Project 2.b.vii – Implementing the INTERACT project (inpatient transfer avoidance program for SNF)

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

Instructions :

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

The PPS conducted several surveys of the SNFs to inform project development. According to the survey results, 74% of the partner SNFs have some experience using the INTERACT program. Of these, however, not surprisingly, regular use of program tools varies greatly, and during project planning it became clear that most – if not all – of the SNFs that have experience with INTERACT tools have not thoroughly embedded the tools consistently within their operations to maximize impact. For example, some SNFs complete the SBAR only when a hospital transfer occurs, diluting its impact to avoid a hospital transfer. In summary, every SNF will benefit from a more thorough and robust training and monitoring protocol on the use of the various INTERACT tools. The following risks to the successful implementation of this project have been identified:

Issue: Of those who currently utilize INTERACT, most do so on paper. Additionally, wide variation in EMR systems exists among the PPS partners that have them. Among these facilities, many different EHR platforms are utilized.
Risk Mitigation: The PPS will develop a simple interface (e.g., using Direct Messaging, etc.) to link SNFs to hospital partners in the short term and this will be built upon as full connectivity becomes more or a reality. Consistent with PPS goals, electronic connectivity with hospital partners will be completed over the project lifetime. The SNFs will work with the local RHIO to ensure useful electronic communication. As INTERACT tools are embedded in EHR products, SNFs will move from paper to electronic use of these tools.

Issue: Efforts to engage the multiple staffing agencies relied upon by SNFs for weekend coverage to ensure that these weekend staff learn to properly use INTERACT tools may prove cumbersome
Risk Mitigation: The PPS will create and implement a Provider Engagement to train weekend staff in proper use of INTERACT tools and documentation through the PPS wide IT infrastructure.

Issue: Patients/families may be skeptical, or unaware, of the benefits from avoiding readmission
Risk Mitigation: All SNFs will provide orientation materials at facility admission outlining the policies and benefits of transfer avoidance, as well as materials on advance care planning.

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IPQR Module 2.b.vii.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
SNFs participating in the INTERACT program	46	0	0	0	0	0	10	25	46	46	46
Total Committed Providers	**46**	**0**	**0**	**0**	**0**	**0**	**10**	**25**	**46**	**46**	**46**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**21.74**	**54.35**	**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
SNFs participating in the INTERACT program	46	46	46	46	46	46	46	46	46	46	46
Total Committed Providers	**46**	**46**	**46**	**46**	**46**	**46**	**46**	**46**	**46**	**46**	**46**
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.vii.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	1,914

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	478	717	1,148	382	765	1,340	1,914	478	957
Percent of Expected Patient Engagement(%)	**0.00**	**24.97**	**37.46**	**59.98**	**19.96**	**39.97**	**70.01**	**100.00**	**24.97**	**50.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	1,435	1,914	478	957	1,435	1,914	1,914	1,914	1,914	1,914
Percent of Expected Patient Engagement(%)	**74.97**	**100.00**	**24.97**	**50.00**	**74.97**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT principles implemented at each participating SNF.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Nursing home to hospital transfers reduced.	Provider	Skilled Nursing Facilities / Nursing Homes	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT 3.0 Toolkit used at each SNF.	Provider	Skilled Nursing Facilities / Nursing Homes	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Administer baseline assessment to SNFs to determine gap toward INTERACT implementation	Project		Completed	04/01/2015	05/20/2015	06/30/2015	DY1 Q1
Task Step 2: Determine implementation schedule to roll out program starting with SNF's at highest degree of readiness	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Execute the PPS participation agreements	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop training and communication plan	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Develop monitoring procedures and schedule	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Identify INTERACT 4.0 Toolkit principles and implementation plan	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Create process for quarterly report narrative demonstrating successfully implementation of project requirements	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Formalize INTERACT principles and implementation plan	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Clinical Governance Committee approval of INTERACT principles and implementation plan	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
Task Step 10: 2.b.vii Education & Training program and communication plan implemented at each PPS SNF	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 11: Establish a system to monitor nursing home to hospital transfer rate	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 12: Initiate data collection, aggregate data from partners and review gaps in data collection	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 13: Analyze data against commitments in accordance with monitoring procedures and schedule	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 14: Report baseline data from the partner SNFs to determine current nursing home to hospital transfer volume to key project stakeholders	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 15: Analyze data to determine baseline transfer rate	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 16: Collect monthly reports in transfers from the SNF	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 17: Create Quarterly Report Narrative to be submitted to the DOH on a quarterly basis	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 18: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 19: Collect and maintain, in a centralized location, all pertinent project artifacts such as the quarterly report narrative demonstrating successful implementation of project requirements	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Facility champion identified for each SNF.	Provider	Skilled Nursing Facilities / Nursing Homes	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify SNF Facility Champion Role Description	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2; Role description defined, standardized, and approved by Project Committee, Project Leads and Workforce	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3

