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

DSRIP Implementation Plan Project

State University of New York at Stony Brook University Hospital (PPS ID:16)

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

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

Instructions :

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

PATIENT CHALLENGES 1) Lack of transportation results in missed follow-up appointments post hospital discharge. 2) Many patients need to be discharged to a SNF, however a number of long-term care facilities are reluctant to take Medicaid patients which delays the patient's disposition. 3) Homelessness places patients at risk of readmission due to increased difficulty of providing care management services to this population..
PATIENT REMEDIES: 1) Expansion of Suffolk County Accessible Transportation (SCAT) program; the PPS will work to streamline the process to make transportation services more accessible to the patient. 2) The PPS will forge collaborative relationships with all participating SNFs and ensure that the payment model creates alignment of the SNFs with the purpose of the PPS. 3) A Multi-disciplinary teaming process that includes a Social Worker from the time of admission will be built to address these potential issues. The social worker will work closely with PPS CBO's to reach patients in their communities in an effort to educate and engage them in their own health and monitor their progress towards adequate self-management of disease.

PROVIDER CHALLENGES: 1) Lack of available PCP or BH appointments for post-discharge visits. 2) Coordination of handoffs between multiple entities can be difficult and the patient may receive conflicting messages. 3) Providers might be at different stages of readiness for meeting project requirements
PROVIDER REMEDIES: 1) As relevant PPS providers move towards NCQA PCMH Level 3 status, additional appointments will be available as practices become more efficient. PCP recruiting efforts will occur and the collaborative with BH providers will ensure improved access. 2) Protocols will be established to ensure early notification of discharge and avoid duplication of effort. This will be accomplished in the following ways:
a)Hospital must alert PCP office, Health Homes and CM b) Discharge summaries transmitted electronically within 24 hours c) The PCP – Hospitalist communication exceeds simply the discharge summary. 3) PPS will develop provider prioritization plan to provide the appropriate training to providers and develop plan for a staged roll-out project implementation

INFRASTRUCTURE CHALLENGES: 1) Difficulty redeploying or hiring the CMs required for the program 2) Lack of interconnectivity and use between existing EHRs and the RHIO.
INFRASTRUCTURE REMEDIES: 1) The PPS will leverage existing Health Homes capability/capacity and then work together as a PPS to identify sources of CM's to redeploy and to hire. Training resources will be made available through the creation of a Provider Engagement team to engage the redeployed staff in appropriate training programs (e.g., online, in person, etc.). Additionally, The PPS is actively searching, through collaboration with a vendor, for enough CM's to be effective in providing CM services across Suffolk County. Overarching management structure will ensure appropriate risk stratification and effective use of CM resources. 2) Effective implementation of the PPS's IDS IT strategy, and an emphasis on continual improvement, will enable the PPS to create this route for information sharing and communication.

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

Instructions :

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

Benchmarks
100% Total Committed By
DY2,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	430	0	0	0	0	107	214	321	430	430	430
Non-PCP Practitioners	1,862	0	0	0	0	465	930	1,395	1,862	1,862	1,862
Hospitals	12	0	0	0	0	3	6	9	12	12	12
Health Home / Care Management	11	0	0	0	0	2	5	8	11	11	11
Community Based Organizations	38	0	0	0	0	7	15	23	38	38	38
All Other	1,136	0	0	0	0	100	300	636	1,136	1,136	1,136
Total Committed Providers	**3,489**	**0**	**0**	**0**	**0**	**684**	**1,470**	**2,392**	**3,489**	**3,489**	**3,489**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**19.60**	**42.13**	**68.56**	**100.00**	**100.00**	**100.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	430	430	430	430	430	430	430	430	430	430	430
Non-PCP Practitioners	1,862	1,862	1,862	1,862	1,862	1,862	1,862	1,862	1,862	1,862	1,862
Hospitals	12	12	12	12	12	12	12	12	12	12	12
Health Home / Care Management	11	11	11	11	11	11	11	11	11	11	11
Community Based Organizations	38	38	38	38	38	38	38	38	38	38	38
All Other	1,136	1,136	1,136	1,136	1,136	1,136	1,136	1,136	1,136	1,136	1,136
Total Committed Providers	**3,489**	**3,489**	**3,489**	**3,489**	**3,489**	**3,489**	**3,489**	**3,489**	**3,489**	**3,489**	**3,489**
Percent Committed Providers(%)		**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	25,326

