Performing Provider System (PPS)

Westchester Medical Center Health Network

CENTER *for* REGIONAL HEALTHCARE INNOVATION

A MEMBER OF THE **WMCHEALTH** NETWORK

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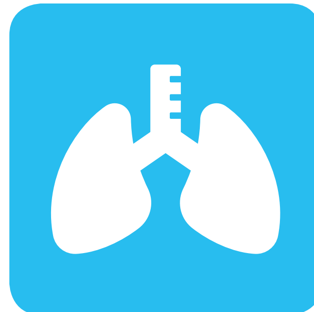


WMCHEALTH PPS

Implementation Plan

Provider Engagement

Actively Engaged Patients

Contents

2.a.i	Create Integrated Delivery System	1
2.a.iii	Health Home At-Risk Intervention Program	6
2.a.iv	Create A Medical Village	11
2.b.iv	Post Hospital Care Transitions	14
2.d.i	Patient Activation	17
3.a.i	Integration of Primary Care and Behavioral Health Services	22
3.a.ii	Behavioral Health Community Crisis Stabilization Services	25
3.c.i	Diabetes Management	31
3.d.iii	Asthma Care Management	35
4.b.i	Tobacco Cessation	39
4.b.ii	Cancer Screening	40

2.a.i

INTEGRATED DELIVERY SYSTEM

Implementation Plan

Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management.

MILESTONE	PROJECT PLAN	COMPLETION DATE*
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.	12/31/16
DELIVERABLE	PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	12/31/15
STEP 1	WMC PPS customizes Salesforce to support IDS network; establish provider type, geographic, and other categories.	12/31/15
STEP 2	Execute Master Services Agreement with PPS network Participants and/or services contract between the PPS PMO and CBOs as appropriate.	03/31/16
STEP 3	WMC PPS to identify gaps in provider types, geographic coverage or other factors by crosswalking existing network to needs identified in CNA.	12/31/16
STEP 4	WMC PPS practitioner engagement and IDS teams reach out to potential new partners.	12/31/16
STEP 5	WMC PPS practioner engagement and communication teams develop and deploy "onboarding" materials and processes to integrate new partners in network and programs.	03/31/16
MILESTONE #2	Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	03/31/17
DELIVERABLE	PPS produces a list of participating HHs and ACOs.	03/31/16
DELIVERABLE	Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	03/31/17
DELIVERABLE	Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	03/31/17
STEP 1	WMC PPS identifes Health Homes and assesses capabilities to underpin IDS including sharing systems and best practices.	09/30/15
STEP 2	WMC PPS identifies ACOs and assesses capabilities to underpin IDS including sharing systems and best practices.	03/31/16
STEP 3	Unlike other PPSs who have experience as a result of developing ACOs and/or HHs, WMC PPS will meet with ACOs & HHs within and external to our network to identify successful models which can be replicated in our own IDS strategy.	12/31/16

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/17
DELIVERABLE	Clinically Interoperable System is in place for all participating providers.	03/31/17
DELIVERABLE	PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	03/31/17
DELIVERABLE	PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	03/31/17
DELIVERABLE	PPS trains staff on IDS protocols and processes.	03/31/17
STEP 1	WMC PPS plans clinical governance structure to include participation of medical, behavioral health, post acute and long term care and public health partners.	09/30/15
STEP 2	Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.	12/31/15
STEP 3	As part of the practitioner engagement workstream, WMC PPS wll establish local deployment councils to include local CBOs which will be encouraged to participate; CBOs will also be invited to participate in the Quality Committee.	03/31/16
STEP 4	Assess network to confirm specialties and provider types for HIE capability, links to care management including Health Homes and links to social services.	03/31/16
STEP 5	WMC PPS creates protocols for care coordination and process flow as part of Hospital Transitions and Health Home at Risk projects.	03/31/17
STEP 6	As part of Practicioner Engagement workstream PPS will plan training for appropriate partners and staff on care transitions protocols for Hosptial Transitions and Health Home at Risk projects.	09/30/16
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.	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net-PCP, Non-PCP, HOspital, Mental Health, Nursing Home).	03/31/18
DELIVERABLE	PPS uses alerts and secure messaging functionality.	03/31/18
STEP 1	WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.	06/30/16
STEP 2	WMC PPS completes current state analysis of current EHR based connections to RHIO.	03/31/16
STEP 3	PPS reviews and finalizes action plan.	03/31/16
STEP 4	Identify pilot partner/early adopter sites for QE connection.	12/31/15
STEP 5	In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.	12/31/16
STEP 6	Evaluate lessons learned from initial connections.	09/30/16
STEP 7	Plan phased implementation for network rollout.	09/30/16
STEP 8	Implement Phase 1 of network rollout.	03/31/17
STEP 9	Implement Phase 2 of network rollout.	03/31/18
STEP 10	As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners to activate functionality.	03/31/18

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/18
DELIVERABLE	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	03/31/18
DELIVERABLE	PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM (Provider: Safety Net-PCP).	03/31/18
STEP 1	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.	03/31/16
STEP 2	WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.	03/31/16
STEP 3	WMC PPS, based on findings of MS #1 (current state assessment) finalizes plan for procuring and rolling out certified EHRs to safety net primary care providers.	03/31/18
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."	03/31/18
DELIVERABLE	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	03/31/18
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	03/31/17
STEP 2	Define functional reporting requirements for clinical projects.	06/30/16
STEP 3	WMC PPS creates roadmap for data sharing and reporting to support population health analytics.	12/31/16
STEP 4	Begin IT based population health reporting.	09/30/16
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.	03/31/18
DELIVERABLE	Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	03/31/18
DELIVERABLE	All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards (Provider: Practitioner-PCP).	03/31/18
DELIVERABLE	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	03/31/18
STEP 1	WMC PPS issues RFP for vendor to do a PCMH readiness assessment.	09/30/15
STEP 2	WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .	03/31/16
STEP 3	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.	03/31/16
STEP 4	WMC PPS working with PCMH vendor creates action plan for PCMH eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	12/31/17

2.a.i INTEGRATED DELIVERY SYSTEM

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 8	Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	03/31/17
DELIVERABLE	Medicaid Managed Care contract(s) are in place that include value-based payments.	03/31/17
STEP 1	WMC PPS identifies and meets with MCOs doing business in our service area.	12/31/15
STEP 2	WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.	12/31/15
STEP 3	Conduct current state assessment of value based payment arrangements across all WMC PPS participants.	03/31/16
STEP 4	Identify lessons learned from PPS partner experiences with value based payment arrangements.	03/31/17
STEP 5	Per Financial Sustainability milestones contract with medicaid managed care organizations and other payors.	03/31/17
MILESTONE # 9	Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	03/31/17
DELIVERABLE	PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	03/31/17
STEP 1	Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.	09/30/15
STEP 2	WMC PPS and MCOs plan for sharing reports including establishing data sharing agreements.	03/31/17
STEP 3	Create PPS/MCO agenda series aimed at developing business case for MCO engagement; incorporate principles of DOH Value-Based Payment roadmap including the alignment of incentives, regulatory amendments and other requirements of payment reform.	03/31/17
STEP 4	WMC PPS and MCOs establish a regular meeting schedule to review performance and develop action plans as appropriate.	03/31/17
MILESTONE # 10	Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	03/31/18
DELIVERABLE	PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	03/31/18
DELIVERABLE	Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	03/31/18
STEP 1	Review final State value-based payment roadmap with Finance and Executive Committees.	12/31/15
STEP 2	WMC aligns PPS payments for patient engagement for DSRIP projects.	03/31/18
STEP 3	Establish Value-Based Payment Task Force (note, previously referred to as Financial Sustainability Taskforce in DSRIP Application; further guidance on financial sustainability workstream expectations from DOH led to modification).	03/31/16
STEP 4	Conduct current state assessment of value-based payment across all WMC PPS Participants.	03/31/16
STEP 5	Review baseline assessment of Participants' value-based payment arrangements (and capabilities).	12/31/16
STEP 6	Conduct gap assessment to achieving stated goal of 90% within five years.	12/31/16
STEP 7	PPS Draft VBP Plan, including MCO strategy, distributed for stakeholder feedback.	12/31/16
STEP 8	WMC PPS establishes guidelines for calculating incentive payments.	12/31/16
STEP 9	Incorporate stakeholder feedback into final VBP Plan; Plan signed off on by Finance Committee and Executive Committee.	12/31/16
STEP 10	WMC PPS working with performance reporting, network partners, and the MAPP development team, creates and deploys dashboards to support VBP.	06/30/17

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	12/31/16
DELIVERABLE	Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	12/31/16
STEP 1	Establish a Community Engagement Quality Advisory Committee.	06/30/15
STEP 2	Identify cultural competency and health literacy champions within the local deployment groups established as part of Clinical Governance who are responsible for patient and provider engagement. These Champions will communicate cultural competency strategy and plans to our provider network and report back to the WMC Quality Committee and Workforce Committee.	12/31/16
STEP 3	Conduct Focus groups with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	12/31/16
STEP 4	Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee.	12/31/16
STEP 5	WMC PPS creates staffing plan to support patient engagement including documented human resource/ workforce needs & reporting relationships.	12/31/16
STEP 6	Complete identification of appropriate and meaningful measures to monitor ongoing impact of the WMC PPS Cultural Competency Strategy. Work with IT Committee to develop a platform for required quarterly reports and for sharing annual results with community stakeholders via portals that allow for web-based feedback.	12/31/16

Provider Engagement

Number of providers who will have met all requirements by March 31, 2018.

