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

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

Instructions :

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

The difficulty of activating and engaging the UI, LU and NU populations cannot be underestimated. It will require extensive coordination and communication across the system, dedication to all aspects of "case-finding", assessment, triage and case management, and ensuring that financially accessible primary care is available across the county. The actions taken to mitigate these risks will be as follows:

Case-finding Issue: The targeted population is difficulty to locate and build relationships with, which could result in difficulty engaging them in PAM.
Case-finding Risk Mitigation: Navigator-coaches will be recruited from and deployed to sites in hot-spots. They will be trained in outreach and PAM, and will have educational materials that are designed to address and improve health literacy. A special focus will be dedicated toward navigator-coaches developing relationships with CBOs in order to connect with patients in a more timely and sustainable manner. Additionally, all PPS partners will be engaged in identifying UI, LU and NU individuals, and linking them to navigators and/or case managers. Navigator-coaches, case managers and primary care staff will be trained in the use of PAM and the appropriate follow-up for individuals based on their PAM score.

Case management Issue: Current case management is siloed at the hospitals, CBOs and other PPS partners.
Case Management Risk Mitigation: Creating an overarching case management infrastructure will better equip the PPS to ensure such services are provided in an integrated fashion to individuals regardless of where they "touch" the system, and that resources are deployed to the venues where they are most needed. The PPS IT infrastructure is being developed to include a care management documentation tool that will enable the CM workforce to manage their patients in a timely and clinically appropriate fashion.

Provider Engagement Issue: Lack of participation and outreach from the necessary amount of providers
Provider Engagement Risk Mitigation: The PPS will need to engage PCPs across the county. Where gaps exist, the PPS will recruit practitioners and place them in those communities with a special focus placed on appropriately staffing ""hotspot"" communities. This will be done collaboratively with clinics, health centers and existing practices. To ensure that communication is maximized across the system, all partners will be linked electronically. The PPS will work toward connecting all providers through the RHIO, but will also develop a robust provider communication plan that allows the PPS provider network to provide input, insights and shared experiences to the appropriate stake holders (peers, administration, etc.). Regular meetings among CBOs, PCPs and case management will occur. Finally, the formation of a PPS wide MCO Relations team will utilize the provider feedback to better structure value-based provider payment methodologies to ensure that providers are being financially compensated for DSRIP participation.

IPQR Module 2.d.i.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
DY4,Q2

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
PAM(R) Providers	350	0	5	5	5	5	5	5	35	85	135
Total Committed Providers	**350**	**0**	**5**	**5**	**5**	**5**	**5**	**5**	**35**	**85**	**135**
Percent Committed Providers(%)		**0.00**	**1.43**	**1.43**	**1.43**	**1.43**	**1.43**	**1.43**	**10.00**	**24.29**	**38.57**

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
PAM(R) Providers	350	185	235	285	350	350	350	350	350	350	350
Total Committed Providers	**350**	**185**	**235**	**285**	**350**	**350**	**350**	**350**	**350**	**350**	**350**
Percent Committed Providers(%)		**52.86**	**67.14**	**81.43**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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IPQR Module 2.d.i.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
DY4,Q4	45,426

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	4,542	7,950	11,356	1,817	9,085	15,899	22,712	3,180	15,899
Percent of Expected Patient Engagement(%)	**0.00**	**10.00**	**17.50**	**25.00**	**4.00**	**20.00**	**35.00**	**50.00**	**7.00**	**35.00**

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	23,849	34,069	4,542	22,712	34,069	45,426	45,426	45,426	45,426	45,426
Percent of Expected Patient Engagement(%)	**52.50**	**75.00**	**10.00**	**50.00**	**75.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

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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)

IPQR Module 2.d.i.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 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Project	N/A	In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.	Project		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Project implementation plan design series calls	Project		Completed	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Task Step 2: Suffolk PPS PMO assignment of project manager to project	Project		Completed	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Task Step 3: Identify, engage and evolve project stakeholders	Project		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 4: Confirm adequate representation on project stakeholder groups for initial pilot program	Project		Completed	04/01/2015	07/01/2015	09/30/2015	DY1 Q2
Task Step 5: Develop project 2D1 project plan	Project		Completed	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 6: Organize weekly communications and meeting series with key project stakeholders	Project		In Progress	04/01/2015	08/01/2015	09/30/2015	DY1 Q2
Task Step 7: Create baseline assessment for CBO to identify key CBO partnerships to engage target populations using PAM® and other patient activation techniques.	Project		Completed	04/01/2015	05/01/2015	06/30/2015	DY1 Q1
Task Step 8: Initiate baseline assessment with key CBO partners	Project		Completed	04/01/2015	07/01/2015	09/30/2015	DY1 Q2
Task Step 9: Aggregate baseline data and evaluation against project requirements	Project		Completed	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task	Project		Completed	04/01/2015	07/31/2015	09/30/2015	DY1 Q2