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	6,354	9,531	15,255	2,034	10,170	15,255	25,326	2,543	12,713
Percent of Expected Patient Engagement(%)	**0.00**	**25.09**	**37.63**	**60.23**	**8.03**	**40.16**	**60.23**	**100.00**	**10.04**	**50.20**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	19,018	25,326	2,543	12,713	19,018	25,326	25,326	25,326	25,326	25,326
Percent of Expected Patient Engagement(%)	**75.09**	**100.00**	**10.04**	**50.20**	**75.09**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify Project 2.b.iv Committee and Project 2.b.iv Hospital Workgroup Participants in concert with Project 2.b.ix	Project		Completed	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Initiate Baseline Survey Questionnaire for Projects 2.b.ix and 2.b.iv for all hospital partners	Project		Completed	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 3: Develop Project Charter in conjunction with the Project Leads and Project Committee	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Assess each partner's capabilities and development/resource needs to meet project requirements and milestones by doing a needs assessment on project scope against available resources	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Identify PPS partners including participating hospitals, partnering with a home care service or other appropriate community agency to evaluate current strengths and resources that can be leveraged as best practices for the project	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Develop Care Transitions Intervention Model (CTIM) which will standardize protocols with Project Lead & present to Project Committee	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Engage partners, including health homes, to promote project understanding and partner alignment	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Convene Project Committee to aid in the development of the written	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
training materials and workflow including responsible resource at each stage							
Task Step 9: Ensure protocols and procedures are in place that include a 30 day transition of care period is established & include care record transitions with timely updates provided to the members' providers especially, PCPs	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 10: CTIM is finalized by Project 2.b.ix Committee and incorporated into the CTIM	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 11: Clinical Committee review and approval of CTIM, then PPS Board review and approval	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 12: Engage Workforce Project Lead in training strategy	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 13: Develop training documents with key project stakeholders	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 14: Communicate and distribute CTIM to PPS Partners in preparation for implementation of the project	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 16: Collect and maintain, in a centralized location, all pertinent project artifacts such as documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; training documentation	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 15: Engage Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1: Develop MCO and Health Home (MCO/HH) Roster to be engaged in the project	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Include MCO/HH Stakeholders to Project 2.b.vii Committee Meetings for CTIM development and review	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Contract with PPS Partners(written attestation) and stakeholders ensuring coordination of care transition strategies with HH and supportive housing sites & implement protocols as applicable	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Develop a process to continually assess audit reports and recommendations adopted by partners engaged in the project	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Monitor MCO/HH adoption of CTIM to continually assess partner performance	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Develop a payment strategy with key stakeholders for the transition of care services developed in concert with Medicaid Managed Care Plans and Health Homes	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Engage MCO Team to develop TOC payment strategy for TOC services and incorporate the 30 day care transition period into payer agreements	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Meet with MCOs during the planning phase to identify triggers and processes for payer care coordination and chronic care services to ensure coordination and gaps in care and redundant services within Suffolk County	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Execute payment agreements or MOU with MCO for TOC services and ensure payers provide coverage and coordination of service benefits	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: Collect and maintain, in a centralized location, all pertinent project artifacts such as Payment Agreements or MOUs with Managed Care Plans, Documentation of methodology and strategies including identification of responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations; Written attestation or evidence of coordination of care transition strategies with Health Homes and the supportive housing site, Documentation of process and workflow including responsible	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained"							
Task Step 1a: Prioritize HARP-eligible members for Health Home and MCO referral contingent on obtaining HARP-eligible member list from HH and MCOs	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Ensure required social services participate in the project.	Project	N/A	In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: With the support of the Project Lead and Project 2.b.iv Committee determine and identify necessary social services to be engaged in the project including network medically tailored home food services	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Develop Support Services (Social Services) Lists in concert with Project 2.d.i Community Navigation Program	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Develop Communication Plan & Communication Documents for Support Services	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Engage Hospital Partner Workgroup via baseline survey results and leverage key services in their TOC implementation	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Obtain participation agreements with Social Services Partners (Participation Agreements)	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Add Social Services Partnerships to Performance Reporting Program throughout the life of the project	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Collect and maintain, in a centralized location, all pertinent project artifacts including Support Services Lists; Documentation of process and workflow including responsible resources at each stage of the workflow; Written attestation or evidence of agreement; Periodic self-audit reports and recommendations	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Primary Care Physicians	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Non-PCP Practitioners	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospitals	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop workflow to operationalize CTIM with respect to early notification of planned discharges and ability of the transition care manager to visit the patient in the hospital	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Evaluate hospitals current TOC care management visitation procedures and engagements and determine gaps	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Organize System to document early notification of planned discharge and implement	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop training plan and engage Workforce Lead in development	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Approval of training, education and written training materials by the Project 2.b.iv Committee and Workforce Lead	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Endorse and recommend for approval by the Clinical Committee to the PPS Board	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Review and approval by the PPS Board	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Ensure training materials include cultural competency and health literacy content	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Determine necessary frequency of staff training, establish training dates, keep record of dates as well as number of staff trained at each session	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: Develop a system to monitor programs in conjunction with the	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Performance Evaluation and Management Workgroup							