PROVIDER TYPE**		TOTAL COMMITTED	SAFETY NET COMMITTED
PRACTITIONER - PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	578	177
PRACTITIONER - NON-PCP		1784	332
HOSPITAL		13	11
CLINIC		40	41
CASE MANAGEMENT		25	16
MENTAL HEALTH		307	80
SUBSTANCE ABUSE		26	25
NURSING HOME		36	35
PHARMACY		3	0
HOSPICE		6	0
ALL OTHER		1094	200

** Provider Type defined by New York State Department of Health.

2.a.iii

HEALTH HOME AT-RISK INTERVENTION PROGRAM

Implementation Plan

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.

MILESTONE	PROJECT PLAN	COMPLETION DATE*
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.	03/31/17
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	03/31/17
STEP 1	In consultation with partner organizations (including health homes and case management agencies) and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), explore models for implementing a health home at risk intervention program attributed to our PPS. DY1, Q2.	12/31/15
STEP 2	Convene HHPAQC to review and discuss the candidate care management plan tools and components and the roles and responsibilities of both health homes and primary care providers in the health home at risk project.	3/31/16
STEP 3	In consultation with PMO and HHPAQC develop staffing, training and implementation plan including roles of PCMH PCPs and HHs.	09/30/16
STEP 4	Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	03/31/17
MILESTONE # 2	Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	03/31/18
DELIVERABLE	All practices meet NCQA 2014 Level 3 PCMH and APCM standards (Provider: Practitioner-PCP).	03/31/18
STEP 1	WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.	07/01/15
STEP 2	WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH.	03/31/16
STEP 3	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics primary care provider type, as well as current PCMH or APC certification if any and EHR and MU capabilities.	03/31/16
STEP 4	WMC PPS working with PCMH/APC practice transformation vendor creates action plan for P2/17/16CMH/ APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	12/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net PCP, Non-PCP, Safety Net Case Management/Health Home).	03/31/18
DELIVERABLE	PPS uses alerts and secure messaging functionality.	03/31/18
STEP 1	WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.	06/30/16
STEP 2	Step 2. WMC PPS completes current state analysis of current EHR based connections to RHIO.	03/31/16
STEP 3	PPS reviews and finalizes action plan.	03/31/16
STEP 4	Plan phased implementation for network rollout.	06/30/17
STEP 5	As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.	03/31/18
MILESTONE # 4	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	03/31/18
DELIVERABLE	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	03/31/18
DELIVERABLE	PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM (Provider: Safety Net PCP).	03/31/18
STEP 1	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as current PCMH/APC certification if any and EHR and MU capabilities.	03/31/16
STEP 2	WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.	03/31/18
STEP 3	As detailed in 2aiii Milestone 2, step 4 the WMC PPS working with the PCMH/APC practice transformation vendor creates an action plan for the PCMH eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes an services. This includes techinical assistance from the vendor to assist practices in achieving MY stage 2 CMS requirements and NCQA Level 3 PCMH standards.	03/31/18
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.	03/31/18
DELIVERABLE	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services delivered during DY1.	03/31/16
STEP 2	Define functional reporting requirements for Health home at Risk project.	06/30/16
STEP 3	WMC PPS creates roadmap for data sharing and reporting.	09/30/16
STEP 4	Report and track actively engaged patients.	03/31/18

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 6	Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	03/31/18
DELIVERABLE	Procedures to engage at-risk patients with care management plan instituted.	03/31/18
STEP 1	In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify evidence based literature and best practices for candidate care management plans, tools, components.	12/31/15
STEP 2	Convene Health Home at Risk Project Advisory Quality Committee (HHPAQC) to review and discuss the candidate care management plan tools and components.	03/31/16
STEP 3	In consultation with PMO and HHPAQC develop staffing, trianing and implementation plan including roles of PCMH PCPs and HHs.	09/30/16
STEP 4	In consultation with partner organizations and PMO the HHPAQC will identify or develop metrics to assess success of project implementation.	06/30/17
STEP 5	Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the HHPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	03/31/18
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.	03/31/17
DELIVERABLE	Each identified PCP establish partnerships with the local Health Home for care management services (Provider: PCP, Case Mangement/Health Home).	03/31/17
STEP 1	In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate Health Home partners to provide care management services.	12/31/15
STEP 2	Convene Health Home at Risk Project Advisory Committee to review and discuss the roles and responsibilities of both health homes and primary care providers in the health home at risk project.	03/31/16
STEP 3	Explore successful models for information sharing between PCPs and Health Homes.	03/31/17
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).	03/31/17
DELIVERABLE	PPS has established partnerships to medical, behavioral health, and social services (Provider: PCP, Case Management/Health Home).	03/31/17
DELIVERABLE	PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	03/31/17
STEP 1	Meet with Health Homes to assess capacity and links to other care providers: medical, behavioral health, social services.	06/30/16
STEP 2	Meet with partners to share experiences and identify gaps and opportunities.	03/31/16
STEP 3	Assess network to confirm specialties and provider types for ability to exchange information, links to care management including Health Homes and links to social services.	03/31/16
STEP 4	Identify by provider type and project role the clinical information to be shared among providers.	06/30/16
STEP 5	Create roadmap for data sharing and reporting.	06/30/16
STEP 6	Plan training for appropiate partners and staff.	03/31/17

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/17
DELIVERABLE	PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	12/31/16
DELIVERABLE	Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	06/30/16
DELIVERABLE	PPS has included social services agencies in development of risk reduction and care practice guidelines.	12/31/16
DELIVERABLE	Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	03/31/17
STEP 1	In consultation with partner organizations and the Health Home at Risk Project Advisory Quality Committee (HHPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing risk factor reduction, care engagement, and chronic disease management.	03/31/16
STEP 2	Convene the HHPAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The HHPAQC includes clinical leaders from partner organizations and other stakeholder including social service agencies representing a range of credentials and experience relevant to the project.	06/30/16
STEP 3	The Cultural Competency/Health Literacy workgroup, a subset of the Workforce Committee, is charged with identification of evidence-based clinical training and educational materials that takes into consideration disease risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup will suggest approaches for patient self management of disease risk factors that are culturally appropriate and will review these with WMC PPS quality steering committee and its workgroups.	11/30/16
STEP 4	Plan phased roll out of culturally competent materials adapted to local considerations.	03/31/17

Provider Engagement

Number of providers who will have met all requirements by March 31, 2018.

PROVIDER TYPE**		TOTAL COMMITTED	SAFETY NET COMMITTED
PRACTITIONER - PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	497	132
PRACTITIONER - NON-PCP		950	243
CASE MANAGEMENT		25	16
HOSPITAL		0	0
CLINIC		23	25
MENTAL HEALTH		71	26
SUBSTANCE ABUSE		8	7
NURSING HOME		0	0
PHARMACY		3	0
HOSPICE		0	0
ALL OTHER		280	280

** Provider Type defined by New York State Department of Health.

2.a.iii **HEALTH HOME** AT-RISK INTERVENTION PROGRAM

Actively Engaged Patients

The number of participating patients who completed a new or updated comprehensive care management plan.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	500	1,000	5,000	600	4,000	5,000	10,000	750	7500	10,000	20,000	800	8,000	10,000	20,000

2.a.iv

CREATE A MEDICAL VILLAGE

Implementation Plan

Create a medical village using existing hospital infrastructure.

MILESTONE	PROJECT PLAN	COMPLETION DATE*
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.	03/31/19
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	03/31/19
DELIVERABLE	Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.	03/31/19
STEP 1	Establish a Medical Village Project Quality Advisory Committee that includes representatives from BSCH and HealthAlliance as well as project management from the PMO who will be responsible for monitoring and reporting on the progress of the WMC PPS Medical Village Project.	03/31/19
STEP 2	Review community health assessments undertaken in Ulster and Orange county as well as CNA conducted by the PPS to determine service needs.	11/05/15
STEP 3	Convene Medical Village Project team to review project plan, implementation timelines and deliverables against submitted capital Restructuring Financing Program submissions.	03/31/19
STEP 4	Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required.	03/31/19
STEP 5	Once CRFP is approved, a plan for marketing and promotion of the medical village and consumer education regarding access to medical village services will be developed.	03/31/19
STEP 6	Plan community presentations as town hall type review that will be open to neighbors and stakeholders.	03/31/19
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.	03/31/17
DELIVERABLE	PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.	03/31/17
STEP 1	Once CRFP is approved, make adjustments to Medical Village Implementation Plan as required and review timeline as it relates to staffed bed reduction.	03/31/17
STEP 2	Complete and submit Certificate of Need (CON) for bed reduction.	03/31/17
STEP 3	Once CON approved, maintain baseline bed capacity and periodic progress reports documenting bed reduction.	03/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/18
DELIVERABLE	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards (Provider: PCP).	03/31/18
STEP 1	WMC PPS issues RFP for vendor to do a PCMH readiness assessment.	09/30/15
STEP 2	WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH .	06/30/16
STEP 3	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR and MU capabilities.	03/31/16
STEP 4	WMC PPS working with PCMH vendor creates action plan for PCMH eligible organiztions as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	03/31/16
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."	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net PCP, Non-PCP, Hospital, Mental Health).	03/31/18
STEP 1	WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.	03/31/16
STEP 2	WMC PPS completes current state analysis of current EHR based connections to RHIO.	03/31/16
STEP 3	PPS reviews and finalizes action plan.	03/31/16
STEP 4	Identify pilot partner/early adopter sites for QE connection.	12/31/15
STEP 5	In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.	12/31/16
STEP 6	Evaluate lessons learned from initial connections.	09/30/16
STEP 7	Plan phased implementation for network rollout.	09/30/16
STEP 8	Implement Phase 1 of network rollout.	03/31/17
STEP 9	Implement Phase 2 of network rollout.	03/31/18
STEP 10	As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.	03/31/18
MILESTONE # 5	Use EHRs and other technical platforms to track all patients engaged in the project.	03/31/17
DELIVERABLE	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	03/31/17
STEP 2	Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of EHRs.	09/30/16
STEP 3	WMC PPS creates roadmap for data sharing and reporting to support population health analytics.	12/31/16
STEP 4	Begin IT based population health reporting.	03/31/17

