of attendees at meeting pertaining to development of collaborative evidence-based standards of care including medication management and care engagement process

Deliverable: Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.

Documentation Needed:

1. Documentation of policy surrounding evidence-based guidelines and the sources of the guidelines used.

3ai: Integration of Primary Care and Behavioral Health Services (Model 1)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

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.

DUE DATE: 3/31/18

Deliverable: Policies and procedures are in place to facilitate and document completion of screenings.

Documentation Needed:

1. Documentation of the policies and procedures used to conduct preventive care screenings, including behavioral health screenings.

Deliverable: Screenings are documented in Electronic Health Record.

Documentation Needed:

1. Screenshots or other evidence of notifications of patient identification and screening alerts.
2. Evidence that the system is an EHR certified vendor.

Deliverable: 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).

Documentation Needed:

1. Roster of identified patients.
2. Number of screenings completed at established project sites.

Deliverable: Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.

Documentation Needed:

1. Notation in EHR demonstrating that warm transfers have occurred.

3ai: Integration of Primary Care and Behavioral Health Services (Model 1)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 4: Use EHRs or other technical platforms to track all patients engaged in this project.

DUE DATE: 3/31/17

Deliverable: EHR demonstrates integration of medical and behavioral health record within individual patient records.

Documentation Needed:

1. Screenshots in EHR showing treatment by both medical and behavioral health providers.

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

1. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

3ai: Integration of Primary Care and Behavioral Health Services (Model 1)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 4: Use EHRs or other technical platforms to track all patients engaged in this project.

DUE DATE: 3/31/17

Deliverable: EHR demonstrates integration of medical and behavioral health record within individual patient records.

Documentation Needed:

2. Screenshots in EHR showing treatment by both medical and behavioral health providers.

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

3. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
4. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

3aii: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 1: Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.

DUE DATE: 3/31/19

Deliverable: PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.

Documentation Needed:

1. Quarterly report narrative demonstrating successful implementation of project requirements

Milestone 2: Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.

DUE DATE: 3/31/19

Deliverable: PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).

Documentation Needed:

1. Documentation of the diversion management guidelines and protocols.
2. Documentation detailing how the diversion protocols were developed.
3. List/inventory of the policies and procedures regarding frequency of updates to guidelines and protocols.

3a: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 3: Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.

DUE DATE: 3/31/19

Deliverable: PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.

Documentation Needed:

1. List/inventory of MOU between PPS and MCO and/or documentation demonstrating negotiation for coverage of services with MCO.

Milestone 4: Develop written treatment protocols with consensus from participating providers and facilities.

DUE DATE: 3/31/17

Deliverable: Regularly scheduled formal meetings are held to develop consensus on treatment protocols.

Documentation Needed:

1. Inventory of meeting schedules, meeting agendas, meeting minutes, and list of attendees at meeting pertaining to development of written treatment protocols with consensus from participating providers and facilities.

Deliverable: Coordinated treatment care protocols are in place.

Documentation Needed:

1. Documentation of protocols and guidelines.
2. PPS must upload a document that articulates the inventory of training materials developed for this project.



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3. Provide an inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.

3aii: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 5: Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.

DUE DATE: 3/31/17

Deliverable: PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network.

Documentation Needed:

1. List of participating physicians/practitioners comprising name, license #, start/end date of contract, type of provider, full address, etc.

The information must be provided in excel spreadsheet format.

Deliverable: PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.

Documentation Needed:

1. Documentation which demonstrates how the PPS plans to address access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.
2. Documentation which demonstrates how the PPS plans to improve access to psychiatric and crisis-oriented services as detailed in the project requirement.
3. Reports which detail access to psychiatric and crisis-oriented services (including geographic access and service wait time reports).

3a: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 6: Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).

DUE DATE: 3/31/19

Deliverable: PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.

Documentation Needed:

1. List of participating physicians/practitioners comprising name, license #, start/end date of contract, type of provider, full address, etc.

The information must be provided in excel spreadsheet format.

Deliverable: PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.