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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 3: Contract with SNF Partners within our PPS	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Role description of facility champion communicated to each PPS SNF	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5; Facility champion identified by each SNF and provided to SCC, including CV outlining experience with INTERACT principles	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as role description of the facility champion, CV (explaining experience with INTERACT principles), contract, individual trained INTERACT principles identified	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage key project stakeholders in developing a plan to identify care pathways, clinical tool (s) to monitor chronically ill patients, and a tool to identify patients at highest risk for readmission leveraging INTERACT principles	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Evaluate the use of care pathways and clinical tools at participating SNFs	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Engage the Workforce Project Lead, Project Leads, and Project Committee to incorporate care pathways and clinical tools into the education and training program for INTERACT	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop interventions aimed at avoiding hospital transfer including the development of escalation strategies, strategic plan for monitoring of chronically ill patients, and implementation plan with the Project Committee.	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	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
Step 5: Standardize training materials, including written training materials, and have them approved by Project Committee							
Task Step 6: Schedule training sessions with PPS contracted/engaged SNF staff	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Collect and maintain, in a centralized location, all pertinent project artifacts such as documentation of care pathway and clinical tool methodology, documented strategic plan for monitoring of chronically ill patients and hospital avoidance, implementation plan, written training materials, list of training dates along with number of staff trained	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT principles.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	Provider	Skilled Nursing Facilities / Nursing Homes	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop a training program for SNF staff, including the SNF Medical Director, encompassing care pathways and INTERACT principles with Project Leads, Project Committee and Workforce Lead	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Include written training materials and define INTERACT trainer's scope of work and role definition	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Engage the Cultural Competency and Health Literacy Workgroup to include these components in the training and education program	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Finalize and approve training, education and written training materials by the Project Committee and hire INTERACT trainers	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: Determine necessary frequency of staff training, establish training dates, host training sessions and keep record of training dates with number of staff trained at each SNF, and monitoring and reporting program to key stakeholders	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Implement Advance Care Planning tools to assist residents and families in	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
expressing and documenting their wishes for near end of life and end of life care.							
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Incorporate Advance Care Planning tools into the project using MOLST (as evidenced by policies and procedures)	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Identify and standardize Advance Care Planning tool using MOLST	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Formalize principles and obtain approval of MOLST by the Project Committee and Clinical Committee	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Incorporate MOLST into the education and training program to implement at SNFs	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of tool(s)/toolkit materials	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT coaching program established at each SNF.	Provider	Skilled Nursing Facilities / Nursing Homes	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Create INTERACT coaching program in concert with INTERACT training program, ensure written training materials are developed	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Incorporate and develop written training materials into the education & training program with the Project Leads, Project Committee and Workforce Lead	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Identify, recruit, and train coaches from engaged SNFs within the PPS	Project		In Progress	09/01/2015	12/01/2016	12/31/2016	DY2 Q3
Task Step 4: Finalize and approve training, education, and written training materials by the Project Committee	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
Task Step 5: Determine necessary frequency of staff training, establish training dates, host training sessions and keep record of training dates with number of staff trained at each SNF	Project		In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of written training materials, list of training dates, along with number of staff trained	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT principles.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage the Directors of Nursing Workgroup to create INTERACT handout/pamphlet for patients, families, and caretakers with the assistance of the Project Leads and Project Committee	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Incorporate into INTERACT training program and schedule ways to educate the families and caretakers from the provider perspective	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Collect and maintain education materials that include formats that address health literacy and language concerns	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Engage Cultural Competency and Health Literacy Workgroup Advisory Board to review and approve materials	Project		In Progress	03/31/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 5: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of patient/family education methodology, and patient/family education materials	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Project	N/A	In Progress	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Provider	Safety Net Hospitals	In Progress	06/01/2015	03/31/2018	03/31/2018	DY3 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
EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Skilled Nursing Facilities / Nursing Homes	In Progress	06/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Practitioner Engagement Team to support development and communication plan to educate and support on-boarding of engaged/contracted practices for this particular milestone.	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Engage in discussions with RHIO partners to organize an enrollment process in partnership with the SCC. Identify monitoring process for RHIO enrollments and two-way communication between SCC PMO and RHIO outreach staff.	Project		In Progress	06/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task Step 3: Incorporate RHIO enrollment into SCC Contracting Enrollment scope of work. Which will include RHIO enrollment directions, agreement, FAQ for all on-boarded safety net partner who falls within the partner cohort for this project requirement.	Project		In Progress	06/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task Step 4: Conduct assessment of Engaged/Contracted partners' EMR for Meaningful Use and RHIO connectivity (e.g. assessment can include analysis of data sharing readiness, interoperable IT platforms, etc.).	Project		In Progress	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Create best practice examples around advantages of RHIO participation and how patient RHIO "agree" or "deny" status can be obtained.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Create global plan for how EHRs will meet the connectivity to RHIO's HIE and SHIN-NY requirements.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Create plan for how the PPS uses alerts and secure messaging functionality.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 8: Create provider training materials/education required to support IDS functions/processes developed to include training schedule, engaged/contracted partners to be trained and number of staff trained in use of alerts and secure messaging (if applicable).	Project		In Progress	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Develop written training materials on secure messaging,	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Develop and initiate WBS to demonstrate use of DIRECT secure	Project		In Progress	03/01/2016	06/30/2016	06/30/2016	DY2 Q1