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 6	Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2.	03/31/18
DELIVERABLE	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	03/31/18
STEP 1	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH based on primary care provider type, as well as current PCMH certification if any and EHR capabilities.	03/31/16
STEP 2	WMC PPS creates and implement mechanism to track EHR, MU, and PCMH status for each network provider.	03/31/16
STEP 3	WMC PPS, based on findings of current state assessment finalizes plan for procuring and rolling out certified EHRs.	03/31/18
MILESTONE # 7	Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.	03/31/17
DELIVERABLE	Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.).	03/31/17
STEP 1	Review Community Needs Assessment to determine migration plan.	09/30/15
STEP 2	Develop guidelines and protocols to ensure appropriate migration.	03/31/17
STEP 3	Policies and procedures are developed to determine the frequency of updates to guidelines and protocols.	03/31/17

Provider Engagement

Number of providers who will have met all requirements by March 31, 2019.

PROVIDER TYPE**		SAFETY NET COMMITTED
PRACTITIONER - PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	73
PRACTITIONER - NON-PCP		155
HOSPITAL		4
CLINIC		6
MENTAL HEALTH		3
SUBSTANCE ABUSE		2
CASE MANAGEMENT		1
NURSING HOME		
PHARMACY		0
HOSPICE		0
ALL OTHER		216

** Provider Type defined by New York State Department of Health.

Actively Engaged Patients

The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village in a year.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	600		2000		2200		6000		3500		9450		4400		12000

2.b.iv

POST HOSPITAL CARE **TRANSITIONS**

Implementation Plan

Care transitions intervention model to reduce 30 day readmissions for chronic health conditions.

MILESTONE	PROJECT PLAN	COMPLETION DATE*
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.	03/31/17
DELIVERABLE	Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	03/31/17
STEP 1	In consultation with partner organizations and the Care Transitions Project Advisory Quality Committee (CTPAQC,a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing care transitions.	03/31/16
STEP 2	Convene the CTPAQC review and discuss the candidate best best practices/protocols/ guidelines/standards. The Care Transitions Project Advisory Quality Committee includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	03/31/16
STEP 3	Compare status of current practice among participating partners to identified best practices, including current ability of partner hospitals to identify Health Home enrolled or Health Home eligible patients, to notify of planned discharge, to provide a care manager visit with transition services prior to discharge, and to create and share a timely care transition record.	06/30/16
STEP 4	Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations. Protocols will include: notification of early discharge, transmission of a transition care record, facilitation of visit by transition care manager, assessment of Health Home enrollment and or eligiblity, notification of MCO and, if applicable, Health Home and will include a 30 day transition period.	03/31/17
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.	03/31/18
DELIVERABLE	A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	03/31/18
DELIVERABLE	Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	03/31/18
DELIVERABLE	PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	03/31/18
STEP 1	WMC PPS cunducts analysis of current practice among participating hospital partners regarding current ability to identify Health Home enrolled or Health Home eligible patients.	03/31/16
STEP 2	In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for implementing identification of Health Home enrolled or eligible patients and to link the patient to Health Home services.	03/31/17
STEP 3	WMC PPS identifies Medicaid Managed Care Organizations (MCOs) and Health Homes (HHs) doing business in our service area whose members and clients are at risk of admission to partner hospitals.	09/30/15
STEP 4	WMC PPS conducts learning sessions for area HH and MCO care managers on the new care transition protocols. See role out of protocols 2biv M1: 8/17/2016-3/31/2017.	03/31/17
STEP 5	MCOs and HHs are invited to participate in committees, work groups and local deployment councils working on care coordination. WMC PPS seeks to identify a contact person at each MCO who will work with PPS partners to ensure coordination of care management.	09/30/15

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
STEP 6	Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for reimbursement for transition services.	03/31/18
MILESTONE # 3	Ensure required social services participate in the project.	03/31/18
DELIVERABLE	Required network social services, including medically tailored home food services, are provided in care transitions.	03/31/18
STEP 1	In collaboration with PPS partners working on community engagement and patient activation, identify local social services, including medically tailored home food services, within the service area of each participating hospital.	09/30/16
STEP 2	In consultation with CBOs, social service agencies, network partners and the CTPQAC, create resource tools including lists of available social services and protocols for making referals for use by care managers, hospitals, primary care and other network providers.	06/30/17
STEP 3	Partner feedback will be solicited. Based on lessons learned and feedback from Partners and local deployment workgroups, the CTPAQC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	03/30/18
MILESTONE # 4	Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient in the hospital to develop the transition of care services.	03/31/17
DELIVERABLE	Policies and procedures are in place for early notification of planned discharges (Provider: PCP, Non-PCP, Hospital).	03/31/17
DELIVERABLE	PPS has program in place that allows case managers access to visit patients in the hospital and provide care transition services and advisement.	03/31/17
STEP 1	WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to notify of planned discharges and provide care manager visit prior to discharge to provide transition services.	09/30/16
STEP 2	In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for implementing early notification of planned discharges and care manager visits prior to discharge to provide transition services.	03/31/17
MILESTONE # 5	Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	03/31/17
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.	03/31/17
STEP 1	WMC PPS completes current state analysis of current EHR based connections to RHIO.	03/31/16
STEP 2	WMC PPS completes analysis of current practice among participating hospital partners regarding current ability to create and share a timely care transition record.	09/30/16
STEP 3	In consultation with partner organizations and the CTPAQC the PMO will work with each participating hospital to develop a plan for closing gaps to enable the sharing of a care transition plan with primary care practices caring for discharged patients.	03/31/17
STEP 4	As described in M1 S1 and M1 S2 we will convene providers, from different care settings, under the auspices of the project advisory quality committee to identify appropriate evidence based literature and best practices addressing care transitions. As described in M1, S2 the committee will review and discuss the cadidate best practoces/protocols/guidelines/standards. This includes defiing specific information and clinical data between sending and receiving providers as the patient goes from one care setting to another to be part of the care transition record. We are aware of NTOCC and will include the NTOCC ToolBox among literature reviewed.	03/31/17

2.b.iv POST HOSPITAL CARE **TRANSITIONS**

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 6	Ensure that a 30-day transition of care period is established.	03/31/17
DELIVERABLE	Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	03/31/17
STEP 1	Phased roll out of best practices/protocols/ guidelines/standards will include a 30 day transition period.	03/31/17
MILESTONE # 7	Use EHRs and other technical platforms to track all patients engaged in the project.	03/31/17
DELIVERABLE	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking tacking into account all project compliant services for DY1.	03/31/16
STEP 2	Define functional reporting requirements for care transition project.	06/30/16
STEP 3	WMC PPS creates roadmap for data sharing and reporting.	12/31/16
STEP 4	Begin reporting to track all activated patients.	09/30/16

Provider Engagement

Number of providers who will have met all requirements by March 31, 2018.

PROVIDER TYPE**		TOTAL COMMITTED	SAFETY NET COMMITTED
PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	497	132
NON-PCP		950	243
HOSPITAL		9	7
CLINIC		0	0
CASE MANAGEMENT		25	16
MENTAL HEALTH		0	0
SUBSTANCE ABUSE		0	0
NURSING HOME		0	0
PHARMACY		0	0
HOSPICE		0	0
ALL OTHER		415	294
TOTAL PROJECT LEVEL COMMITMENT		1,901	744

** Provider Type defined by New York State Department of Health.

Actively Engaged Patients

The number of participating patients with a care transition plan developed prior to discharge.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	250	300	1,000	300	1,200	1,500	2,800	400	1,750	2,100	5,600	500	2,200	2,500	5,600