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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 10: Identify CBO Partners to be engaged in project 2.d.i pilot program							
Task Step 11: Schedule weekly project 2.d.i workgroup meetings to plan day 1 of pilot program operations	Project		Completed	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 12: Develop pilot program scope of work outline	Project		Completed	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 13: Request and collect CBO partner budgets, surveys targets and proposals	Project		Completed	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 14: Aggregate CBO partner proposals and engage SCC Executive Director, Project Lead, Director of PMO and Project Analyst to determine CBO patient activation program addendum to the SCC coalition partner participation agreement	Project		Completed	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 15: Execute CBO agreement with CBO partners for project to engage target populations using PAM, the Wellness Coaching program, and initial community navigation program	Project		Completed	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 16: Collaborate with engaged/contracted CBO partners to build the SCC project 2.d.i Patient Activation Program Survey Encounter Decision Tree and list of locations and CBO partners in county to host Community Health Navigators to perform surveys.	Project		Completed	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 17: Collaborate with engaged/contracted CBO partners to determine regional Suffolk County strategy and "hot spotting" for engagement efforts.	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 18: Announce initial pilot program. Initiate reporting, monitoring procedures by Project 2di Project Workgroup to ensure that engagement is sufficient and appropriate.	Project		In Progress	08/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 19: Initiate collaboration with SCC project 2.d.i. workgroup and committee to identify contract and development pilot program by on-boarding additional "locations" and CBO partnerships	Project		In Progress	08/01/2015	01/01/2018	03/31/2018	DY3 Q4
Task Step 20: Update SCC CBO directory with newly on-boarded program partners	Project		In Progress	08/01/2015	01/01/2018	03/31/2018	DY3 Q4
Task Step 21: Ongoing monitoring by Project 2di Project Workgroup of program development on current and future engagement metrics to ensure project	Project		In Progress	08/01/2015	01/31/2018	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
requirements are continuously met and oversight to ensure engagements are appropriate							
Task Step 22: Repeat steps 13-21 with each newly contracted/engaged CBO partner	Project		In Progress	08/01/2015	01/31/2018	03/31/2018	DY3 Q4
Task Step 23: Estalish appropriate quarterly reporting template for 2di for NYS DOH reporting. Including MOUs, contracts, letters of agreement or other partnership documentation.	Project		In Progress	08/01/2015	01/31/2018	03/31/2018	DY3 Q4
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patient Activation Measure(R) (PAM(R)) training team established.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage Insignia to execute license agreement for PAM	Project		Completed	04/01/2015	07/15/2015	09/30/2015	DY1 Q2
Task Step 2: Identify initial set of staff from CBO engaged partner pilot to establish PAM training team ("Trainers")	Project		In Progress	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 3: Engage PPS Workforce Project Lead in training design	Project		In Progress	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 4: Develop and engage Insignia representative to organize PAM written training materials to be consolidated into Project 2.d.i education/training handbook	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 5: Engage Cultural Competency and Health Literacy Project Lead for material review	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 6: Approval of training materials by Project 2di Workgroup	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 7: Determine necessary frequency of training, include training requirements and expectations in partnership agreements with CBO	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 8: Develop PPS-wide Project 2di Training Attestation to document training for monitoring by Project 2di Project Workgroup	Project		Completed	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 9: Initiate training program and oversight, collect name and roles of team staff who are trained in PAM (maintain in Project 2di Trained Staff Directory)	Project		In Progress	04/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 10: Engage Project 2di Project Workgroup to continuously monitor	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
training in accordance with SCC workforce objectives. Collect names and roles of team staff trained in PAM® or other patient activation methods; Copy of training materials and trainers.							
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage key project stakeholders to initiate "hot spot" analytics and determine data sources available to support Community Outreach/Navigation Program Development	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Engage SCC biomedical informatics team to develop hot-spot mapping to support strategy for contracted/engaged CBO's and their respective trained Community Health Workers for fieldwork. Consider output of "hot spot" analytics in the "locations" strategy of CBO Community Health Worker's survey.	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Share maps with engaged/contracted CBO to collaborate on identify specific "locations" where our program can be delivered with these "hot spot" areas (e.g.. Food pantries, Shelters)	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Create outreach plan for CBO strategy in each "hot spot" location. To include mechanism to track and quantify outreach at these locations.	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: Contract with CBO's to perform outreach within the identified "hot spot" areas	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Develop master Project 2di PAM outreach locations and calendar for community engagement of targeted populations.	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 7: Assure "locations" which are identified for outreach are incorporated into the "Appendix" of the Project 2di CBO Participation Agreement for Project 2.d.i Patient Activation Measures	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8: Engage Community Engagement key stakeholders to support grass-roots efforts in "hot spot" locations. To include opportunities for PAM outreach at specific community events and forums.	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 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 9: Initiate recurring strategy sessions of the Project 2di Project Workgroup to continue to evaluate, determine new locations and monitor programs based on "hot spot" mapping strategy	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 10: Engage Project 2di Project Workgroup to monitor outreach at designated locations, collect recurring reports demonstrating strategy by engaged/contracted CBOs. Collect "Hot spot" map delineated by UI, NU, LU types; Evidence of CBO outreach within appropriate "hot spot" areas; Outreach lists for UI, NU, and LU populations.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community engagement forums and other information-gathering mechanisms established and performed.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify a SCC Community Engagement Lead	Project		In Progress	07/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 2: Orient Community Engagement Project Lead to Project 2di requirements, program objectives and all key internal and external project stakeholders	Project		In Progress	07/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 3: Project 2di Community Engagement opportunities are brainstormed. List of community events and CBO partners engagement opportunities is developed	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: Community Engagement opportunities are added to the outreach locations and calendar for Project 2di. Program agenda, marketing and promotional plan, speakers options are organized.	Project		In Progress	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Other information-gathering mechanisms are brainstormed with Project 2di Workgroup and Community Engagement Project Stakeholders	Project		In Progress	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Survey tool is developed to understand healthcare needs in Suffolk County. Other ways to obtain data about the health care needs of Suffolk County is considered.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 7: Cultural Competency & Health Literacy Advisory Group is engaged in milestone and review of survey tool	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 8: Initiate surveys (or other options to collect data) and begin aggregating data and maintain data base of responses. Community engagement forums and other information-gathering mechanisms established and performed.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Present data to Project 2di Committee and other key project stakeholders	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: Engage Project 2di Project Workgroup to collect and monitor list of community forums held, detailing locations, agenda, and presenters; Documentation surveys or other information- gathering techniques	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Project	N/A	In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	Project		In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Engage Project 2di Workgroup, key internal project stakeholders to coordinate plan to develop written training materials and techniques	Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Engage Insignia representative to collect PAM Tool training materials	Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Training Materials developed for PAM survey outrach activities for community engagement, includes other training components such as motivational interviewing and other social work techniques, soft skills, PAM survey scripts/talking-points and a PAM survey Decision Tree	Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Training Materials, Agenda and program designed is shared with Cultural Competency & Health Literacy Advisory Group, Project 2di Workgroup and Committee, Key internal and external project stakeholders for review and comment.	Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: Trainees identified in "hot spot" areas by Project Manager, Project Lead and Contracted/Engaged CBO partners.	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 6: Identify Project 2di PAM Trainers from SCC CBO engagement to support training of additional PAM providers. Project Manager to support	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2