Documentation Needed:

1. Documentation which demonstrates how the PPS plans to address access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.
2. Documentation which demonstrates how the PPS plans to improve access to psychiatric and crisis-oriented services as detailed in the project requirement.
3. Reports which detail access to psychiatric and crisis-oriented services (including geographic access and service wait time reports).

3a: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 7: Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.

DUE DATE: 3/31/19

Deliverable: PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.

Documentation Needed:

1. List/inventory providing the roster of mobile crisis team members as defined in the project requirements.

Deliverable: Coordinated evidence-based care protocols for mobile crisis teams are in place.

Documentation Needed:

1. Documentation of care protocols and implementation plan.
2. PPS must upload a document that articulates the inventory of training materials developed for this project.
3. Provide an inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.

3aii: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 8: Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.

DUE DATE: 3/31/18

Deliverable: EHR demonstrates integration of medical and behavioral health record within individual patient records.

Documentation Needed:

1. Screenshots in EHR showing treatment by both medical and behavioral health providers.

Deliverable: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.

Documentation Needed:

1. List/inventory of participation agreement with Qualified Entities as detailed in project requirement.
2. Evidence of electronic information exchange of patient information within PPS network.
3. Evidence of secure email transactions using national standards, e.g. DIRECT. Evidence should include screenshot of email between multiple parties demonstrating encryption.

Deliverable: Alerts and secure messaging functionality are used to facilitate crisis intervention services.

Documentation Needed:

1. Documentation supporting the certification of the EHR system from a national certification entity.
2. Screenshots or other evidence of use of alerts and secure messaging.



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3. PPS must upload a document that articulates the inventory of training materials developed for this project.
4. Provide an inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.

3aii: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 9: Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.

DUE DATE: 3/31/19

Deliverable: PPS has implemented central triage service among psychiatrists and behavioral health providers.

Documentation Needed:

1. List/inventory of operating agreements to implement a central triage service among psychiatrists and behavioral health providers
2. Documentation of the policies and procedures related to triage services.
3. Reports demonstrating triage performance.
4. PPS must upload a document that articulates the inventory of training materials developed for this project.
5. Provide an inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.

3a: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 10: Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care

DUE DATE: 3/31/17

Deliverable: PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.

Documentation Needed:

1. List/inventory of committee members comprising name, organization represented and staff category as defined in the milestone requirement.

Deliverable: Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.

Documentation Needed:

1. Documentation of quality improvement plans developed by the quality committee which identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.
2. Documentation which demonstrates a root cause analysis has been performed on the issues raised in the quality improvement plans.
3. Documentation which demonstrates how the issues raised in the quality improvement plans will be addressed. (Implementation reports)
4. Documentation which demonstrates the results of the implementation plans. (Implementation results)



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5. List/inventory of the meeting minutes of the quality committee.

3a: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Continued: Milestone 10: Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care

DUE DATE: 3/31/17

Deliverable: PPS evaluates and creates action plans based on key quality Deliverables, to include applicable Deliverables listed in Attachment J Domain 3 Behavioral Health Deliverables.

Documentation Needed:

1. List/inventory of the meeting minutes of the quality committee pertaining to the evaluation and creation of action plans based on key quality Deliverables, including applicable Deliverables listed in Attachment J Domain 3 Perinatal Care Deliverables.
2. Documentation which demonstrates the PPS has created a clinical quality improvement action plan.
3. Documentation which demonstrates the PPS has performed a follow-up evaluation of action plans.

Deliverable: PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.

Documentation Needed:

1. List/inventory of periodic self-audit reports and recommendations to ensure compliance with processes and procedures developed for this project.

Deliverable: Service and quality outcome measures are reported to all stakeholders including PPS quality committee.

Documentation Needed:

1. List/inventory of website URLs with published reports.



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2. List/inventory of newsletters
3. Other documentation demonstrating distribution of quality outcomes
4. Reports to PPS quality committee.

3a: Behavioral health community crisis stabilization services

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 11: Use EHRs or other technical platforms to track all patients engaged in this project.

DUE DATE: 3/31/17

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

1. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

Project 3.c.i: Evidence-based strategies for diseases management in high risk/affected populations (Adult only)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 1: Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.

DUE DATE: 3/31/17

Deliverable: Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.