2.d.i

PATIENT ACTIVATION

Implementation Plan

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

MILESTONE	PROJECT PLAN	COMPLETION DATE*
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.	03/31/19
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.	03/31/19
STEP 1	Establish a Community Engagement Quality Advisory Committee.	06/30/15
STEP 2	PPS will establish relationships with CBOs by connecting to local/ regional coalitions and quality advisory groups.	03/31/16
STEP 3	Execute MSA with some PPS Participants and/or service contracts between PMO and CBOs as appropriate.	03/31/16
STEP 4	The Community Engagement Quality Advisory Committee will evaluate and provide oversight and ensure the engagement is sufficient and appropriate	03/31/19
MILESTONE # 2	Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	03/31/16
DELIVERABLE	Patient Activation Measure(R) (PAM(R)) training team established.	03/31/16
STEP 1	Conduct trainings with Core PAM Team.	08/11/15
STEP 2	Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation. Develop mechanism to measure training effectiveness in relation to goals once strategy and plan implemented.	03/31/16
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.	03/31/17
DELIVERABLE	Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	03/31/17
STEP 1	Utilize CNA's baseline data as a starting point to ascertain "hot spot" areas where the UI, NU, and LU are most likely to go to for health care or social support services; emergency departments, community health centers, public hospitals, charitable clinics, teaching and community hospitals, and the Departments of Social Services, in the Hudson Valley region.	03/31/17
STEP 2	Collaborate with CBOs through the (Community Engagement Quality Advisory) Committee as per Milestone 1.	03/31/17
MILESTONE # 4	Survey the targeted population about healthcare needs in the PPS' region.	03/31/17
DELIVERABLE	Community engagement forums and other information-gathering mechanisms established and performed.	03/31/17
STEP 1	Conduct Focus groups / community engagement session with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	12/31/15
STEP 2	Participate in monthly community / regional network meetings that will allow us to identify the CBO in our hot spots and engage community members throughout the Hudson Valley.	03/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 5	Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	03/31/19
DELIVERABLE	PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	03/31/19
STEP 1	Working with the Cultural Competency/Health Literacy workgroup, assess risk factors for sub populations based on race, ethnicity, disability, and behavioral health challenges. This workgroup when established will also suggest approaches for patient self-management of disease risk factors that are culturally appropriate and review these with the WMC PPS Quality Committee	12/31/15
STEP 2	Finalize appropriate role-based training strategy for non-clinical and clinical segments of workforce based on the previous step, incorporating on- site and on-line based input from providers and CBOs.	03/31/19
STEP 3	Identify cultural competancy and health literacy champions within the local deployment groups established as part of Clinical governance who are responsible for patient and provider emgagement.	12/31/15
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.	03/31/17
DELIVERABLE	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.	03/31/17
STEP 1	Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS.	09/30/15
STEP 2	WMC PPS and MCOs plan for sharing reports to help reconnect benificiaries to designated PCPs including establishing data sharing agreements.	03/31/17
STEP 3	Review with respective MCOs and PCPs outreach materials.	03/31/17
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.	09/30/19
DELIVERABLE	For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	03/31/19
STEP 1	LU/NU Medicaid beneficiaries and the UI in the Hudson Valley region will be engaged and activated through the administration of PAM.	03/31/19
STEP 2	Identify by User IDs, baseline PAM activation level and score will be captured and tracked at the individual level. These PAM respondents will be followed-up at set intervals defined by the State by their providers.	09/30/19
STEP 3	Through data analysis, cohorts of LU/NU and UI, as well as subgroups based on PAM activation level and score will be assessed at each follow-up to determine progress and improvement trend, and to establish subsequent achievement goals.	09/30/19

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 8	Include beneficiaries in development team to promote preventive care.	03/31/17
DELIVERABLE	Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	03/31/17
STEP 1	The Community Engagement Quality Advisory Committee through the local deployment council will provide oversight to include beneficiaries in the development process.	03/31/17
STEP 2	Conduct Community engagement sessions with community consumers/residents and CBOs to help identify key access factors and effective communication pathways that acknowledge cultural differences, language and health literacy competencies from a community perspective.	03/31/17
MILESTONE # 9	Measure PAM(R) components, including: Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or “hot spot” area for health service. If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS’ network, assess patient using PAM(R) survey and designate a PAM(R) score. Individual member’s score must be averaged to calculate a baseline measure for that year’s cohort. The cohort must be followed for the entirety of the DSRIP program. On an annual basis, assess individual members’ and each cohort’s level of engagement, with the goal of moving beneficiaries to a higher level of activation. If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS’ network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. The PPS will NOT be responsible for assessing the patient via PAM(R) survey. PPS will be responsible for providing the most current contact information to the beneficiary’s MCO for outreach purposes. Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	03/31/19
DELIVERABLE	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	03/31/19
STEP 1	WMC PPS creates a plan for the development of platforms to share administrative, milestone, and project information with network partners with includes patients using PAM and their scores.	03/31/19
STEP 2	Based on MAPP portal data, WMC PPS identifies MCOs whose members have been attributed to our PPS (see Milestone #6)	09/30/15
STEP 3	As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of clinicians trained in PAM.	03/31/17
STEP 4	As noted in IT Milestone 3 Step 8, "Create roadmap for data sharing and reporting using platform to support population health analytics including assessment of patient engagement."	12/31/16
STEP 5	Generate reports and submit to Department of Health.	03/31/18

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 10	Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	03/31/19
DELIVERABLE	Volume of non-emergent visits for UI, NU, and LU populations increased.	03/31/19
STEP 1	Through PAM administration and its coaching functionality and capability, many providers in our network (FQHCs, MCOs) will be able to assess our beneficiaries' access to care information for non-emergent care.	03/31/19
STEP 2	WMC-PPS project teams will collaborate with these providers to create a referral network for our beneficiaries to access these primary care services.	03/31/19
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.	03/31/19
DELIVERABLE	Community navigators identified and contracted PAM(R) Providers.	03/31/19
DELIVERABLE	Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education. PAM(R) Providers.	03/31/19
STEP 1	Contract with CBOs as described in Milestone 1.	03/31/19
STEP 2	Develop preliminary training strategy (e.g., scale, timing, scope, methodologies, content and cultural competency considerations) as defined in Milestone 5 of the Workforce Strategy.	03/31/17
STEP 3	Similar to Milestone 10, through PAM administration and its coaching functionality, this group of trained community navigators will be able to coach and connect patients to relevant preventive care services and educational resources.	03/31/19
MILESTONE # 12	Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	03/31/17
DELIVERABLE	Policies and procedures for customer service complaints and appeals developed.	03/31/17
STEP 1	WMC PPS will follow WMC policy on Patient Complaints and Grievances, policy # RI-11A.	03/31/17
STEP 2	Step 2. Along with WMC's 24/7 toll free help line which is available to patients and staff, WMC is well positioned to receive and respond to all recipients and project participants.	03/31/17
MILESTONE # 13	Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	03/31/17
DELIVERABLE	List of community navigators formally trained in the PAM(R).	03/31/17
STEP 1	Core team will train community navigators who will be responsible for performing PAM.	03/31/17
STEP 2	As indicated in Milestone 5 Task 7 of Workforce, "Work with IT Committee to develop a platform for required quarterly reports and for tracking program offerings and participation." This system will also track the number of community navigators.	03/31/17
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.	03/31/19
DELIVERABLE	Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas. PAM(R) Providers.	03/31/19
STEP 1	Identify hot spots as indicated in Milestone 3.	03/31/19
STEP 2	Train navigators as indicated in Milestone 5, 11 and 13.	03/31/19
STEP 3	Community navigators will utilize resources that will allow them to connect, track and follow up on engaged UI/LU/NU to ensure appropriate health services and insurance options were provided and/or discussed.	03/31/19

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 15	Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	03/31/19
DELIVERABLE	Navigators educated about insurance options and healthcare resources available to populations in this project.	03/31/19
STEP 1	Train navigators as indicated in Milestones 5, 11, 13 and 14.	03/31/19
MILESTONE # 16	Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	03/31/19
DELIVERABLE	Timely access for navigator when connecting members to services.	03/31/19
STEP 1	Plan training for navigators on care transition protocols.	03/31/19
STEP 2	Follow care transition strategy as outlined in 2biv Milestone #2.	03/31/18
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.	03/31/17
DELIVERABLE	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	03/31/17
STEP 2	Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential	03/31/16
STEP 3	WMC PPS creates roadmap for datasharing and reporting to support health population analysis	12/31/16
STEP 4	Begin IT based population health reporting	09/30/16

Provider Engagement

Number of Individuals trained to conduct a PAM Survey.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	3	20	80	120	160	200	275								

Actively Engaged Patients

Number of uninsured, low or non-utilizing individuals who completed the Patient Activation Measure (PAM) survey.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	5000	5001	12000	5000	10000	10001	25000	5000	20000	20001	45000	5000	30000	30001	81500

3.a.i

INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES

Implementation Plan

Integration of Primary Care and Behavioral Health Services.