Task Step 11: Collect and maintain, in a centralized location, all pertinent project artifacts that include documentation of early notification of planned discharge process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained; Contract; Vendor System Documentation; Documentation demonstrating that the care manager has access to visit their patients in the hospital	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage PCPs in communication plan for CTIM as well as Project 2.b.iv Committee and Project 2.b.iv Workgroup	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Schedule meetings with Project Leads and recurring standing meetings with Project Committee	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Assess PCPs, non-PCPs, and hospitals capabilities and development/resources needs to meet project requirements and milestones	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Identify PCP, non-PCP, and hospital current strengths and resources that can be leveraged as best practices for the project	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Develop Project Charter in conjunction with the Project Leads and Project Committee	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Add scope of work into CTIM & engage physicians and other stakeholders to review	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Develop workflow including responsible resources at each stage	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Work with Population Health IT to develop EMR is interoperable at all PPS partner sites so the care transition plan is in the patient's medical record	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 9: Incorporate written training materials in reference to this project requirement into TOC training & education program							
Task Step 10: Schedule training dates and keep a record of number of staff trained	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step11: Work with IT and the Performance Reporting and Evaluation Workgroup to develop strategy for periodic self audit reports and recommendations	Project		In Progress	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 12: Collect and maintain, in a centralized location, all pertinent project artifacts including documentation of care record transition process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained; Periodic self-audit reports and recommendations	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4a: Ensure providers from different care settings are members of the Project Committee and define clinical data that needs to be exchanged in the care transition record as one patient transfers from one care setting to another	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage Project 2.b.iv Committee Participants and Project Lead	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop policies and procedures that reflect the requirement that 30 day transition of care period is implemented and utilized	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Engage Hospital Partner Workgroup and other key stakeholders to develop implementation plan for 30 day transition period	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Ensure protocols and procedures are in place that include a 30 day transition of care period is established and included in CTIM	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Implement policies and procedures in concert with policies and procedures referenced in Milestone 1	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Collect and maintain, in a centralized location, all pertinent project	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
artifacts including polices and procedures							
Task Step 6: Engage Project Workgroup to monitor implementation of policies and procedures on an ongoing basis	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Meet with project stakeholders to iteratively define and refine project specific patient identification and report filtering requirements.	Project		In Progress	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Define report format and extract frequency required to satisfy the patient engagement metrics for project	Project		In Progress	06/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Phase 1 tactical reporting bridge solution followed by longer term programmatic strategic solution.	Project		In Progress	06/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Iterative development and testing approach is followed as providers are on-boarded and reporting feedback is received from project stakeholders and the DOH.	Project		In Progress	06/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Run reports reports using tactical solution as needed for quarterly report submission to the DOH (This task will transition into the longer term strategic reporting solution when it becomes available.)	Project		In Progress	06/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Iteratively develop, test and deploy Enterprise Data Warehouse (EDW) HealtheRegistries, HealtheAnalytics, HealtheIntent in accordance with applicable DOH domain requirements.	Project		In Progress	06/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Assure iterative development strategy allows for early EMR integration and testing with providers.	Project		In Progress	06/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Engage with relevant providers to begin EMR integration discussions, share technical message specifications, on-boarding requirements and connectivity details. (Note: This task is dependent on BAA and data use agreements being signed by engaged providers).	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 9: Test, validate, configure, integrate and Maintain EMR data acquisition feeds from all relevant providers for usage within the HealtheAnalytics, HealtheRegistries and HealtheIntent applications.	Project		In Progress	11/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: End date is shown for this task only for the purpose of IDS project milestone completion. However, data acquisition and maintenance will continue for the life of the Population Health Platform.	Project		In Progress	11/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 11: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications.	Project		In Progress	01/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 12: Strategic reporting system is finalized, patient identification, tracking, and matching algorithms are tested and fully deployed into production.	Project		In Progress	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 13: Population Health Platform is capable of identifying targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	09/30/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Step 1: Identify Project 2.b.iv Committee and Project 2.b.iv Hospital Workgroup Participants in concert with Project 2.b.ix										
Task Step 2: Initiate Baseline Survey Questionnaire for Projects 2.b.ix and 2.b.iv for all hospital partners										
Task Step 3: Develop Project Charter in conjunction with the Project Leads and Project Committee										
Task Step 4: Assess each partner's capabilities and										