Documentation Needed:

3. Protocols for disease management and control of diabetes.
4. Documentation of the process and workflow demonstrating implementation of evidence- based best practice for diabetes management and control, including responsible parties at every stage, as defined by project requirement.
5. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.
6. List/inventory of staff training materials developed for this project.
7. List/inventory of periodic self-audit reports and recommendations that demonstrate the PPS is monitoring strategies for the management and control of diabetes in the PPS designated area

Project 3.c.i: Evidence-based strategies for diseases management in high risk/affected populations (Adult only)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 2: Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.

DUE DATE: 3/31/17

Deliverable: PPS has engaged at least 80% of their PCPs in this activity.

Documentation Needed:

1. List of total participating PCPs physicians/practitioners comprising name, license #, start/end date of contract, full address, etc. The information must be provided in excel spreadsheet format.
2. List of engaged participating PCPs physicians/practitioners comprising name, license #, start/end date of contract, full address, etc. The information must be provided in excel spreadsheet format.

Project 3.c.i: Evidence-based strategies for diseases management in high risk/affected populations (Adult only)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 3: Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self- efficacy, and patient self-management.

DUE DATE: 3/31/17

Deliverable: Clinically Interoperable System is in place for all participating providers.

Documentation Needed:

1. Provide standard contract or agreement between network partners for care coordination development as defined in project requirement.
2. System report demonstrating Clinical Interoperability across all providers.
3. Evidence that the system is an EHR certified vendor.
4. Other sources demonstrating implementation of the system.

Deliverable: Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.

Documentation Needed:

1. List/inventory of care coordination team comprising name, license #, start/end date of contract, type of provider, full address, etc. The information must be provided in excel spreadsheet format.
2. Documentation of the care coordination policies and procedures as defined in project Deliverable.
3. Standard clinical protocol and treatment plans.

Deliverable: Care coordination processes are established and implemented.

Documentation Needed:

1. Documentation of process and workflow including responsible resources at each stage of the workflow for care coordination



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processes establishment and implementation as defined in project requirement.

2. List/inventory of staff training materials developed for this project.
3. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.

Project 3.c.i: Evidence-based strategies for diseases management in high risk/affected populations (Adult only)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 4: Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.

DUE DATE: 3/31/17

Deliverable: If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.

Documentation Needed:

1. REAL dataset, as defined in project Deliverable, to develop "hot spotting" strategies according to project requirement.
2. Documentation of the process and workflow demonstrating development and implementation of "hot spotting" strategies, in concert with participating providers as defined in project requirement. The document must include responsible parties at every stage for project development and implementation.
3. List/inventory of staff training materials developed for this project.
4. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.
5. List/inventory of periodic self-audit reports and recommendations to monitor "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.

Deliverable: If applicable, PPS has established linkages to health homes for targeted patient populations.

Documentation Needed:

1. List/inventory of written attestation or evidence of agreements to establish linkages to health homes for targeted patient population.
2. Documentation of process and workflow including responsible resources at each stage of the workflow to establish linkages to health



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homes for targeted patient population.

3. List/inventory of staff training materials developed for this project.
4. Provide an inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.

Project 3.c.i: Evidence-based strategies for diseases management in high risk/affected populations (Adult only)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Continued: Milestone 4: Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.

Deliverable: If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.

Documentation Needed:

1. List/inventory of written attestation or evidence of agreement with community partner in association for this project implementation.
2. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.
3. List/inventory of staff training materials developed for this project.

Milestone 5: Ensure coordination with the Medicaid Managed Care organizations serving the target population

DUE DATE: 3/31/17

Deliverable: PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.

Documentation Needed:

1. List/Inventory of written attestations or evidence of agreement of coordination of services for high risk populations with Medicaid Managed Care companies, as it is defined in project requirement and Deliverable.

Project 3.c.i: Evidence-based strategies for diseases management in high risk/affected populations (Adult only)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 6: Use EHRs or other technical platforms to track all patients engaged in this project.

DUE DATE: 3/31/17

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

1. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.

Deliverable: PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.