MILESTONE	PROJECT PLAN	COMPLETION DATE*
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.	03/31/18
DELIVERABLE	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3 (Provider: PCP).	03/31/18
DELIVERABLE	Behavioral health services are co-located within PCMH/APC practices and are available (Provider: Mental Health).	03/31/18
STEP 1	WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.	9/30/15
STEP 2	Conduct current state analysis of BH services, if any, at PPS participating primary care sites & identifies co-location staffing needs.	03/31/16
STEP 3	WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH or APC model.	03/31/16
STEP 4	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics, as well as current PCMH or APC certification if any and EHR and MU capabilities.	03/31/16
STEP 5	WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	12/31/17
MILESTONE # 2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	03/31/17
DELIVERABLE	Regularly scheduled formal meetings are held to develop collaborative care practices.	03/31/17
DELIVERABLE	Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.	03/31/17
STEP 1	In consultation with partner organizations and the Behavioral Health Project Quality Committee (BHPQC), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care.	06/30/16
STEP 2	Convene the BHPQC to review and discuss the candidate best practices/protocols/guidelines/standards. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	09/30/16
STEP 3	Compare status of current practice among participating partners to identified best practices.	12/31/16
STEP 4	Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.	03/31/17
STEP 5	Gather lessons learned and feedback from Partners and local deployment workgroups; BHPQC, and/or Quality Steering Committee (QSC) and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	03/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/18
DELIVERABLE	Policies and procedures are in place to facilitate and document completion of screenings.	03/31/18
DELIVERABLE	Screenings are documented in Electronic Health Record.	03/31/18
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).	03/31/18
DELIVERABLE	Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record (Provider: PCP).	03/31/18
STEP 1	Assess current practice among partners at participating primary care sites re BH screening, follow-up treatment (warm transfer) and documentation in the EHR.	12/31/16
STEP 2	Assess barriers to screening, to completing "warm transfer" for patients screening positive and to recording screening and transfer in EHR.	03/31/17
STEP 3	Convene the BHPQC to address the appropriate frequency of each recommended screening and appropriate inclusion criteria for patients to be screened. The BHPQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	03/31/17
STEP 4	The BHPCQ and/or the QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to appropriate care documented in EHR. Measures of success may be revised as appropriate.	03/31/18
STEP 5	Sites where BH care has been integrated will develop a plan for workflow, policies and proceedures to support screening, "warm transfer" to BH care, documentation of all in the EHR and regular calculation of performance rates to facilitate improvement.	03/31/18
STEP 6	Summarize lessons learned from early adoption sites, through discussions among partners in local deployment workgroups.	03/31/17
STEP 7	Based on lessons learned and feedback from Partners and local deployment workgroups, The BHPQC and/or QSC or its workgroup will review lessons learned, feedback from partners and, in consultation with PMO staff, will adjust plan for on-going monitoring of screening and connection of patients to care.	03/31/18
STEP 8	Agree to collaborate with other PPSs to share best practices, educational materials, training strategies and strategies to overcome project implementation barriers.	03/31/18
MILESTONE # 4	Use EHRs or other technical platforms to track all patients engaged in this project.	03/31/17
DELIVERABLE	EHR demonstrates integration of medical and behavioral health record within individual patient records.	03/31/17
DELIVERABLE	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	03/31/17
STEP 1	Implement interim reporting tool for DSRIP milestone reporting and performance taking into account all project compliant services for DY1.	03/31/17
STEP 2	Identify by provider type and project role the clinical information to be shared among providers.	12/31/16
STEP 3	Create roadmap for data sharing and reporting using platform to support population health analytics.	09/30/16
STEP 4	At sites where BH care has been integrated, develop workflow to support electronic reporting of BH screenings and tracking of patients for milestone reporting; to support documentation within an individual patient record of connection with BH provider after a positive screening and transfer for appropriate BH services.	03/31/17

3.a.i INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES

Provider Engagement

Number of providers who will have met all requirements by March 31, 2018.

PROVIDER TYPE**		TOTAL COMMITTED	SAFETY NET COMMITTED
PRACTITIONER - PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	95	45
MENTAL HEALTH		109	25
PRACTITIONER - NON-PCP		95	32
HOSPITAL		0	0
CLINIC		20	20
CASE MANAGEMENT		0	0
SUBSTANCE ABUSE		10	9
NURSING HOME		0	0
PHARMACY		0	0
HOSPICE		0	0
ALL OTHER		190	19

** Provider Type defined by New York State Department of Health.

Actively Engaged Patients

Number of patients receiving appropriate preventive care screenings that include mental health/substance abuse.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	2,000	2,500	5,000	1,000	5,000	6,000	12,000	2,000	9,000	10,000	23,000	5,000	19,000	20,000	31,000

3.a.ii

BEHAVIORAL HEALTH **COMMUNITY CRISIS STABILIZATION** SERVICES

Implementation Plan

Behavioral Health Community Crisis Stabilization Services

MILESTONE	PROJECT PLAN	COMPLETION DATE*
MILESTONE # 1	Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	03/31/19
DELIVERABLE	PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.	03/31/19
STEP 1	Review partners and county crisis intervention programs to establish a baseline of existing services, including hot spots.	09/30/15
STEP 2	Establish the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group with Montefiore Hudson Valley Collaborative and Refuah Community Health Collaborative to collaborate on development of coordinated crisis intervention services and programming in the Hudson Valley Region.	03/30/18
STEP 3	Convene HRD Behavioral Health Crisis Leadership Group	06/30/16
STEP 4	Work with counties to determine if gaps exist.	03/31/16
STEP 5	Analyze the existing services funding to determine opportunities for leverage and development of new models.	03/31/17
STEP 6	Plan for implementation of services.	03/29/19
STEP 7	Monitor completeness of implementation plan.	03/31/19
STEP 8	Once gaps are identified, continue work with the counties and providers to identify opportunities and strategies for filling service gaps. From there, the PPS, counties, and providers will develop a road map for implementation. Road map will identify potential funding sources (from all payers including governemt grants) to initiate service expansions and sustainability uin collaboration with the other PPSs.	03/31/19
STEP 9	Apply road map to service implementation.	03/31/19
STEP 10	Monitor road map/ implementation plan by county to determine if gaps in services and geographic areas are being adressed.	03/31/19
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.	03/31/19
DELIVERABLE	PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).	03/31/19
STEP 1	In consultation with partner organizations and the Behavioral Health Crisis Project Advisory Committee (a workgroup of the WMC PPS Quality Committee), identify appropriate best practices addressing diversion management processes.	09/30/16
STEP 2	Convene the Project Advisory Committee to review and discuss best practices for diversion management processes.	03/31/17
STEP 3	PPS works with counties, health homes, and hospitals to review best practices for diversion management processes.	12/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
STEP 4	Compare status of current diversion practice among participating partners to identified best practices.	06/30/18
STEP 5	Plan phased rollout of diversion management processes.	03/31/19
STEP 6	Provide training resources for key personnel and finalize protocols.	03/31/19
STEP 7	Document diversion management protocols.	03/31/19
STEP 8	Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	03/31/19
MILESTONE # 3	Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	03/31/19
DELIVERABLE	PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.	03/31/19
STEP 1	WMC PPS identifies and meets with MCOs doing business in our service area and at other times as needed to consider which services may be covered	12/31/17
STEP 2	WMC meets with Hudson Health Plan/MVP, represented on the Executive Committee, to explore successful models for data sharing and value based contracting.	12/31/15
STEP 3	Begin dialogue with MCO regarding value-based payment models as indicated in 2ai Milestone 8.	03/31/16
STEP 4	Review options for coverage through the HARPs and HCBS for Medicaid recipients.	03/31/19
MILESTONE # 4	Develop written treatment protocols with consensus from participating providers and facilities.	03/31/17
DELIVERABLE	Regularly scheduled formal meetings are held to develop consensus on treatment protocols.	03/31/17
DELIVERABLE	Coordinated treatment care protocols are in place.	03/31/17
STEP 1	In consultation with partner organizations and the Behavioral Health Crisis Project Advisory Quality Committee (a workgroup of WMC PPS), identify appropriate evidence based literature and best practices addressing coordinated treatment protocols.	03/31/17
STEP 2	Convene BHCAQC to review and discuss the best practice options for implementation.	03/31/17
STEP 3	Compare the status of current practices among participating partners to identify the best practices	03/31/17
STEP 4	Plan phased rollout of best practices adapted to local considerations.	03/31/17
STEP 5	Provide training resources for key personnel and finalize protocols.	03/31/17
STEP 6	Document treatment practices.	03/31/17
STEP 7	Gather lessons learned and feedback as a result of deployment; review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	03/31/17

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/17
DELIVERABLE	PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network.	03/31/17
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 (Provider: Safety Net Hospital).	03/31/17
STEP 1	Use results from the CNA and a mapping of providers to evaluate access to specialty services and crisis-oriented services and identify gaps in service coverage.	12/31/15
STEP 2	PPS will work to identify a hospital with the capacity and ability to expand access to specialty psychiatric and crisis-oriented services.	03/31/17
STEP 3	PPS will draft an action plan that may be used to improve access to psychiatric crisis and crisis-oriented services.	03/31/17
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).	03/31/19
DELIVERABLE	PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.	03/31/19
DELIVERABLE	PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps (Provider: Safety Net Hospital).	03/31/19
DELIVERABLE	PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps (Provider: Safety Net Clinic).	03/31/19
DELIVERABLE	PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps (Provider: Safety Net Mental Health).	03/31/19
STEP 1	With the Hudson Region DSRIP (HRD) Behavioral Health Crisis Leadership Group, use results from CNA to evaluate access and identify gaps in service coverage.	03/31/16
STEP 2	Use results from CNA and a mapping of providers to evaluate access and identify gaps in service coverage.	03/31/18
STEP 3	PPS will work to identify a hospital outpatient or off campus crisis residence that could provide an opportunity to provide access.	03/31/19
STEP 4	WMC PPS will consult with the Hudson Region DSRIP (HRD) Leadership Group and draft an action plan that may be used to improve access to services.	03/31/19