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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
email transactions with selected PPS partners							
Task Step 11: Develop process to make RHIO consent form readily available to all Engaged/Contracted provider offices/locations.	Project		In Progress	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 12: Initiate roll-out to Contracted partners to be engaged in milestone to include training (to include, actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange, secure messaging, alerts and patient record look up).	Project		In Progress	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 13: Initiate quality control of engaged/contracted partners to be able to provide evidence of EHR Vendor Documentation and show evidence of screenshots of use of alerts and secure messaging	Project		In Progress	01/01/2017	03/30/2017	03/31/2017	DY2 Q4
Task Step 14: Complete roll-out to Engaged/Contracted partners within the PPS. Includes documentation of training dates and number of staff trained (to include participation agreements, sample of transactions to public health registries, and use of DIRECT secure email transactions).	Project		In Progress	10/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Service and quality outcome measures are reported to all stakeholders.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage Clinical Committee to participate and act as the Quality Improvement Committee and ensure that is representative of the PPS staff involved in quality improvement processes and other stakeholders, especially the Director's of Nursing	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2: Document attendees from respective organization and staff title in the directory	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Clinical Committee identifies opportunities for quality improvement using rapid cycle and root cause analysis improvement methodologies	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Create quality improvement action plans and evaluate results of quality improvement initiatives as necessary	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Develop implementation reports from quality improvement results and present them at recurring Project 2.b.vii Committee & Clinical Committee Meetings	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Record meeting minutes from Clinical Committee Meetings	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Evaluate and create action plans based on key quality metrics, to include applicable metrics in Attachment J	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Report service and quality outcome measures to all stakeholders via newsletters, website URLs	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Collect and maintain, in a centralized location, all pertinent project artifacts including quality committee membership list with indication of organization represented and staff category, if applicable, Quality improvement plans; Root cause analysis; Implementation Reports; Implementation results; Meeting minutes, Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans, Website URLs with published reports; Newsletters; Documentation demonstrating quality outcomes	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	06/01/2015	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	06/01/2015	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	Project		In Progress	06/01/2015	09/30/2016	09/30/2016	DY2 Q2

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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
Step 2: Define report format and extract frequency required to satisfy the patient engagement metrics for project. Phase 1 tactical reporting bridge solution followed by longer term programmatic strategic solution. Iterative development and testing approach is followed as providers are on-boarded and reporting feedback is received from project stakeholders and the DOH. Run reports as needed for submission of quarterly reports.							
Task Step 3: Iteratively develop, test and deploy Enterprise Data Warehouse (EDW) HealtheRegistries, HealtheAnalytics, HealtheIntent in accordance with applicable DOH domain requirements. 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 4: 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
Task Step 5: 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 6: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications. (Note: Roster and DOH claims data subject to the completion of the DOH Opt Out Process.)	Project		In Progress	01/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: 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 8: 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 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources										