Documentation Needed:

1. Sample of recall reports demonstrating EHRs or other technical platforms' ability to track patients who are overdue for preventive services.
2. Roster of identified patients, demonstrating EHRs or other technical platforms' ability to track patients who are overdue for preventive services.
3. Screenshots of recall system, demonstrating EHRs or other technical platforms' ability to track patients who are overdue for preventive services.

Project 3.c.i: Evidence-based strategies for diseases management in high risk/affected populations (Adult only)

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 7: Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.

DUE DATE: 3/31/18

Deliverable: EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).

Documentation Needed:

1. CMS, NYS or EHR meaningful use certification.

Deliverable: PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.

Documentation Needed:

1. List of participating physicians/practitioners comprising name, license #, start/end date of contract, type of provider, full address, etc.
The information must be provided in excel spreadsheet format.

Deliverable: EHR meets connectivity to RHIO/SHIN-NY requirements.

Documentation Needed:

1. List/inventory of participation agreement with Qualified Entities as detailed in project requirement.
2. Evidence of electronic information exchange of patient information within PPS network.
3. Evidence of secure email transactions using national standards, e.g. DIRECT. Evidence should include screenshot of email between multiple parties demonstrating encryption.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 1: Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional

DUE DATE: 3/31/17

Deliverable: PPS has agreements from participating providers and community programs to support an evidence-based asthma management guidelines.

Documentation Needed:

1. List/inventory of agreements with participating asthma specialists and asthma educators as it is defined in milestone requirement.
2. Identification of participating providers' affiliation with Regional Asthma Coalition.

Deliverable: All participating practices have a Clinical Interoperability System in place for all participating providers.

Documentation Needed:

1. Provide standard contract or agreement between network partners which demonstrates a requirement for participating providers to have a Clinical Interoperability System in place.
2. Documentation supporting the Clinical Interoperability System in place for all participating providers.
3. Other sources demonstrating implementation of the system.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 2: Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine. *DUE DATE: 3/31/17*

Deliverable: Agreements with asthma specialists and asthma educators are established.

Documentation Needed:

1. List/inventory of agreements with participating asthma specialists and asthma educators as it is defined in milestone requirement.
2. Evidence of methodology used to establish a patient to physician ratio.

Deliverable: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.

Documentation Needed:

1. List/inventory of participation agreement with Qualified Entities as detailed in project requirement.
2. Evidence of electronic information exchange of patient information within PPS network.
3. Evidence of secure email transactions using national standards, e.g. DIRECT. Evidence should include screenshot of email between multiple parties demonstrating encryption.

Deliverable: Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to:

- Analysis of the availability of broadband access in the geographic area being served.
- Gaps in services.
- Geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients.
- Why telemedicine is the best alternative to provide these services.
- Challenges expected and plan to pro-actively resolve
- Plan for long term sustainability

Documentation Needed:

1. List/inventory of standard clinical protocols and treatment plans as defined in the project milestone.
2. List of telemedicine sites.
3. Documentation which demonstrates telemedicine implementation (claims, screenshots, or service agreements).

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 3: Deliver educational activities addressing asthma management to participating primary care providers.

DUE DATE: 3/31/17

Deliverable: Participating providers receive training in evidence-based asthma management.

Documentation Needed:

1. List/inventory of training materials developed to train PPS staff on evidence-based asthma management.
2. List/inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online) as well as the number of staff trained.

Milestone 4: Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.

DUE DATE: 3/31/16

Deliverable: PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.



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Documentation Needed:

1. List/Inventory of agreements with participating MCOs as it is defined in milestone requirement.
2. List/inventory of written agreements with participating Health Homes as it is defined in milestone requirement.

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

NOTE: ONE PIECE OF DOCUMENTATION/ DATA SOURCE NEEDS TO BE PROVIDED UNDER EACH DELIVERABLE

Milestone 5: Use EHRs or other technical platforms to track all patients engaged in this project.

DUE DATE: 3/31/17

Deliverable: PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

Documentation Needed:

1. Sample report which demonstrates process for tracking patients between multiple providers in the EHR.
2. Screenshots demonstrate completeness of EHR system including evidence of patient name, appointments, and services received by patient.