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 7	Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	03/31/19
DELIVERABLE	PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.	03/31/19
DELIVERABLE	Coordinated evidence-based care protocols for mobile crisis teams are in place.	03/31/19
STEP 1	In consultation with the Behavioral Health Crisis & Primary Care Integration Project Quality Advisory Committee (a workgroup of the WMC PPS Quality Committee), review appropriate evidence-based literature and best practices (including current crisis teams) for mobile crisis.	09/30/16
STEP 2	Convene the BHCAQC to review and discuss best practices and procedures including current team practices and procedures.	09/30/16
STEP 3	Work with counties, the Hudson Region DSRIP (HRD) Leadership Group and providers to review practices and procedures.	09/30/17
STEP 4	Plan phased roll out of best practices and procedures adapted to local considerations.	03/31/18
STEP 5	Provide training resources for key personnel and finalize best practices and procedures.	09/28/18
STEP 6	Document evidence based protocols.	06/30/18
STEP 7	Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.	03/31/19
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.	03/31/18
DELIVERABLE	EHR demonstrates integration of medical and behavioral health record within individual patient records.	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net PCP).	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net Non-PCP).	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net Hospitals).	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net Behavioral Health).	03/31/18
DELIVERABLE	Alerts and secure messaging functionality are used to facilitate crisis intervention services.	03/31/18
STEP 1	WMC PPS in coordination with QE, establishes preliminary plan to connect network partners to RHIO.	03/31/16
STEP 2	WMC PPS completes current state analysis of current EHR based connections to RHIO.	03/31/16
STEP 3	PPS reviews and finalizes action plan.	03/31/16
STEP 4	Identify pilot partner/early adopter sites for QE connection.	12/31/15
STEP 5	In accordance with IT & Systems workstream, obtain PPS Board Approval: Data Security and Confidentiality Plan.	12/31/16
STEP 6	Evaluate lessons learned from initial connections.	09/30/17
STEP 7	Plan phased implementation for network rollout.	09/30/16
STEP 8	Implement Phase 1 of network rollout.	03/31/16
STEP 9	Implement Phase 2 of network rollout.	03/31/18
STEP 10	As RHIO alert and secure messaging functionality is established and rolled out, WMC PPS will provide technical support and training to network partners activate functionality.	03/31/18

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 9	Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	03/31/19
DELIVERABLE	PPS has implemented central triage service among psychiatrists and behavioral health providers.	03/31/19
STEP 1	Work with communities to identify existing triage services within their jurisdiction.	12/31/15
STEP 2	Identify gaps in existing triage services.	12/31/16
STEP 3	Identify opportunities and partnerships to expand or better coordinate triage services.	12/31/17
STEP 4	Work with partners to establish agreements for triage services.	03/31/19
MILESTONE # 10	Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	03/31/17
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.	03/31/17
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.	03/31/17
DELIVERABLE	PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.	03/31/17
DELIVERABLE	PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.	03/31/17
DELIVERABLE	Service and quality outcome measures are reported to all stakeholders including PPS quality committee.	03/31/17
STEP 1	Establish Behavioral Health (Crisis) and Primary Care (Integration) Project Advisory Quality Committee (a workgroup of the WMC PPS Quality Committee), to identify appropriate evidence based measures addressing the quality of relevant crisis intervention approaches.	03/31/17
STEP 2	Convene the Project Advisory Committee to review and discuss quality of service interventions. The committee includes clinical leaders and representatives from county mental health departments, hospitals and behavioral health partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	03/31/17
STEP 3	Create roadmap for data sharing and reporting of best practices and protocols specific to the milestones above.	12/31/16
STEP 4	Gather lessons learned and feedback as a result of deployment; review and adjust training materials and best practices and procedures as warranted and further implementation plans in consultation with PMO staff.	03/31/17
MILESTONE # 11	Use EHRs or other technical platforms to track all patients engaged in this project.	03/31/17
DELIVERABLE	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	03/31/17
STEP 2	WMC PPS creates roadmap for data sharing and reporting.	06/30/16

3.a.ii BEHAVIORAL HEALTH **COMMUNITY CRISIS STABILIZATION** SERVICES

Provider Engagement

Number of providers who will have met all requirements by March 31, 2018.

PROVIDER TYPE**		SAFETY NET COMMITTED
PRACTITIONER - PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	177
PRACTITIONER - NON-PCP		81
HOSPITAL		10
CLINIC		38
MENTAL HEALTH		44
SUBSTANCE ABUSE		25
CASE MANAGEMENT		10
NURSING HOME		0
PHARMACY		0
HOSPICE		0
ALL OTHER		285

** Provider Type defined by New York State Department of Health.

Actively Engaged Patients

Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	150	151	500	100	250	251	750	300	1,000	1,001	2,000	400	1,200	500	3,150

3.c.i

DIABETES MANAGEMENT

Implementation Plan

Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease. Evidence-based strategies for disease management in high risk/affected populations. Adult only.

MILESTONE	PROJECT PLAN	COMPLETION DATE*
MILESTONE # 1	Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	03/31/17
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.	03/31/17
STEP 1	In consultation with partner organizations and the Diabetes Project Advisory Quality Committee (DPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing management of diabetes in community and ambulatory settings.	02/18/16
STEP 2	Convene the DPAQC to review and discuss the candidate best ractices/protocols/guidelines/standards. The DPAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	03/31/16
STEP 3	Compare status of current practice among partners to identified best practices.	06/30/16
STEP 4	Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.	09/30/16
STEP 5	Gathering lessons learned and feedback from Partners and local deployment workgroups, DPAQC and/or Quality Steering Committee and/or its workgroups will review and adjust best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	03/31/17
MILESTONE # 2	Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	03/31/17
DELIVERABLE	PPS has engaged at least 80% of their PCPs in this activity (Provider: PCP).	03/31/17
STEP 1	Compare status of current practice among partners to identified best practices.	06/30/16
STEP 2	Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.	09/30/16
STEP 3	Monitor number of primary care providers participating or not participating, by specialty of PCP.	03/31/17
STEP 4	If necessary, modify the program to be able to engage Pediatric practices.	03/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/17
DELIVERABLE	Clinically Interoperable System is in place for all participating providers.	03/31/17
DELIVERABLE	Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	03/31/17
DELIVERABLE	Care coordination processes are established and implemented.	03/31/17
STEP 1	Identify by provider type and project role the clinical information to be shared among providers.	09/30/16
STEP 2	Create roadmap for data sharing and reporting using platform to support population health analytics.	12/31/16
STEP 3	Gathering lessons learned and feedback from Partners and local deployment workgroups; DPAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/ standards and further implementation plans in consultation with PMO staff.	03/31/17
STEP 4	In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners, as well as pharmacists, dieticians or diabetes educators and community health workers in the community.	03/31/16
STEP 5	Convene DPAQC with network partners and stakeholders broadly to discuss the roles and responsibilities of all care team members and protocols for referring patients to ensure care coordination.	03/31/17
STEP 6	In consultation with PMO and DPAQC develop staffing, training and implementation plan including roles of PCPs and other team members for care coordination.	03/31/17
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.	03/31/17
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.	03/31/17
DELIVERABLE	If applicable, PPS has established linkages to health homes for targeted patient populations.	03/31/17
DELIVERABLE	If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	03/31/17
STEP 1	Identify participating partners providing the Stanford Model Diabetes Self-Management Program.	03/31/16
STEP 2	Update CNA hot spotting using final attribution to identify priority groups in terms of health disparities. Socioeconomic analyses will be based on zip code analysis using the Area Deprivation Index identified in the CNA and from responses from the Consumer Survey (N=4900) on access and use of services.	12/31/15
STEP 3	In consultation with partner organizations and the DPAQC, identify appropriate Health Home partners.	03/31/16
STEP 4	Convene DPAQC with network partners and stakeholders to discuss the roles and responsibilities of PCP and HH and protocols for referring patients to ensure coordination.	12/31/16
STEP 5	Meet with Stanford Disease Self Management programs to identify ways to support, promote and expand model in the Hudson Valley.	12/31/16
STEP 6	Prioritize locations to conduct diabetes self-management programs based on diabetes hot spotting evidence from step 2 above.	12/31/16
STEP 7	Develop education materials for PCPs and Health Home providers regarding local standard disease self-management programs available for their clients.	09/30/16
STEP 8	Provide ongoing support to partners implementing or referring patients to the Stanford Diabetes Self-Management programs.	03/31/17

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 5	Ensure coordination with the Medicaid Managed Care organizations serving the target population.	03/31/17
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.	03/31/17
STEP 1	WMC PPS identifies Medicaid Managed Care Organizations (MCOs) doing business in our service area whose members may be patients of Partner providers.	09/30/15
STEP 2	MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.	09/30/15
STEP 3	Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for coordination of services.	03/31/17
MILESTONE # 6	Use EHRs or other technical platforms to track all patients engaged in this Project.	03/31/17
DELIVERABLE	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	03/31/17
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.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.	03/31/16
STEP 2	Define functional reporting requirements for diabetes projects.	06/30/16
STEP 3	WMC PPS creates roadmap for data sharing and reporting.	12/31/16
STEP 4	Report and track actively engaged patients.	09/30/16
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.	03/31/18
DELIVERABLE	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	03/31/18
DELIVERABLE	PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM (Provider: PCP).	03/31/18
DELIVERABLE	EHR meets connectivity to RHIO/SHIN-NY requirements (Provider: PCP, Safety Net PCP, Safety Net Non-PCP, Safety Net Mental Health).	03/31/18
STEP 1	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH/APC based on primary care provider type, as well as current PCMH/APC certification if any and EHR and MU capabilities.	03/31/16
STEP 2	WMC PPS creates and implement mechanism to track EHR, MU, and PCMH/APC status for each network provider.	03/31/16

3.c.i **DIABETES** MANAGEMENT

Provider Engagement

Number of providers who will have met all requirements by March 31, 2017.