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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
available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	0	0	0	0	0	10	25	46	46	46
Task INTERACT 3.0 Toolkit used at each SNF.	0	0	0	0	0	10	25	46	46	46
Task Step 1: Administer baseline assessment to SNFs to determine gap toward INTERACT implementation										
Task Step 2: Determine implementation schedule to roll out program starting with SNF's at highest degree of readiness										
Task Step 3: Execute the PPS participation agreements										
Task Step 4: Develop training and communication plan										
Task Step 5: Develop monitoring procedures and schedule										
Task Step 6: Identify INTERACT 4.0 Toolkit principles and implementation plan										
Task Step 7: Create process for quarterly report narrative demonstrating successfully implementation of project requirements										
Task Step 8: Formalize INTERACT principles and implementation plan										
Task Step 9: Clinical Governance Committee approval of INTERACT principles and implementation plan										
Task Step 10: 2.b.vii Education & Training program and communication plan implemented at each PPS SNF										
Task Step 11: Establish a system to monitor nursing home to hospital transfer rate										
Task Step 12: Initiate data collection, aggregate data from partners and review gaps in data collection										
Task Step 13: Analyze data against commitments in accordance with monitoring procedures and schedule										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 14: Report baseline data from the partner SNFs to determine current nursing home to hospital transfer volume to key project stakeholders										
Task Step 15: Analyze data to determine baseline transfer rate										
Task Step 16: Collect monthly reports in transfers from the SNF										
Task Step 17: Create Quarterly Report Narrative to be submitted to the DOH on a quarterly basis										
Task Step 18: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met										
Task Step 19: Collect and maintain, in a centralized location, all pertinent project artifacts such as the quarterly report narrative demonstrating successful implementation of project requirements										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	0	0	0	0	0	10	25	46	46	46
Task Step 1: Identify SNF Facility Champion Role Description										
Task Step 2; Role description defined, standardized, and approved by Project Committee, Project Leads and Workforce										
Task Step 3: Contract with SNF Partners within our PPS										
Task Step 4: Role description of facility champion communicated to each PPS SNF										
Task Step 5; Facility champion identified by each SNF and provided to SCC, including CV outlining experience with INTERACT principles										
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as role description of the facility champion, CV (explaining experience with INTERACT principles), contract, individual trained INTERACT principles identified										

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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
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task Step 1: Engage key project stakeholders in developing a plan to identify care pathways, clinical tool (s) to monitor chronically ill patients, and a tool to identify patients at highest risk for readmission leveraging INTERACT principles										
Task Step 2: Evaluate the use of care pathways and clinical tools at participating SNFs										
Task Step 3: Engage the Workforce Project Lead, Project Leads, and Project Committee to incorporate care pathways and clinical tools into the education and training program for INTERACT										
Task Step 4: Develop interventions aimed at avoiding hospital transfer including the development of escalation strategies, strategic plan for monitoring of chronically ill patients, and implementation plan with the Project Committee.										
Task Step 5: Standardize training materials, including written training materials, and have them approved by Project Committee										
Task Step 6: Schedule training sessions with PPS contracted/engaged SNF staff										
Task Step 7: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met										
Task Step 8: Collect and maintain, in a centralized location, all pertinent project artifacts such as documentation of care pathway and clinical tool methodology, documented strategic plan for monitoring of chronically ill patients and hospital avoidance, implementation plan, written training materials, list										