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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
coordination of training sessions.							
Task Step 7: Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. Use Project 2di Training Attestation to document training.	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 8: Project Manager to engage with Trainers following training sessions to collect lessons learned, risks, risk mitigation strategies and additional feedback to continue to support program developments.	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 9: Project Manager to collect and maintain list of PPS providers trained in PAM®; Training dates; Written training materials	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Project	N/A	In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage VBP Team to orient on Project 2di Project Requirement and Objective to engage partnering MCO's within the program. Purpose to engage MCO's into Project 2di Community Navigation Program.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Develop scope of work for MCO integration into program	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Partnership and arrangements organized with partnering MCO's for	Project		In Progress	03/31/2016	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
Project 2di. This shall include procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.							
Task Step 4: Obtain list of PCPs assigned to NU and LU enrollees from engaged MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Initiate discussions with engaged MCOs and key PPS PCPs partners to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Engaged CBO's engaged and oriented to new procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Engage Practitioner Engagement Project Lead to review procedures and design. PCP communication and engagement plan for procedures are developed and promoted.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Appropriate consent is in place for new procedures. Including Information-exchange agreements between PPS and MCO	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Collect documented procedures and protocols, Information-exchange agreements between PPS and MCO for SCC records	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Project	N/A	In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2

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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 1: Operationalize process for setting baselines and intervals towards improvement for each PAM activation level. Baselines and intervals towards improvement set for each cohort at the beginning of each performance period.							
Task Step 2: Engage key project stakeholders to identify method developed by state for baselining each beneficiary cohort	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 3: Agreement of method for data collection of baseline for each cohort and appropriate intake intervals towards improvement	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 4: Identify workflow and plan to set baseline for each beneficiary cohort.	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 5: Prepare baseline, periodic and annual cohort reporting calendar	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 6: Educate key project stakeholders for baseline metric reporting	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 7: Project 2di Project Workgroup to monitor monthly engaged stakeholders for baseline and interval metric reporting for periodic and annual reports	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 8: Collect and maintian baseline, periodic and annual PAM® cohort reports and communicate results via presentations to key project stakeholders	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Milestone #8 Include beneficiaries in development team to promote preventive care.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage Project 2di workgroup to develop Community Navagation Program for post-PAM operations to include the promotion of preventive care and community-based resources.	Project		In Progress	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: identify beneficiaries in development team to organize the Project 2di Community Navigation Program to promote preventive care. Beneficiaries to be used as a resource in program development and awareness efforts, communication efforts, health literacy efforts.	Project		In Progress	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Document participation of beneficiaries in program development. Utilize creative engagement opportunities such as focus groups. Document participate	Project		In Progress	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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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)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
of beneficiaries in awareness efforts.							
Task Step 4: Collect & Maintain list of contributing patient members participating in program development and on-going awareness efforts	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	Project	N/A	In Progress	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of	Project		In Progress	03/31/2016	03/31/2018	03/31/2018	DY3 Q4