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
development/resource needs to meet project requirements and milestones by doing a needs assessment on project scope against available resources										
Task Step 5: Identify PPS partners including participating hospitals, partnering with a home care service or other appropriate community agency to evaluate current strengths and resources that can be leveraged as best practices for the project										
Task Step 6: Develop Care Transitions Intervention Model (CTIM) which will standardize protocols with Project Lead & present to Project Committee										
Task Step 7: Engage partners, including health homes, to promote project understanding and partner alignment										
Task Step 8: Convene Project Committee to aid in the development of the written training materials and workflow including responsible resource at each stage										
Task Step 9: Ensure protocols and procedures are in place that include a 30 day transition of care period is established & include care record transitions with timely updates provided to the members' providers especially, PCPs										
Task Step 10: CTIM is finalized by Project 2.b.ix Committee and incorporated into the CTIM										
Task Step 11: Clinical Committee review and approval of CTIM, then PPS Board review and approval										
Task Step 12: Engage Workforce Project Lead in training strategy										
Task Step 13: Develop training documents with key project stakeholders										
Task Step 14: Communicate and distribute CTIM to PPS Partners in preparation for implementation of the project										
Task Step 16: Collect and maintain, in a centralized location, all pertinent project artifacts such as documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; training documentation										
Task Step 15: Engage Project Workgroup to monitor implementation										