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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
of training dates along with number of staff trained										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	0	0	0	0	0	10	25	46	46	46
Task Step 1: Develop a training program for SNF staff, including the SNF Medical Director, encompassing care pathways and INTERACT principles with Project Leads, Project Committee and Workforce Lead										
Task Step 2: Include written training materials and define INTERACT trainer's scope of work and role definition										
Task Step 3: Engage the Cultural Competency and Health Literacy Workgroup to include these components in the training and education program										
Task Step 4: Finalize and approve training, education and written training materials by the Project Committee and hire INTERACT trainers										
Task Step 5: Determine necessary frequency of staff training, establish training dates, host training sessions and keep record of training dates with number of staff trained at each SNF, and monitoring and reporting program to key stakeholders										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task Step 1: Incorporate Advance Care Planning tools into the project using MOLST (as evidenced by policies and procedures)										
Task Step 2: Identify and standardize Advance Care Planning tool using MOLST										
Task Step 3: Formalize principles and obtain approval of MOLST by the Project Committee and Clinical Committee										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 4: Incorporate MOLST into the education and training program to implement at SNFs										
Task Step 5: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met										
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of tool(s)/toolkit materials										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	0	0	0	0	0	10	25	46	46	46
Task Step 1: Create INTERACT coaching program in concert with INTERACT training program, ensure written training materials are developed										
Task Step 2: Incorporate and develop written training materials into the education & training program with the Project Leads, Project Committee and Workforce Lead										
Task Step 3: Identify, recruit, and train coaches from engaged SNFs within the PPS										
Task Step 4: Finalize and approve training, education, and written training materials by the Project Committee										
Task Step 5: Determine necessary frequency of staff training, establish training dates, host training sessions and keep record of training dates with number of staff trained at each SNF										
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of written training materials, list of training dates, along with number of staff trained										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 1: Engage the Directors of Nursing Workgroup to create INTERACT handout/pamphlet for patients, families, and caretakers with the assistance of the Project Leads and Project Committee										
Task Step 2: Incorporate into INTERACT training program and schedule ways to educate the families and caretakers from the provider perspective										
Task Step 3: Collect and maintain education materials that include formats that address health literacy and language concerns										
Task Step 4: Engage Cultural Competency and Health Literacy Workgroup Advisory Board to review and approve materials										
Task Step 5: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of patient/family education methodology, and patient/family education materials										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	7	7	7
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	38	38	38
Task Step 1: Practitioner Engagement Team to support development and communication plan to educate and support on-boarding of engaged/contracted practices for this particular milestone.										
Task Step 2: Engage in discussions with RHIO partners to organize an enrollment process in partnership with the SCC. Identify monitoring process for RHIO enrollments and two-way communication between SCC PMO and RHIO outreach staff.										
Task Step 3: Incorporate RHIO enrollment into SCC Contracting Enrollment scope of work. Which will include RHIO enrollment directions, agreement, FAQ for all on-boarded safety net										