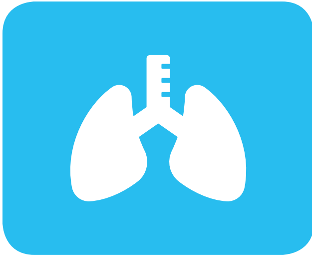
PROVIDER TYPE**		TOTAL COMMITTED	SAFETY NET COMMITTED
PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	497	132
NON-PCP		760	182
MENTAL HEALTH		103	38
HOSPITAL		0	0
CLINIC		10	10
CASE MANAGEMENT		25	16
SUBSTANCE ABUSE		10	9
NURSING HOME		0	0
PHARMACY		3	0
HOSPICE		0	0
ALL OTHER		454	33
TOTAL PROJECT LEVEL COMMITMENT		1,867	493

** Provider Type defined by New York State Department of Health.

Actively Engaged Patients

The number of participating patients with at least one hemoglobin A1c test within the previous 12 months.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	500	700	1,250	500	2,700	3,000	8,039	500	2,700	3,000	8,039	500	2,700	3,000	8,039



3.d.iii

ASTHMA CARE MANAGEMENT

Implementation Plan

Implementation of Evidence Based Medicine Guidelines for Asthma Management

MILESTONE	PROJECT PLAN	COMPLETION DATE*
MILESTONE # 1	Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	03/31/17
DELIVERABLE	PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.	03/31/17
DELIVERABLE	All participating practices have a Clinical Interoperability System in place for all participating providers (Provider: PCP).	03/31/17
DELIVERABLE	All participating practices have a Clinical Interoperability System in place for all participating providers (Provider: Non-PCP).	03/31/17
STEP 1	In consultation with partner organizations and the Asthma Project Advisory Quality Committee (APAQC; a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing medication management, care engagement, delivery of integrated care, practice standards and chronic disease management.	02/14/16
STEP 2	Convene the APAQC to review and discuss the candidate best practices/protocols/guidelines/standards. The APAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project, particularly the Hudson Valley Asthma Coalition.	03/31/16
STEP 3	Compare status of current practice among participating partners to identified best practices.	06/30/16
STEP 4	Plan phased roll out of best practices/protocols/ guidelines/standards adapted to local considerations.	09/30/16
STEP 5	Identify by provider type and project role the clinical information to be shared among providers.	09/30/16
STEP 6	Create roadmap for data sharing and reporting using platform to support population health analytics.	12/31/16
STEP 7	Gather lessons learned and feedback from Partners and local deployment workgroups; APAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/ standards and further implementation plans in consultation with PMO staff.	03/31/17
STEP 8	At participating sites, identify barriers and develop plans to implement workflow to support electronic reporting and sharing of asthma action plans.	03/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
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.	03/31/17
DELIVERABLE	Agreements with asthma specialists and asthma educators are established.	03/31/17
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net PCP).	03/31/17
DELIVERABLE	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Provider: Safety Net Non-PCP).	03/31/17
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	03/31/17
STEP 1	Identify AE-C's and Asthma specialists WMC PPS network.	03/31/16
STEP 2	Establish agreements with asthma specialists and educators to adhere to national guidelines for asthma management.	03/31/17
STEP 3	Research the potential impact of telemedicine on Asthma care in underserved areas.	12/30/16
STEP 4	WMC PPS completes Current state analysis of current EHR based connections to RHIO.	03/31/16
STEP 5	WMC PPS in coordination with QE, establishes plan to connect network partners to RHIO.	06/30/16
STEP 6	Asthma project participants to be included among early adopters/pilot for QE connections.	03/31/17
STEP 7	Identify gaps in care that might be addressed by telemedicine based geographyl on availability of specialists or other factors.	12/31/16
STEP 8	Establish whether telemedicine may be the best alternative to provide these services to these geographic areas.	12/31/16
STEP 9	Make plan to implement a pilot program using telemedicine if it is found to be a likely successful endeavor.	03/31/17
MILESTONE # 3	Deliver educational activities addressing asthma management to participating primary care providers.	03/31/17
DELIVERABLE	Participating providers receive training in evidence-based asthma management.	03/31/17
STEP 1	WMC PPS provides oversight for the design of curriculum and modalities for training PPS clinicians on best practices of evidence-based management of Asthma, identified in Milestone 1.	12/30/16
STEP 2	Identify a subgroup of key personnel within provider network who can be initially trained.	12/30/16
STEP 3	Collect feedback from key personnel and if necessary revise education protocol and guidelines.	03/31/17
MILESTONE # 4	Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	03/31/16
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.	03/31/16
STEP 1	WMC PPS identifies MCOs and Health Homes serving Medicaid beneficiaries in our service area.	09/30/15
STEP 2	MCOs and HHs are invited to participate in committees, work groups and local deployment councils. WMC PPS seek to identify a contact person at each MCO who will work with PPS partners to ensure coordination of services.	09/30/15
STEP 3	Step 3. Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including asthma health issues.	03/31/16

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 5	Use EHRs or other technical platforms to track all patients engaged in this project.	03/31/17
DELIVERABLE	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking taking into account all project compliant services for DY1.	03/31/17
STEP 2	Identify by provider type and project role the clinical information to be shared among providers. Include in evaluation all the provider types essential to management of asthma including asthma educators, community health workers, asthma educators, pharmacists, to build patient self-efficacy and confidence in self manamagment.	06/30/16
STEP 3	WMC PPS creates roadmap for data sharing and reporting.	12/31/16
STEP 4	Report and track actively engaged patients.	03/31/17

Provider Engagement

Number of providers who will have met all requirements by March 31, 2017.

PROVIDER TYPE**		TOTAL COMMITTED	SAFETY NET COMMITTED
PRACTITIONER - PCP	These provider types have specific reporting requirements to N.Y.S.D.O.H. See MILESTONES.	497	132
PRACTITIONER - NON-PCP		760	182
HOSPITAL		0	0
CLINIC		12	12
CASE MANAGEMENT		25	16
MENTAL HEALTH		0	0
SUBSTANCE ABUSE		0	0
NURSING HOME		0	0
PHARMACY		3	0
HOSPICE		0	0
ALL OTHER		432	333

** Provider Type defined by New York State Department of Health.

Actively Engaged Patients

The number of participating patients with an asthma action plan.

DEMONSTRATION YEAR 1				DEMONSTRATION YEAR 2				DEMONSTRATION YEAR 3				DEMONSTRATION YEAR 4			
06/30/15	09/30/15	12/31/15	03/31/16	06/30/16	09/30/16	12/31/16	03/31/17	06/30/17	09/30/17	12/31/17	03/31/18	06/30/18	09/30/18	12/31/18	03/31/19
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
-	500	600	1200	700	2500	2600	6800	700	2500	2600	6800	700	2500	2600	6800

4.b.i

TOBACCO CESSATION

Implementation Plan

Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

MILESTONE	PROJECT PLAN	COMPLETION DATE*
MILESTONE # 1	Initially survey PPS Participants about their outdoor policies, share best practices, and re-survey Participants DY2 to assess progress in implementing tobacco-free outdoor policies.	03/31/20
STEP 1	Develop contented of survey in consultation with HRD_PHC and the provider groups represented in tobacco and asthma committees.	03/31/16
STEP 2	Incorporate survey in detailed assessment by PCMH vendor. Y1Q4	10/08/15
STEP 3	In consultation with partner organizations and the tobacco cesssation workgroup, identify appropriate evidence based literature and best practices addressing tobacco cessation and tobacco-free outdoor policies.	03/31/17
STEP 4	Use PPS meetings and other forums to desseminate best practices on tobacco free outdoor policies to PPS partners.	09/30/19
STEP 5	Resurvey those who responded in round 1 re Outdoor smoking policies Y2Q1-2.	09/30/19
STEP 6	Develop plan to facilitate those who have succeeded with outdoor policies assist those who have not. Y2Q4	03/31/20
MILESTONE # 2	Convene a region-wide tobacco cessation campaign committee.	03/31/16
STEP 1	In collaboration with Montefiore PPS, and Refuah PPS convene the Hudson River DSRIP Public Health Council (HRDPHC) tobacco cessation work group. HRDPHC includes representatives of all three Hudson valley PPSs (Montefiore, Refuah and WMCHealth) as well as representatives of County Health Departments and from the 8 Counties in the region.	03/31/16
MILESTONE # 3	Engage Medicaid MCOs around coverage and payment.	12/31/18
STEP 1	WMC PPS identifies Medicaid Managed Care Organizations (MCOs) doing business in our service area. .	09/30/15
STEP 2	MCOs are invited to participate in committees, and work group working on tobacco cessation.	06/30/16
STEP 3	Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including coverage for smoking cessation treatment.	12/31/18