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
and ongoing development to assure schedule and metrics are met										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1: Develop MCO and Health Home (MCO/HH) Roster to be engaged in the project										
Task Step 2: Include MCO/HH Stakeholders to Project 2.b.vii Committee Meetings for CTIM development and review										
Task Step 3: Contract with PPS Partners(written attestation) and stakeholders ensuring coordination of care transition strategies with HH and supportive housing sites & implement protocols as applicable										
Task Step 4: Develop a process to continually assess audit reports and recommendations adopted by partners engaged in the project										
Task Step 5: Monitor MCO/HH adoption of CTIM to continually assess partner performance										
Task Step 6: Develop a payment strategy with key stakeholders for the transition of care services developed in concert with Medicaid Managed Care Plans and Health Homes										
Task Step 7: Engage MCO Team to develop TOC payment strategy for TOC services and incorporate the 30 day care transition period into payer agreements										

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

DSRIP Implementation Plan Project

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 8: Meet with MCOs during the planning phase to identify triggers and processes for payer care coordination and chronic care services to ensure coordination and gaps in care and redundant services within Suffolk County										
Task Step 9: Execute payment agreements or MOU with MCO for TOC services and ensure payers provide coverage and coordination of service benefits										
Task Step 10: Collect and maintain, in a centralized location, all pertinent project artifacts such as Payment Agreements or MOUs with Managed Care Plans, Documentation of methodology and strategies including identification of responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations; Written attestation or evidence of coordination of care transition strategies with Health Homes and the supportive housing site, Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained"										
Task Step 1a: Prioritize HARP-eligible members for Health Home and MCO referral contingent on obtaining HARP-eligible member list from HH and MCOs										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Step 1: With the support of the Project Lead and Project 2.b.iv Committee determine and identify necessary social services to be engaged in the project including network medically tailored home food services										
Task Step 2: Develop Support Services (Social Services) Lists in concert with Project 2.d.i Community Navigation Program										
Task Step 3: Develop Communication Plan & Communication Documents for Support Services										
Task Step 4: Engage Hospital Partner Workgroup via baseline survey results and leverage key services in their TOC										

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
implementation										
Task Step 5: Obtain participation agreements with Social Services Partners (Participation Agreements)										
Task Step 6: Add Social Services Partnerships to Performance Reporting Program throughout the life of the project										
Task Step 7: Collect and maintain, in a centralized location, all pertinent project artifacts including Support Services Lists; Documentation of process and workflow including responsible resources at each stage of the workflow; Written attestation or evidence of agreement; Periodic self-audit reports and recommendations										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	107	214	321	430	430	430
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	465	930	1,395	1,862	1,862	1,862
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	3	6	9	12	12	12
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task Step 1: Develop workflow to operationalize CTIM with respect to early notification of planned discharges and ability of the transition care manager to visit the patient in the hospital										
Task Step 2: Evaluate hospitals current TOC care management visitation procedures and engagements and determine gaps										
Task Step 3: Organize System to document early notification of planned discharge and implement										
Task Step 4: Develop training plan and engage Workforce Lead in										

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
development										
Task Step 5: Approval of training, education and written training materials by the Project 2.b.iv Committee and Workforce Lead										
Task Step 6: Endorse and recommend for approval by the Clinical Committee to the PPS Board										
Task Step 7: Review and approval by the PPS Board										
Task Step 8: Ensure training materials include cultural competency and health literacy content										
Task Step 9: Determine necessary frequency of staff training, establish training dates, keep record of dates as well as number of staff trained at each session										
Task Step 10: Develop a system to monitor programs in conjunction with the Performance Evaluation and Management Workgroup										
Task Step 11: Collect and maintain, in a centralized location, all pertinent project artifacts that include documentation of early notification of planned discharge process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained; Contract; Vendor System Documentation; Documentation demonstrating that the care manager has access to visit their patients in the hospital										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Step 1: Engage PCPs in communication plan for CTIM as well as Project 2.b.iv Committee and Project 2.b.iv Workgroup										
Task Step 2: Schedule meetings with Project Leads and recurring standing meetings with Project Committee										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 3: Assess PCPs, non-PCPs, and hospitals capabilities and development/resources needs to meet project requirements and milestones										
Task Step 4: Identify PCP, non-PCP, and hospital current strengths and resources that can be leveraged as best practices for the project										
Task Step 5: Develop Project Charter in conjunction with the Project Leads and Project Committee										
Task Step 6: Add scope of work into CTIM & engage physicians and other stakeholders to review										
Task Step 7: Develop workflow including responsible resources at each stage										
Task Step 8: Work with Population Health IT to develop EMR is interoperable at all PPS partner sites so the care transition plan is in the patient's medical record										
Task Step 9: Incorporate written training materials in reference to this project requirement into TOC training & education program										
Task Step 10: Schedule training dates and keep a record of number of staff trained										
Task Step11: Work with IT and the Performance Reporting and Evaluation Workgroup to develop strategy for periodic self audit reports and recommendations										
Task Step 12: Collect and maintain, in a centralized location, all pertinent project artifacts including documentation of care record transition process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained; Periodic self-audit reports and recommendations										
Task Step 4a: Ensure providers from different care settings are members of the Project Committee and define clinical data that needs to be exchanged in the care transition record as one patient transfers from one care setting to another										
Milestone #6 Ensure that a 30-day transition of care period is established.										