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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
engagement							
Task Step 1: Engage Project 2di Workgroup to organize the Project 2di PAM Tool Performance Measurement Program	Project		In Progress	03/31/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 2: Ensure Project 2di PAM Tool Performance Measurement Program includes how to operationalize the PAM Tool. Including: screening patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM® survey and designate a PAM® score.	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Ensure Project 2di PAM Tool Performance Measurement Program highlights how member's score must be averaged to calculate a baseline measure for that year's cohort.	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Identify a method with Insignia to follow cohorts for the entirety of the DSRIP program. To include determining specifications for unique identifiers.	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Following the initiation of the PAM pilot program, initiate a calendar to follow cohorts annually.	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop program procedures for training whereby on an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Engage partnering MCOs to develop procedures for determining if the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 8: Project Manager to organize method to provide the current contact information to the beneficiary's MCO for outreach purposes.	Project		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Project Managers to provide member engagement lists to engaged/relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	Project		In Progress	09/30/2016	12/31/2016	12/31/2016	DY2 Q3
Task	Project		In Progress	01/01/2017	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
Step 10: Performance measurement reports established, including but not limited to: Number of patients screened, by engagement level, Number of clinicians trained in PAM® survey implementation, Number of patient: PCP bridges established, Number of patients identified, linked by MCOs to which they are associated, Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, Member engagement lists to DOH (for NU & LU populations) on a monthly basis, Annual report assessing individual member and the overall cohort's level of engagement							
Task Step 11: Collect output of the Project 2di PAM Tool Performance Measurement Program, to include, performance measurement reports and presentations; Annual reports; Member engagement lists, by PAM® cohort	Project		In Progress	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	In Progress	06/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Volume of non-emergent visits for UI, NU, and LU populations increased.	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Engage Project 2di Workgroup to brainstorm the Project 2di Community Navigator Program	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Engage key primary, behavioral and dental care providers in Community Navigation Program, to include planning the handoffs for individuals surveyed, through Wellness Coaching then navigated to a community-based resource	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Track the number of referrals made by PAM Providers into the Community Navigation Program (as new PAM Providers are on-boarded the number of referrals are expected to increase)	Project		In Progress	08/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 4: Determine how SCC and Health Home care management staff will be involved in the patient activation process.	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Engage Project 2di Workgroup to monitor the referrals made across the County for individuals who receive the PAM survey, receive Wellness Coaching though the CBO partnership and then receive a handoff/referral into the Community Navigation Program.	Project		In Progress	08/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task	Project		In Progress	03/31/2016	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
Step 6: Engage SCC biomedical informatics key project stakeholders to monitor the ED usage of these cohorts. Monitor the usage of non-emergent care by the captive cohort.							
Task Step 7: Enage SCC biomedical informatics team to develop a baseline of non-emergent volume. Develop in collaboration with the Project 2di Workgroup a method of periodic reports to demonstrating increase/trends in visits (specific to UI, NU, and LU patients)	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 8: Project Manager to monitor, collect and report ongoing data acquisition to enhance program design and development	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Project	N/A	In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Community navigators identified and contracted.	Provider	PAM(R) Providers	In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	Provider	PAM(R) Providers	In Progress	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Begin Executing initial CBO agreements (pilot program) with CBO partners for project to engage target populations using PAM, the Wellness Coaching program, and initial community navigation program.	Project		In Progress	07/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 2: Collaborate with engaged/contracted CBO partners to build the SCC project 2.d.i Patient Activation Program to include a Community Navigator Program. This shall include FTE roles, responsibilities and staffing guidelines based on the project scale and speed schedule.	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 3: PPS to identify CBO's with an interest in partnering to develop a group of community navigators (community health workers, wellness coaches and navigators) who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Project		In Progress	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Project 2di Workgroup and key project stakeholders reviews and	Project		In Progress	09/30/2015	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
provides feedback on the Project 2di Community Navigator Program.							
Task Step 5: Orient potential CBO partners on the term and scope of the Project 2di CBO partnership agreements, which defines roles of Community navigators	Project		In Progress	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Identify communication requirements for program	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 7: Engage Cultural Competency & Health Literacy Project Lead in program development	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8: Engage SCC Workforce Project Lead in development processes.	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 9: Project 2di Workgroup to develop training curriculum and procedures for Community Navigation Program. Assure participating members are subject matter experts in workgroup with experience in community-based services in Suffolk County.	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 10: Determine necessary training program, including frequency of training, re-training and competency evaluations, training dates, schedule training sessions.	Project		In Progress	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 11: Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 12: PPS to collect and maintain lists of contracted/engaged CBO's and community navigator credentials (by designated area) detailing navigator names, location, and contact information	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 13: PPS to collect list of training dates along with number of staff trained; Written training materials, and Project 2di Training Attestations	Project		In Progress	03/31/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Project	N/A	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures for customer service complaints and appeals developed.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Engage key project stakeholders to develop process for Medicaid	Project		In Progress	01/01/2016	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
recipients and project participants to report complaints and receive customer service.							
Task Step 2: Draft protocols for customer service complaints and appeals.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Determine staffing requirements and modes for customer service to be engaged to support project requirement	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Engage Compliance Officer to review protocols for complaints. Add protocols to SCC enterprise complaints procedures.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Begin communicating protocols to key internal, external project stakeholders including posting to the SCC website	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Project Manager to initiate a method to monitor the effectiveness of the protocols for customer service complaints and appeals.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task List of community navigators formally trained in the PAM(R).	Provider	PAM(R) Providers	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Begin Executing initial CBO agreements (pilot program) with CBO partners contract includes Train the Trainer responsibilities to educate future PAM providers in how to appropriately assist project beneficiaries using PAM.	Project		In Progress	07/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 2: SCC to identify additional CBO partnerships and county-based resources to be engaged as Community Navigators and trained in PAM	Project		In Progress	08/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Project 2di Workgroup to develop training curriculum and procedures for Community Navigation Program. Assure participating members are subject matter experts in workgroup with experience in community-based services in Suffolk County.	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: PPS to organize a training strategy with engaged/Contracted CBO partners, listing a schedule, logistics and a trainer directory	Project		In Progress	08/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Community navigators trained in including how to appropriately assist project beneficiaries using the PAM®.	Project		In Progress	03/31/2016	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 6: PPS to collect and maintain lists of contracted/engaged CBO's and community navigator credentials (by designated area) detailing navigator names, location, and contact information	Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: PPS to collect description including the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy of training agenda materials, and team staff roles who will be engaged in patient activation	Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Project	N/A	In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	Provider	PAM(R) Providers	In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Project Manager engage key project stakeholders to evaluate initial data collected with Project 2di Pilot CBO partnerships to organize Community Navigator strategy needs	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Community navigator needs and scope of work further defined. To include education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Program materials developed to promote education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. Materials are reviewed by the cultural competency & health literacy advisory group.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Project 2di Workgroup to identify key partnerships with CBO's whereby Community Navigators will be readily available to assume direct hand-offs. Will include SCC and Health Home Care managers in the partnerships.	Project		In Progress	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Community Navigators trained	Project		In Progress	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Contracted CBO's place Community Navigators in key locations (with high visibility) identified "hot spot" areas. Direct handoffs are operationalized	Project		In Progress	06/30/2016	12/31/2016	12/31/2016	DY2 Q3