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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
partner who falls within the partner cohort for this project requirement.										
Task Step 4: Conduct assessment of Engaged/Contracted partners' EMR for Meaningful Use and RHIO connectivity (e.g. assessment can include analysis of data sharing readiness, interoperable IT platforms, etc.).										
Task Step 5: Create best practice examples around advantages of RHIO participation and how patient RHIO "agree" or "deny" status can be obtained.										
Task Step 6: Create global plan for how EHRs will meet the connectivity to RHIO's HIE and SHIN-NY requirements.										
Task Step 7: Create plan for how the PPS uses alerts and secure messaging functionality.										
Task Step 8: Create provider training materials/education required to support IDS functions/processes developed to include training schedule, engaged/contracted partners to be trained and number of staff trained in use of alerts and secure messaging (if applicable).										
Task Step 9: Develop written training materials on secure messaging,										
Task Step 10: Develop and initiate WBS to demonstrate use of DIRECT secure email transactions with selected PPS partners										
Task Step 11: Develop process to make RHIO consent form readily available to all Engaged/Contracted provider offices/locations.										
Task Step 12: Initiate roll-out to Contracted partners to be engaged in milestone to include training (to include, actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange, secure messaging, alerts and patient record look up).										
Task Step 13: Initiate quality control of engaged/contracted partners to be able to provide evidence of EHR Vendor Documentation and show evidence of screenshots of use of alerts and secure messaging										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 14: Complete roll-out to Engaged/Contracted partners within the PPS. Includes documentation of training dates and number of staff trained (to include participation agreements, sample of transactions to public health registries, and use of DIRECT secure email transactions).										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1: Engage Clinical Committee to participate and act as the Quality Improvement Committee and ensure that is representative of the PPS staff involved in quality improvement processes and other stakeholders, especially the Director's of Nursing										
Task Step 2: Document attendees from respective organization and staff title in the directory										
Task Step 3: Clinical Committee identifies opportunities for quality improvement using rapid cycle and root cause analysis improvement methodologies										
Task Step 4: Create quality improvement action plans and evaluate results of quality improvement initiatives as necessary										
Task Step 5: Develop implementation reports from quality improvement results and present them at recurring Project 2.b.vii Committee & Clinical Committee Meetings										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 6: Record meeting minutes from Clinical Committee Meetings										
Task Step 7: Evaluate and create action plans based on key quality metrics, to include applicable metrics in Attachment J										
Task Step 8: Report service and quality outcome measures to all stakeholders via newsletters, website URLs										
Task Step 9: Collect and maintain, in a centralized location, all pertinent project artifacts including quality committee membership list with indication of organization represented and staff category, if applicable, Quality improvement plans; Root cause analysis; Implementation Reports; Implementation results; Meeting minutes, Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans, Website URLs with published reports; Newsletters; Documentation demonstrating quality outcomes										
Milestone #10 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. Phase 1 tactical reporting bridge solution followed by longer term programmatic strategic solution. Iterative development and testing approach is followed as providers are on-boarded and reporting feedback is received from project stakeholders and the DOH. Run reports as needed for submission of quarterly reports.										
Task Step 3: Iteratively develop, test and deploy Enterprise Data Warehouse (EDW) HealtheRegistries, HealtheAnalytics, HealtheIntent in accordance with applicable DOH domain requirements. Assure iterative development strategy allows for early EMR integration and testing with providers.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Step 4: 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 5: 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 6: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications. (Note: Roster and DOH claims data subject to the completion of the DOH Opt Out Process.)										
Task Step 7: Reporting system is finalized, patient identification, tracking, and matching algorithms are tested and fully deployed into production.										
Task Step 8: Population Health Platform is capable of identifying targeted patients and is able to track actively engaged patients for project milestone reporting.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	46	46	46	46	46	46	46	46	46	46
Task INTERACT 3.0 Toolkit used at each SNF.	46	46	46	46	46	46	46	46	46	46
Task Step 1: Administer baseline assessment to SNFs to determine gap toward INTERACT implementation										
Task Step 2: Determine implementation schedule to roll out program										

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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
starting with SNF's at highest degree of readiness										
Task Step 3: Execute the PPS participation agreements										
Task Step 4: Develop training and communication plan										
Task Step 5: Develop monitoring procedures and schedule										
Task Step 6: Identify INTERACT 4.0 Toolkit principles and implementation plan										
Task Step 7: Create process for quarterly report narrative demonstrating successfully implementation of project requirements										
Task Step 8: Formalize INTERACT principles and implementation plan										
Task Step 9: Clinical Governance Committee approval of INTERACT principles and implementation plan										
Task Step 10: 2.b.vii Education & Training program and communication plan implemented at each PPS SNF										
Task Step 11: Establish a system to monitor nursing home to hospital transfer rate										
Task Step 12: Initiate data collection, aggregate data from partners and review gaps in data collection										
Task Step 13: Analyze data against commitments in accordance with monitoring procedures and schedule										
Task Step 14: Report baseline data from the partner SNFs to determine current nursing home to hospital transfer volume to key project stakeholders										
Task Step 15: Analyze data to determine baseline transfer rate										
Task Step 16: Collect monthly reports in transfers from the SNF										
Task Step 17: Create Quarterly Report Narrative to be submitted to the DOH on a quarterly basis										

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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 18: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met										
Task Step 19: Collect and maintain, in a centralized location, all pertinent project artifacts such as the quarterly report narrative demonstrating successful implementation of project requirements										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	46	46	46	46	46	46	46	46	46	46
Task Step 1: Identify SNF Facility Champion Role Description										
Task Step 2; Role description defined, standardized, and approved by Project Committee, Project Leads and Workforce										
Task Step 3: Contract with SNF Partners within our PPS										
Task Step 4: Role description of facility champion communicated to each PPS SNF										
Task Step 5; Facility champion identified by each SNF and provided to SCC, including CV outlining experience with INTERACT principles										
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as role description of the facility champion, CV (explaining experience with INTERACT principles), contract, individual trained INTERACT principles identified										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to										