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Delivery System Reform Incentive Payment Project

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State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task Step 1: Engage Project 2.b.iv Committee Participants and Project Lead										
Task Step 2: Develop policies and procedures that reflect the requirement that 30 day transition of care period is implemented and utilized										
Task Step 3: Engage Hospital Partner Workgroup and other key stakeholders to develop implementation plan for 30 day transition period										
Task Step 4: Ensure protocols and procedures are in place that include a 30 day transition of care period is established and included in CTIM										
Task Step 5: Implement policies and procedures in concert with policies and procedures referenced in Milestone 1										
Task Step 7: Collect and maintain, in a centralized location, all pertinent project artifacts including polices and procedures										
Task Step 6: Engage Project Workgroup to monitor implementation of policies and procedures on an ongoing basis										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Meet with project stakeholders to iteratively define and refine project specific patient identification and report filtering requirements.										
Task Step 2: Define report format and extract frequency required to satisfy the patient engagement metrics for project										
Task Step 3: Phase 1 tactical reporting bridge solution followed by longer term programmatic strategic solution.										
Task Step 4: Iterative development and testing approach is followed										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
as providers are on-boarded and reporting feedback is received from project stakeholders and the DOH.										
Task Step 5: Run reports reports using tactical solution as needed for quarterly report submission to the DOH (This task will transition into the longer term strategic reporting solution when it becomes available.)										
Task Step 6: Iteratively develop, test and deploy Enterprise Data Warehouse (EDW) HealtheRegistries, HealtheAnalytics, HealtheIntent in accordance with applicable DOH domain requirements.										
Task Step 7: Assure iterative development strategy allows for early EMR integration and testing with providers.										
Task Step 8: Engage with relevant providers to begin EMR integration discussions, share technical message specifications, on-boarding requirements and connectivity details. (Note: This task is dependent on BAA and data use agreements being signed by engaged providers).										
Task Step 9: Test, validate, configure, integrate and Maintain EMR data acquisition feeds from all relevant providers for usage within the HealtheAnalytics, HealtheRegistries and HealtheIntent applications.										
Task Step 10: End date is shown for this task only for the purpose of IDS project milestone completion. However, data acquisition and maintenance will continue for the life of the Population Health Platform.										
Task Step 11: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications.										
Task Step 12: Strategic reporting system is finalized, patient identification, tracking, and matching algorithms are tested and fully deployed into production.										
Task Step 13: Population Health Platform is capable of identifying targeted patients and is able to track actively engaged patients for project milestone reporting.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Step 1: Identify Project 2.b.iv Committee and Project 2.b.iv Hospital Workgroup Participants in concert with Project 2.b.ix										
Task Step 2: Initiate Baseline Survey Questionnaire for Projects 2.b.ix and 2.b.iv for all hospital partners										
Task Step 3: Develop Project Charter in conjunction with the Project Leads and Project Committee										
Task Step 4: Assess each partner's capabilities and development/resource needs to meet project requirements and milestones by doing a needs assessment on project scope against available resources										
Task Step 5: Identify PPS partners including participating hospitals, partnering with a home care service or other appropriate community agency to evaluate current strengths and resources that can be leveraged as best practices for the project										
Task Step 6: Develop Care Transitions Intervention Model (CTIM) which will standardize protocols with Project Lead & present to Project Committee										
Task Step 7: Engage partners, including health homes, to promote project understanding and partner alignment										
Task Step 8: Convene Project Committee to aid in the development of the written training materials and workflow including responsible resource at each stage										
Task Step 9: Ensure protocols and procedures are in place that include a 30 day transition of care period is established & include care record transitions with timely updates provided to the members' providers especially, PCPs										