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
based on grass-roots relationships within the contracted CBOs.							
Task Step 7: Project Manager maintain reports from CBO partners as evidence of navigator placement by location	Project		In Progress	06/30/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 8: Project 2di Committee monitor program logistics and data to ensure project requirements are met	Project		In Progress	06/30/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project	N/A	In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Navigators educated about insurance options and healthcare resources available to populations in this project.	Project		In Progress	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Evaluation of PPS network yields development of resource pool for populations engaged in this project.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Community navigator needs and scope of work further defined. To include education about insurance options and healthcare resources available to UI, NU, and LU populations.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Program materials developed to promote education regarding health insurance coverage. Materials are reviewed by the cultural competency & health literacy advisory group.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Engaged Community Navigators trained educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project		In Progress	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Project Manager maintain reports from CBO partners, List of navigators trained by PPS; List of the PPS trainers; Training dates; Written training materials	Project		In Progress	06/30/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Project	N/A	In Progress	09/30/2015	09/30/2018	09/30/2018	DY4 Q2
Task Timely access for navigator when connecting members to services.	Project		In Progress	09/30/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Project 2di Workgroup to engage CBO's in a series of planning	Project		In Progress	09/30/2015	12/31/2015	12/31/2015	DY1 Q3

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discussions around Community Navigators access to County-based resources. Objective to ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.							
Task Step 2: Identify network of healthcare providers, and provide list to Community Navigators as resource to connect members to primary/preventive care services	Project		In Progress	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Policies and procedures for intake and/or scheduling staff to receive navigator calls	Project		In Progress	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify initial set of Community Navigator staff to roll-out strategy	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Train Community Navigators, initial set will be used as future "trainers"	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Regional strategy organized for engaged/contracted CBO's across the County	Project		In Progress	06/30/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 8: Strategy is rolled out across all engaged/contracted CBO's and incorporated into on-boarding of all newly engaged/contracted CBO's and PAM Providers	Project		In Progress	06/30/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 9: Project Manager manintain policies and procedures for intake and/or scheduling staff to receive navigator calls; director and list of provider intake staff trained by the PPS	Project		In Progress	06/30/2016	09/30/2018	09/30/2018	DY4 Q2
Task Step 5: Key Project Stakeholders engaged to develop program strategy outlining how the PPS will monitor and ensure timely access for navigators (eg. What data is being collected, who is reviewing, log, reporting procedures) mange in relation to contractual requirements for engaged/contracted partners	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Project	N/A	In Progress	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	06/01/2015	06/30/2016	06/30/2016	DY2 Q1

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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.	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 as needed for submission of quarterly reports.	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. (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 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	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications. (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 11: 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 12: Population Health Platform is capable of identifying targeted patients	Project		In Progress	09/30/2016	03/31/2017	03/31/2017	DY2 Q4

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)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and is able to track actively engaged patients for project milestone reporting.							
Task Step 13: 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

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 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task Step 1: Project implementation plan design series calls										
Task Step 2: Suffolk PPS PMO assignment of project manager to project										
Task Step 3: Identify, engage and evolve project stakeholders										
Task Step 4: Confirm adequate representation on project stakeholder groups for initial pilot program										
Task Step 5: Develop project 2D1 project plan										
Task Step 6: Organize weekly communications and meeting series with key project stakeholders										
Task Step 7: Create baseline assessment for CBO to identify key CBO partnerships to engage target populations using PAM® and other patient activation techniques.										
Task Step 8: Initiate baseline assessment with key CBO partners										
Task Step 9: Aggregate baseline data and evaluation against project requirements										
Task Step 10: Identify CBO Partners to be engaged in project 2.d.i										