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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
monitor critically ill patients and avoid hospital readmission.										
Task Step 1: Engage key project stakeholders in developing a plan to identify care pathways, clinical tool (s) to monitor chronically ill patients, and a tool to identify patients at highest risk for readmission leveraging INTERACT principles										
Task Step 2: Evaluate the use of care pathways and clinical tools at participating SNFs										
Task Step 3: Engage the Workforce Project Lead, Project Leads, and Project Committee to incorporate care pathways and clinical tools into the education and training program for INTERACT										
Task Step 4: Develop interventions aimed at avoiding hospital transfer including the development of escalation strategies, strategic plan for monitoring of chronically ill patients, and implementation plan with the Project Committee.										
Task Step 5: Standardize training materials, including written training materials, and have them approved by Project Committee										
Task Step 6: Schedule training sessions with PPS contracted/engaged SNF staff										
Task Step 7: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met										
Task Step 8: Collect and maintain, in a centralized location, all pertinent project artifacts such as documentation of care pathway and clinical tool methodology, documented strategic plan for monitoring of chronically ill patients and hospital avoidance, implementation plan, written training materials, list of training dates along with number of staff trained										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	46	46	46	46	46	46	46	46	46	46
Task Step 1: Develop a training program for SNF staff, including the SNF Medical Director, encompassing care pathways and INTERACT principles with Project Leads, Project Committee										

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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
and Workforce Lead										
Task Step 2: Include written training materials and define INTERACT trainer's scope of work and role definition										
Task Step 3: Engage the Cultural Competency and Health Literacy Workgroup to include these components in the training and education program										
Task Step 4: Finalize and approve training, education and written training materials by the Project Committee and hire INTERACT trainers										
Task Step 5: Determine necessary frequency of staff training, establish training dates, host training sessions and keep record of training dates with number of staff trained at each SNF, and monitoring and reporting program to key stakeholders										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task Step 1: Incorporate Advance Care Planning tools into the project using MOLST (as evidenced by policies and procedures)										
Task Step 2: Identify and standardize Advance Care Planning tool using MOLST										
Task Step 3: Formalize principles and obtain approval of MOLST by the Project Committee and Clinical Committee										
Task Step 4: Incorporate MOLST into the education and training program to implement at SNFs										
Task Step 5: Engage Director of Nursing Project Workgroup to monitor implementation and ongoing development to assure schedule and metrics are met										
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of tool(s)/toolkit										

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)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
materials										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	46	46	46	46	46	46	46	46	46	46
Task Step 1: Create INTERACT coaching program in concert with INTERACT training program, ensure written training materials are developed										
Task Step 2: Incorporate and develop written training materials into the education & training program with the Project Leads, Project Committee and Workforce Lead										
Task Step 3: Identify, recruit, and train coaches from engaged SNFs within the PPS										
Task Step 4: Finalize and approve training, education, and written training materials by the Project Committee										
Task Step 5: Determine necessary frequency of staff training, establish training dates, host training sessions and keep record of training dates with number of staff trained at each SNF										
Task Step 6: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of written training materials, list of training dates, along with number of staff trained										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task Step 1: Engage the Directors of Nursing Workgroup to create INTERACT handout/pamphlet for patients, families, and caretakers with the assistance of the Project Leads and Project Committee										
Task Step 2: Incorporate into INTERACT training program and schedule ways to educate the families and caretakers from the provider perspective										

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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 3: Collect and maintain education materials that include formats that address health literacy and language concerns										
Task Step 4: Engage Cultural Competency and Health Literacy Workgroup Advisory Board to review and approve materials										
Task Step 5: Collect and maintain, in a centralized location, all pertinent project artifacts such as evidence of patient/family education methodology, and patient/family education materials										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	7	7	7	7	7	7	7	7	7	7
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	38	38	38	38	38	38	38	38	38	38
Task Step 1: Practitioner Engagement Team to support development and communication plan to educate and support on-boarding of engaged/contracted practices for this particular milestone.										
Task Step 2: Engage in discussions with RHIO partners to organize an enrollment process in partnership with the SCC. Identify monitoring process for RHIO enrollments and two-way communication between SCC PMO and RHIO outreach staff.										
Task Step 3: Incorporate RHIO enrollment into SCC Contracting Enrollment scope of work. Which will include RHIO enrollment directions, agreement, FAQ for all on-boarded safety net partner who falls within the partner cohort for this project requirement.										
Task Step 4: Conduct assessment of Engaged/Contracted partners' EMR for Meaningful Use and RHIO connectivity (e.g. assessment can include analysis of data sharing readiness, interoperable IT platforms, etc.).										
Task Step 5: Create best practice examples around advantages of										