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 10: CTIM is finalized by Project 2.b.ix Committee and incorporated into the CTIM										
Task Step 11: Clinical Committee review and approval of CTIM, then PPS Board review and approval										
Task Step 12: Engage Workforce Project Lead in training strategy										
Task Step 13: Develop training documents with key project stakeholders										
Task Step 14: Communicate and distribute CTIM to PPS Partners in preparation for implementation of the project										
Task Step 16: Collect and maintain, in a centralized location, all pertinent project artifacts such as documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; training documentation										
Task Step 15: Engage Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1: Develop MCO and Health Home (MCO/HH) Roster to be engaged in the project										
Task Step 2: Include MCO/HH Stakeholders to Project 2.b.vii Committee Meetings for CTIM development and review										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 3: Contract with PPS Partners(written attestation) and stakeholders ensuring coordination of care transition strategies with HH and supportive housing sites & implement protocols as applicable										
Task Step 4: Develop a process to continually assess audit reports and recommendations adopted by partners engaged in the project										
Task Step 5: Monitor MCO/HH adoption of CTIM to continually assess partner performance										
Task Step 6: Develop a payment strategy with key stakeholders for the transition of care services developed in concert with Medicaid Managed Care Plans and Health Homes										
Task Step 7: Engage MCO Team to develop TOC payment strategy for TOC services and incorporate the 30 day care transition period into payer agreements										
Task Step 8: Meet with MCOs during the planning phase to identify triggers and processes for payer care coordination and chronic care services to ensure coordination and gaps in care and redundant services within Suffolk County										
Task Step 9: Execute payment agreements or MOU with MCO for TOC services and ensure payers provide coverage and coordination of service benefits										
Task Step 10: Collect and maintain, in a centralized location, all pertinent project artifacts such as Payment Agreements or MOUs with Managed Care Plans, Documentation of methodology and strategies including identification of responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations; Written attestation or evidence of coordination of care transition strategies with Health Homes and the supportive housing site, Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained"										
Task Step 1a: Prioritize HARP-eligible members for Health Home and MCO referral contingent on obtaining HARP-eligible										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
member list from HH and MCOs										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Step 1: With the support of the Project Lead and Project 2.b.iv Committee determine and identify necessary social services to be engaged in the project including network medically tailored home food services										
Task Step 2: Develop Support Services (Social Services) Lists in concert with Project 2.d.i Community Navigation Program										
Task Step 3: Develop Communication Plan & Communication Documents for Support Services										
Task Step 4: Engage Hospital Partner Workgroup via baseline survey results and leverage key services in their TOC implementation										
Task Step 5: Obtain participation agreements with Social Services Partners (Participation Agreements)										
Task Step 6: Add Social Services Partnerships to Performance Reporting Program throughout the life of the project										
Task Step 7: Collect and maintain, in a centralized location, all pertinent project artifacts including Support Services Lists; Documentation of process and workflow including responsible resources at each stage of the workflow; Written attestation or evidence of agreement; Periodic self-audit reports and recommendations										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	430	430	430	430	430	430	430	430	430	430
Task Policies and procedures are in place for early notification of	1,862	1,862	1,862	1,862	1,862	1,862	1,862	1,862	1,862	1,862

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
planned discharges.										
Task Policies and procedures are in place for early notification of planned discharges.	12	12	12	12	12	12	12	12	12	12
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task Step 1: Develop workflow to operationalize CTIM with respect to early notification of planned discharges and ability of the transition care manager to visit the patient in the hospital										
Task Step 2: Evaluate hospitals current TOC care management visitation procedures and engagements and determine gaps										
Task Step 3: Organize System to document early notification of planned discharge and implement										
Task Step 4: Develop training plan and engage Workforce Lead in development										
Task Step 5: Approval of training, education and written training materials by the Project 2.b.iv Committee and Workforce Lead										
Task Step 6: Endorse and recommend for approval by the Clinical Committee to the PPS Board										
Task Step 7: Review and approval by the PPS Board										
Task Step 8: Ensure training materials include cultural competency and health literacy content										
Task Step 9: Determine necessary frequency of staff training, establish training dates, keep record of dates as well as number of staff trained at each session										
Task Step 10: Develop a system to monitor programs in conjunction with the Performance Evaluation and Management Workgroup										
Task Step 11: Collect and maintain, in a centralized location, all pertinent project artifacts that include documentation of early notification of planned discharge process and workflow including responsible resources at each stage; Written training										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
materials; List of training dates; Number of staff trained; Contract; Vendor System Documentation; Documentation demonstrating that the care manager has access to visit their patients in the hospital										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Step 1: Engage PCPs in communication plan for CTIM as well as Project 2.b.iv Committee and Project 2.b.iv Workgroup										
Task Step 2: Schedule meetings with Project Leads and recurring standing meetings with Project Committee										
Task Step 3: Assess PCPs, non-PCPs, and hospitals capabilities and development/resources needs to meet project requirements and milestones										
Task Step 4: Identify PCP, non-PCP, and hospital current strengths and resources that can be leveraged as best practices for the project										
Task Step 5: Develop Project Charter in conjunction with the Project Leads and Project Committee										
Task Step 6: Add scope of work into CTIM & engage physicians and other stakeholders to review										
Task Step 7: Develop workflow including responsible resources at each stage										
Task Step 8: Work with Population Health IT to develop EMR is interoperable at all PPS partner sites so the care transition plan is in the patient's medical record										
Task Step 9: Incorporate written training materials in reference to this project requirement into TOC training & education program										
Task Step 10: Schedule training dates and keep a record of number										