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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
pilot program										
Task Step 11: Schedule weekly project 2.d.i workgroup meetings to plan day 1 of pilot program operations										
Task Step 12: Develop pilot program scope of work outline										
Task Step 13: Request and collect CBO partner budgets, surveys targets and proposals										
Task Step 14: Aggregate CBO partner proposals and engage SCC Executive Director, Project Lead, Director of PMO and Project Analyst to determine CBO patient activation program addendum to the SCC coalition partner participation agreement										
Task Step 15: Execute CBO agreement with CBO partners for project to engage target populations using PAM, the Wellness Coaching program, and initial community navigation program										
Task Step 16: Collaborate with engaged/contracted CBO partners to build the SCC project 2.d.i Patient Activation Program Survey Encounter Decision Tree and list of locations and CBO partners in county to host Community Health Navigators to perform surveys.										
Task Step 17: Collaborate with engaged/contracted CBO partners to determine regional Suffolk County strategy and "hot spotting" for engagement efforts.										
Task Step 18: Announce initial pilot program. Initiate reporting, monitoring procedures by Project 2di Project Workgroup to ensure that engagement is sufficient and appropriate.										
Task Step 19: Initiate collaboration with SCC project 2.d.i. workgroup and committee to identify contract and development pilot program by on-boarding additional "locations" and CBO partnerships										
Task Step 20: Update SCC CBO directory with newly on-boarded program partners										
Task Step 21: Ongoing monitoring by Project 2di Project Workgroup of program development on current and future engagement metrics to ensure project requirements are continuously met										

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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
and oversight to ensure engagements are appropriate										
Task Step 22: Repeat steps 13-21 with each newly contracted/engaged CBO partner										
Task Step 23: Estalish appropriate quarterly reporting template for 2di for NYS DOH reporting. Including MOUs, contracts, letters of agreement or other partnership documentation.										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task Step 1: Engage Insignia to execute license agreement for PAM										
Task Step 2: Identify initial set of staff from CBO engaged partner pilot to establish PAM training team ("Trainers")										
Task Step 3: Engage PPS Workforce Project Lead in training design										
Task Step 4: Develop and engage Insignia representative to organize PAM written training materials to be consolidated into Project 2.d.i education/training handbook										
Task Step 5: Engage Cultural Competency and Health Literacy Project Lead for material review										
Task Step 6: Approval of training materials by Project 2di Workgroup										
Task Step 7: Determine necessary frequency of training, include training requirements and expectations in partnership agreements with CBO										
Task Step 8: Develop PPS-wide Project 2di Training Attestation to document training for monitoring by Project 2di Project Workgroup										
Task Step 9: Initiate training program and oversight, collect name and roles of team staff who are trained in PAM (maintain in Project 2di Trained Staff Directory)										

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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 Step 10: Engage Project 2di Project Workgroup to continuously monitor training in accordance with SCC workforce objectives. Collect names and roles of team staff trained in PAM® or other patient activation methods; Copy of training materials and trainers.										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task Step 1: Engage key project stakeholders to initiate "hot spot" analytics and determine data sources available to support Community Outreach/Navigation Program Development										
Task Step 2: Engage SCC biomedical informatics team to develop hot-spot mapping to support strategy for contracted/engaged CBO's and their respective trained Community Health Workers for fieldwork. Consider output of "hot spot" analytics in the "locations" strategy of CBO Community Health Worker's survey.										
Task Step 3: Share maps with engaged/contracted CBO to collaborate on identify specific "locations" where our program can be delivered with these "hot spot" areas (e.g.. Food pantries, Shelters)										
Task Step 4: Create outreach plan for CBO strategy in each "hot spot" location. To include mechanism to track and quantify outreach at these locations.										
Task Step 5: Contract with CBO's to perform outreach within the identified "hot spot" areas										
Task Step 6: Develop master Project 2di PAM outreach locations and calendar for community engagement of targeted populations.										
Task Step 7: Assure "locations" which are identified for outreach are incorporated into the "Appendix" of the Project 2di CBO Participation Agreement for Project 2.d.i Patient Activation Measures										

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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 Step 8: Engage Community Engagement key stakeholders to support grass-roots efforts in "hot spot" locations. To include opportunities for PAM outreach at specific community events and forums.										
Task Step 9: Initiate recurring strategy sessions of the Project 2di Project Workgroup to continue to evaluate, determine new locations and monitor programs based on "hot spot" mapping strategy										
Task Step 10: Engage Project 2di Project Workgroup to monitor outreach at designated locations, collect recurring reports demonstrating strategy by engaged/contracted CBOs. Collect "Hot spot" map delineated by UI, NU, LU types; Evidence of CBO outreach within appropriate "hot spot" areas; Outreach lists for UI, NU, and LU populations.										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task Step 1: Identify a SCC Community Engagement Lead										
Task Step 2: Orient Community Engagement Project Lead to Project 2di requirements, program objectives and all key internal and external project stakeholders										
Task Step 3: Project 2di Community Engagement opportunities are brainstormed. List of community events and CBO partners engagement opportunities is developed										
Task Step 5: Community Engagement opportunities are added to the outreach locations and calendar for Project 2di. Program agenda, marketing and promotional plan, speakers options are organized.										
Task Step 6: Other information-gathering mechanisms are brainstormed with Project 2di Workgroup and Community Engagement Project Stakeholders										
Task Step 4: Survey tool is developed to understand healthcare needs in Suffolk County. Other ways to obtain data about the										