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 4	Survey PPS Participants about USPSTF and PHS guidelines, use of EHRs to facilitate 5 A's, and referrals to the NYS Smokers' Quitline by mid DY1; and Subsequently promulgate best practices.	03/31/20
STEP 1	Develop contents of survey in consultation with HRD_PHC tobacco cessation workgroup and the provider groups represented in tobacco and asthma committees.	09/30/19
STEP 2	Incorporate survey in detailed assessment by PCMH vendor. Y1Q4.	09/30/19
STEP 3	In consultation with partner organizations and the tobacco cesssation workgroup, identify appropriate evidence based literature and best practices addressing implementation of the USPSTF and PHS guidelines on tobacco cessation, use of EHRs to prompt providers to complete "5As" and to promote referrrals to the NYS Quitline.	03/31/17
STEP 4	Use PPS meetings and other forums to desseminate best practices to PPS partners concerning implementation of the USPSTF and PHS guidelines on tobacco cessation to PPS partners, use of EHRs to prompt providers to complete "5As" and to promote referrrals to the NYS Quitline.	03/31/18
STEP 5	In consultation with partner organizations and the tobacco cesssation workgroup, the WMC PPC Quality Steering Committee (QSC) and local hub implementation groups develop a site specific plan to assist providers in implementation of the USPSTF and PHS guidelines on tobacco cessation, use of EHRs to prompt providers to complete "5As" and to promote referrrals to the NYS Quitline.	03/31/20
STEP 6	WMC PPS will work with NYS DOH Bureau of Tobacco Control's Health Systems for a Tobacco-Free NY contractors to make technical assistance on system improvements related to tobacco use cessation available to partners as they implement.	03/31/20
MILESTONE # 5	Launch a campaign to promote tobacco cessation among all eligible providers.	06/30/19
STEP 1	HRD_PHC tobacco cessation workgroup will develop a culturally competent communication strategy for patient and clinician education regarding availability of covered tobacco dependence treatment that encourages patients to use the services.	12/31/17
STEP 2	WMC PPS will budget to support an outreach campaign inclulding dissemination of training and toolkits such as templates for incorporation of "5As" into EHRs.	06/30/18
STEP 3	In consultation with partner organizations and the tobacco cesssation workgroup, the WMC PPC Quality Steering Committee (QSC) and local hub implementation groups develop a site specific plans to support developent of site specific workflow to promote tobacco screeening and cessation counseling including identification of designated staff.	12/31/18
STEP 4	HRD_PHC tobacco cessation workgroup will develop sample policies to support tobacco cessation such as policies for a tobacco free out-doors, templates for EHRs, etc. Having sample policies available will facilitate adoption by partner organizations.	09/30/17
STEP 5	In consultation wit the HRD_PHC tobacco cessation workgroup, the WMC PPS QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to supportive cessation therapy. Measures of success may be revised as appropriate. Metrics will incorporate daa from NYS quitline to the extent permitted by privacy regulations.	06/30/19
MILESTONE # 6	Develop targeted outreach materials for special populations (dental, behavioral health, and DD patients).	12/31/18
STEP 1	HRD_PHC tobacco cessation workgroup will develop a culturally competent communication strategy for patient education targeting the special needs of special popoulations to encourage patients to use the services to faciliItat tobacco cessation. .	12/31/17
STEP 2	WMC PPS will budget to support an outreach campaign to special populaitons.	12/31/15
STEP 3	Partner and client feedback will be solicited. Based on lessons learned and feedback from beneficiaries, Partners and local deployment workgroups, the HRDPHC and/or the Quality Steering Committee and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/standards and further implementation plans in consultation with PMO staff.	12/31/18

4.b.ii

CANCER SCREENING

Implementation Plan

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

MILESTONE	PROJECT PLAN	COMPLETION DATE*
MILESTONE # 1	Development of a comprehensive implementation plan.	03/31/18
STEP 1	In consultation with partner organizations and the Cancer Screening Project Advisory Quality Committee (CPAQC, a workgroup of the WMC PPS Quality Committee), identify appropriate evidence based literature and best practices addressing cancer screening including the NYS Prevention Agenda goals and objectives and experiences of Cancer Services Program. Notify partners of the intention to take action on this project and invite participation in the CPAQC and the Hudson Region DSRIP Public Health Council (HRD-PHC) .	06/30/16
STEP 2	Convene the (CPAQC to review and discuss the candidate best practices/protocols/guidelines/ standards. The CPAQC includes clinical leaders from partner organizations and other stakeholders representing a range of credentials and experience relevant to the project.	09/30/16
STEP 3	In consulation with the Hudson River DSRIP Public Health Council (HRDPHC), review DSRIP Hudson valley Community Needs assessment and other data to identify gaps in cancer screening for Medicaid beneficia-ries. HRDPHC includes representatives of all three Hudson valley PPSs (Montefiore, Refuah and WMCHealth) as well as representatives of County Health Departments and from the 8 Counties in the region. Gap analysis should seek to understand the drivers of low screening and follow-up.	12/31/16
STEP 4	Develop a private group on MIX to share strategies for Cancer Prevention and Management.	03/31/16
STEP 5	Plan phased roll out of best practices/protocols/ guidelines/standards adopted adapted to local consider-ations. To align incentives with identified needs, the plan should be tailored to address barriers to care identified from step 5. For example, if loss of eligibility for insurance coverage is a driver, then one compo-nent of the plan should promote public education around Exchange health insurance products and the Cancer Services (CSP) program for coverage of cancer screening and treatment for the uninsured; If NYS Medicaid or health plan benefit design is a barrier to care then the plan should address benefit deficiencies through advocacy or collaboration with MCOs to improve screening rates.	12/31/17
STEP 6	Work with State organizations such as GNYHA, HANYS, PHSP Coalition and NYS DOH to convene discussion with NY MCOs around DSRIP related issues including successful models for coordination of services and improvement of cancer screening rates.	03/31/18
MILESTONE # 2	Analysis of CSP best practices and lessons learned.	12/31/17
STEP 1	Invite community leaders with experience in NYS Cancer Services Program (CSP) to join the Cancer Screening Project Advisory Quality Committee to share experience and lessons learned.	06/30/16
STEP 2	Convene the (CPAQC to review and discuss the candidate best practices/protocols/guidelines/ standards including experiences in CSP to inform development of a region wide roll-out of best-practices for cancer screening.	12/31/17

* Completion date submitted to NYS Department of Health. The step will begin in a sufficient time to meet the completion date.

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 3	Development of a technology-enablement plan to embed cancer screening guidelines, alerts and reminders in EHRs.	03/31/19
STEP 1	WMC PPS creates roadmap for data sharing and reporting to support cancer screening including plans to embed cancer screening templates and alerts into EHRs.	12/31/18
STEP 2	The CPACQ and/or the QSC or its workgroup will develop metrics to track screening rates, results of screenings, and that patients screening positive are connected to appropriate care. Measures of success may be revised as appropriate.	03/31/19
MILESTONE # 4	Identification of functional requirements for the cancer screening registry.	12/31/19
STEP 1	Define functional reporting requirements for cancer screening projects.	12/31/19
MILESTONE # 5	Piloting rapid cycle evaluation of our PPS' care management function.	09/30/19
STEP 1	The PPS care management function is based on implementation of the Health Home at risk project that will first be piloted in a few large practices and will seek to include appropriate cancer screening in the gaps in care section of the comprehensive care plan.	03/31/16
MILESTONE # 6	Selection of an analytics platform to support patient identification.	03/31/17
STEP 1	WMC PPS implements interim reporting tool for DSRIP milestone reporting and engaged patient tracking.	03/31/17
STEP 2	Aligned with IT development for project 2 ai the WMC PPS begins IT based population health reporting.	09/30/16
STEP 3	Begin phased roll-out of embedded templates and alerts; share templates of early adopters with others to speed adoption.	12/31/16
MILESTONE # 7	Roll-out of a one-stop screening pilot.	03/31/20
STEP 1	Based on past experience we hypothesize that one obstacle to breast cancer screening is getting the referring physician to write a script or an order for the consulting radiologist. If the gap analysis from M1 of this project supports that hypothesis We will examine the feasibility of having a cancer surgeon examine patients, order the mammogram and fu with pt and PCP. Develop proposal with model.	12/31/19
STEP 2	Identify potential sites and partners to test "one stop Breast cancer screening model"	09/30/19
STEP 3	Plan for role-out of pilot test of one-stop Breast Cancer Screening.	03/31/20

Implementation Plan *(continued)*

MILESTONE	PROJECT PLAN	COMPLETION DATE
MILESTONE # 8	Wider roll-out of CSP-adapted protocols DY2 and preliminary evaluation of results. By the end of DY3 the PPS will ensure all providers have developed or adopted PCMH or team- based care models.	12/31/18
STEP 1	Gather lessons learned and feedback from Partners and local deployment workgroups; CPAQC and/or QSC and/or its workgroups will review and adjust training materials/ best practices/ protocols/ guidelines/ standards and further implementation plans for wider roll out in consultation with PMO staff.	12/31/18
STEP 2	WMC PPS issues RFP for vendor to do a PCMH or APC model readiness assessment.	09/30/15
STEP 3	WMC PPS establishes local deployment councils to serve as local PPS contacts for network partners engaging in PCMH or APC model.	03/31/16
STEP 4	WMC PPS completes current state analysis of network partners; included will be determination as to eligibility for PCMH or APC based on practice characteristics, as well as current PCMH or APC certification if any and EHR and MU capabilities.	03/31/16
STEP 5	WMC PPS working with PCMH/APC practice transformation vendor creates action plan for PCMH/APC eligible organizations as appropriate based on their particular gaps so as to enable them to close gaps in processes and services.	12/31/17
STEP 6	Identify pilot partner/early adopter sites to achieve PCMH or APCM by DY3.	12/31/15
STEP 7	Evaluate lessons learned from initial connections; plan phased rollout.	09/30/16
STEP 8	Implement Phase 1 of network rollout PCMH/APCM	03/31/17
STEP 9	Implement Phase 2 of network rollout PCMH/APCM	03/31/18
STEP 10	Document PCMH or APC certification among eligible providers.	12/31/18