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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
RHIO participation and how patient RHIO "agree" or "deny" status can be obtained.										
Task Step 6: Create global plan for how EHRs will meet the connectivity to RHIO's HIE and SHIN-NY requirements.										
Task Step 7: Create plan for how the PPS uses alerts and secure messaging functionality.										
Task Step 8: Create provider training materials/education required to support IDS functions/processes developed to include training schedule, engaged/contracted partners to be trained and number of staff trained in use of alerts and secure messaging (if applicable).										
Task Step 9: Develop written training materials on secure messaging,										
Task Step 10: Develop and initiate WBS to demonstrate use of DIRECT secure email transactions with selected PPS partners										
Task Step 11: Develop process to make RHIO consent form readily available to all Engaged/Contracted provider offices/locations.										
Task Step 12: Initiate roll-out to Contracted partners to be engaged in milestone to include training (to include, actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange, secure messaging, alerts and patient record look up).										
Task Step 13: Initiate quality control of engaged/contracted partners to be able to provide evidence of EHR Vendor Documentation and show evidence of screenshots of use of alerts and secure messaging										
Task Step 14: Complete roll-out to Engaged/Contracted partners within the PPS. Includes documentation of training dates and number of staff trained (to include participation agreements, sample of transactions to public health registries, and use of DIRECT secure email transactions).										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										

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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 Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1: Engage Clinical Committee to participate and act as the Quality Improvement Committee and ensure that is representative of the PPS staff involved in quality improvement processes and other stakeholders, especially the Director's of Nursing										
Task Step 2: Document attendees from respective organization and staff title in the directory										
Task Step 3: Clinical Committee identifies opportunities for quality improvement using rapid cycle and root cause analysis improvement methodologies										
Task Step 4: Create quality improvement action plans and evaluate results of quality improvement initiatives as necessary										
Task Step 5: Develop implementation reports from quality improvement results and present them at recurring Project 2.b.vii Committee & Clinical Committee Meetings										
Task Step 6: Record meeting minutes from Clinical Committee Meetings										
Task Step 7: Evaluate and create action plans based on key quality metrics, to include applicable metrics in Attachment J										
Task Step 8: Report service and quality outcome measures to all stakeholders via newsletters, website URLs										

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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 9: Collect and maintain, in a centralized location, all pertinent project artifacts including quality committee membership list with indication of organization represented and staff category, if applicable, Quality improvement plans; Root cause analysis; Implementation Reports; Implementation results; Meeting minutes, Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans, Website URLs with published reports; Newsletters; Documentation demonstrating quality outcomes										
Milestone #10 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. Phase 1 tactical reporting bridge solution followed by longer term programmatic strategic solution. Iterative development and testing approach is followed as providers are on-boarded and reporting feedback is received from project stakeholders and the DOH. Run reports as needed for submission of quarterly reports.										
Task Step 3: Iteratively develop, test and deploy Enterprise Data Warehouse (EDW) HealtheRegistries, HealtheAnalytics, HealtheIntent in accordance with applicable DOH domain requirements. Assure iterative development strategy allows for early EMR integration and testing with providers.										
Task Step 4: 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 5: Test, validate, configure, integrate and Maintain EMR data acquisition feeds from all relevant providers for usage										

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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
within the HealtheAnalytics, HealtheRegistries and HealtheIntent applications.										
Task Step 6: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications. (Note: Roster and DOH claims data subject to the completion of the DOH Opt Out Process.)										
Task Step 7: Reporting system is finalized, patient identification, tracking, and matching algorithms are tested and fully deployed into production.										
Task Step 8: 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
Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	
Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	
Educate all staff on care pathways and INTERACT principles.	

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	
Create coaching program to facilitate and support implementation.	
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

IPQR Module 2.b.vii.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

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

Instructions :

Milestone 4: The IA recommends the PPS require the training on the INTERACT model, cultural competency and health literacy include the SNF Medical Director, who may not necessarily be the Facility Champion in this initiative.