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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
health care needs of Suffolk County is considered.										
Task Step 7: Cultural Competency & Health Literacy Advisory Group is engaged in milestone and review of survey tool										
Task Step 8: Initiate surveys (or other options to collect data) and begin aggregating data and maintain data base of responses. Community engagement forums and other information-gathering mechanisms established and performed.										
Task Step 9: Present data to Project 2di Committee and other key project stakeholders										
Task Step 10: Engage Project 2di Project Workgroup to collect and monitor list of community forums held, detailing locations, agenda, and presenters; Documentation surveys or other information- gathering techniques										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task Step 1: Engage Project 2di Workgroup, key internal project stakeholders to coordinate plan to develop written training materials and techniques										
Task Step 2: Engage Insignia representative to collect PAM Tool training materials										
Task Step 3: Training Materials developed for PAM survey outrach activities for community engagement, includes other training components such as motivational interviewing and other social work techniques, soft skills, PAM survey scripts/talking-points and a PAM survey Decision Tree										
Task Step 4: Training Materials, Agenda and program designed is shared with Cultural Competency & Health Literacy Advisory Group, Project 2di Workgroup and Committee, Key internal and external project stakeholders for review and comment.										
Task Step 5: Trainees identified in "hot spot" areas by Project										

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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
Manager, Project Lead and Contracted/Engaged CBO partners.										
Task Step 6: Identify Project 2di PAM Trainers from SCC CBO engagement to support training of additional PAM providers. Project Manager to support coordination of training sessions.										
Task Step 7: Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. Use Project 2di Training Attestation to document training.										
Task Step 8: Project Manager to engage with Trainers following training sessions to collect lessons learned, risks, risk mitigation strategies and additional feedback to continue to support program developments.										
Task Step 9: Project Manager to collect and maintain list of PPS providers trained in PAM®; Training dates; Written training materials										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 1: Engage VBP Team to orient on Project 2di Project Requirement and Objective to engage partnering MCO's within the program. Purpose to engage MCO's into Project 2di Community Navigation Program.										

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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 Step 2: Develop scope of work for MCO integration into program										
Task Step 3: Partnership and arrangements organized with partnering MCO's for Project 2di. This shall include procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 4: Obtain list of PCPs assigned to NU and LU enrollees from engaged MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP.										
Task Step 5: Initiate discussions with engaged MCOs and key PPS PCPs partners to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Step 6: Engaged CBO's engaged and oriented to new procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 7: Engage Practitioner Engagement Project Lead to review procedures and design. PCP communication and engagement plan for procedures are developed and promoted.										
Task Step 8: Appropriate consent is in place for new procedures. Including Information-exchange agreements between PPS and MCO										
Task Step 9: Collect documented procedures and protocols, Information-exchange agreements between PPS and MCO for SCC records										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each										

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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
cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task Step 1: Operationalize process for setting baselines and intervals towards improvement for each PAM activation level. Baselines and intervals towards improvement set for each cohort at the beginning of each performance period.										
Task Step 2: Engage key project stakeholders to identify method developed by state for baselining each beneficiary cohort										
Task Step 3: Agreement of method for data collection of baseline for each cohort and appropriate intake intervals towards improvement										
Task Step 4: Identify workflow and plan to set baseline for each beneficiary cohort.										
Task Step 5: Prepare baseline, periodic and annual cohort reporting calendar										
Task Step 6: Educate key project stakeholders for baseline metric reporting										
Task Step 7: Project 2di Project Workgroup to monitor monthly engaged stakeholders for baseline and interval metric reporting for periodic and annual reports										
Task Step 8: Collect and maintian baseline, periodic and annual PAM® cohort reports and communicate results via presentations to key project stakeholders										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task Step 1: Engage Project 2di workgroup to develop Community Navagation Program for post-PAM operations to include the promotion of preventive care and community-based 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
Task Step 2: identify beneficiaries in development team to organize the Project 2di Community Navigation Program to promote preventive care. Beneficiaries to be used as a resource in program development and awareness efforts, communication efforts, health literacy efforts.										
Task Step 3: Document participation of beneficiaries in program development. Utilize creative engagement opportunities such as focus groups. Document participate of beneficiaries in awareness efforts.										
Task Step 4: Collect & Maintain list of contributing patient members participating in program development and on-going awareness efforts										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but										

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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
not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 1: Engage Project 2di Workgroup to organize the Project 2di PAM Tool Performance Measurement Program										
Task Step 2: Ensure Project 2di PAM Tool Performance Measurement Program includes how to operationalize the PAM Tool. Including: screening patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM® survey and designate a PAM® score.										
Task Step 3: Ensure Project 2di PAM Tool Performance Measurement Program highlights how member's score must be averaged to calculate a baseline measure for that year's cohort.										
Task Step 4: Identify a method with Insignia to follow cohorts for the entirety of the DSRIP program. To include determining specifications for unique identifiers.										
Task Step 5: Following the initiation of the PAM pilot program, initiate a calendar to follow cohorts annually.										
Task Step 6: Develop program procedures for training whereby on an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.										
Task Step 7: Engage partnering MCOs to develop procedures for determining if the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel										