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
of staff trained										
Task Step11: Work with IT and the Performance Reporting and Evaluation Workgroup to develop strategy for periodic self audit reports and recommendations										
Task Step 12: Collect and maintain, in a centralized location, all pertinent project artifacts including documentation of care record transition process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained; Periodic self-audit reports and recommendations										
Task Step 4a: Ensure providers from different care settings are members of the Project Committee and define clinical data that needs to be exchanged in the care transition record as one patient transfers from one care setting to another										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task Step 1: Engage Project 2.b.iv Committee Participants and Project Lead										
Task Step 2: Develop policies and procedures that reflect the requirement that 30 day transition of care period is implemented and utilized										
Task Step 3: Engage Hospital Partner Workgroup and other key stakeholders to develop implementation plan for 30 day transition period										
Task Step 4: Ensure protocols and procedures are in place that include a 30 day transition of care period is established and included in CTIM										
Task Step 5: Implement policies and procedures in concert with policies and procedures referenced in Milestone 1										
Task Step 7: Collect and maintain, in a centralized location, all pertinent project artifacts including polices and procedures										

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DSRIP Implementation Plan Project

State University of New York at Stony Brook University Hospital (PPS ID:16)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Step 6: Engage Project Workgroup to monitor implementation of policies and procedures on an ongoing basis										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Meet with project stakeholders to iteratively define and refine project specific patient identification and report filtering requirements.										
Task Step 2: Define report format and extract frequency required to satisfy the patient engagement metrics for project										
Task Step 3: Phase 1 tactical reporting bridge solution followed by longer term programmatic strategic solution.										
Task Step 4: Iterative development and testing approach is followed as providers are on-boarded and reporting feedback is received from project stakeholders and the DOH.										
Task Step 5: Run reports reports using tactical solution as needed for quarterly report submission to the DOH (This task will transition into the longer term strategic reporting solution when it becomes available.)										
Task Step 6: Iteratively develop, test and deploy Enterprise Data Warehouse (EDW) HealtheRegistries, HealtheAnalytics, HealtheIntent in accordance with applicable DOH domain requirements.										
Task Step 7: Assure iterative development strategy allows for early EMR integration and testing with providers.										
Task Step 8: Engage with relevant providers to begin EMR integration discussions, share technical message specifications, on-boarding requirements and connectivity details. (Note: This task is dependent on BAA and data use agreements being signed by engaged providers).										
Task Step 9: Test, validate, configure, integrate and Maintain EMR										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
data acquisition feeds from all relevant providers for usage within the HealtheAnalytics, HealtheRegistries and HealtheIntent applications.										
Task Step 10: End date is shown for this task only for the purpose of IDS project milestone completion. However, data acquisition and maintenance will continue for the life of the Population Health Platform.										
Task Step 11: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications.										
Task Step 12: Strategic reporting system is finalized, patient identification, tracking, and matching algorithms are tested and fully deployed into production.										
Task Step 13: Population Health Platform is capable of identifying targeted patients and is able to track actively engaged patients for project milestone reporting.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	
Ensure required social services participate in the project.	
Transition of care protocols will include early	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
Ensure that a 30-day transition of care period is established.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

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

Instructions :

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