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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
the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.										
Task Step 8: Project Manager to organize method to provide the current contact information to the beneficiary's MCO for outreach purposes.										
Task Step 9: Project Managers to provide member engagement lists to engaged/relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Step 10: Performance measurement reports established, including but not limited to: Number of patients screened, by engagement level, Number of clinicians trained in PAM® survey implementation, Number of patient: PCP bridges established, Number of patients identified, linked by MCOs to which they are associated, Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, Member engagement lists to DOH (for NU & LU populations) on a monthly basis, Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 11: Collect output of the Project 2di PAM Tool Performance Measurement Program, to include, performance measurement reports and presentations; Annual reports; Member engagement lists, by PAM® cohort										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task Step 1: Engage Project 2di Workgroup to brainstorm the Project 2di Community Navigator Program										
Task Step 2: Engage key primary, behavioral and dental care providers in Community Navigation Program, to include planning the handoffs for individuals surveyed, through Wellness Coaching then navigated to a community-based resource										
Task Step 3: Track the number of referrals made by PAM 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
into the Community Navigation Program (as new PAM Providers are on-boarded the number of referrals are expected to increase)										
Task Step 4: Determine how SCC and Health Home care management staff will be involved in the patient activation process.										
Task Step 5: Engage Project 2di Workgroup to monitor the referrals made across the County for individuals who receive the PAM survey, receive Wellness Coaching though the CBO partnership and then receive a handoff/referral into the Community Navigation Program.										
Task Step 6: Engage SCC biomedical informatics key project stakeholders to monitor the ED usage of these cohorts. Monitor the usage of non-emergent care by the captive cohort.										
Task Step 7: Enage SCC biomedical informatics team to develop a baseline of non-emergent volume. Develop in collaboration with the Project 2di Workgroup a method of periodic reports to demonstrating increase/trends in visits (specific to UI, NU, and LU patients)										
Task Step 8: Project Manager to monitor, collect and report ongoing data acquisition to enhance program design and development										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	0	5	5	5	5	5	5	35	85	135
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	0	0	5	5	5	5	5	5	5	35
Task Step 1: Begin Executing initial CBO agreements (pilot program) with CBO partners for project to engage target populations using PAM, the Wellness Coaching program, and initial community navigation program.										
Task Step 2: Collaborate with engaged/contracted CBO partners to build the SCC project 2.d.i Patient Activation Program to										

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include a Community Navigator Program. This shall include FTE roles, responsibilities and staffing guidelines based on the project scale and speed schedule.										
Task Step 3: PPS to identify CBO's with an interest in partnering to develop a group of community navigators (community health workers, wellness coaches and navigators) who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Step 4: Project 2di Workgroup and key project stakeholders reviews and provides feedback on the Project 2di Community Navigator Program.										
Task Step 5: Orient potential CBO partners on the term and scope of the Project 2di CBO partnership agreements, which defines roles of Community navigators										
Task Step 6: Identify communication requirements for program										
Task Step 7: Engage Cultural Competency & Health Literacy Project Lead in program development										
Task Step 8: Engage SCC Workforce Project Lead in development processes.										
Task Step 9: Project 2di Workgroup to develop training curriculum and procedures for Community Navigation Program. Assure participating members are subject matter experts in workgroup with experience in community-based services in Suffolk County.										
Task Step 10: Determine necessary training program, including frequency of training, re-training and competency evaluations, training dates, schedule training sessions.										
Task Step 11: Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.										
Task Step 12: PPS to collect and maintain lists of contracted/engaged CBO's and community navigator credentials (by designated area) detailing navigator names,										

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location, and contact information										
Task Step 13: PPS to collect list of training dates along with number of staff trained; Written training materials, and Project 2di Training Attestations										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task Step 1: Engage key project stakeholders to develop process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Step 2: Draft protocols for customer service complaints and appeals.										
Task Step 3: Determine staffing requirements and modes for customer service to be engaged to support project requirement										
Task Step 4: Engage Compliance Officer to review protocols for complaints. Add protocols to SCC enterprise complaints procedures.										
Task Step 5: Begin communicating protocols to key internal, external project stakeholders including posting to the SCC website										
Task Step 6: Project Manager to initiate a method to monitor the effectiveness of the protocols for customer service complaints and appeals.										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	0	15	15	45	95	165	250	350	350	350
Task Step 1: Begin Executing initial CBO agreements (pilot program) with CBO partners contract includes Train the Trainer responsibilities to educate future PAM providers in how to appropriately assist project beneficiaries using PAM.										

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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 2: SCC to identify additional CBO partnerships and county-based resources to be engaged as Community Navigators and trained in PAM										
Task Step 3: Project 2di Workgroup to develop training curriculum and procedures for Community Navigation Program. Assure participating members are subject matter experts in workgroup with experience in community-based services in Suffolk County.										
Task Step 4: PPS to organize a training strategy with engaged/Contracted CBO partners, listing a schedule, logistics and a trainer directory										
Task Step 5: Community navigators trained in including how to appropriately assist project beneficiaries using the PAM®.										
Task Step 6: PPS to collect and maintain lists of contracted/engaged CBO's and community navigator credentials (by designated area) detailing navigator names, location, and contact information										
Task Step 7: PPS to collect description including the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy of training agenda materials, and team staff roles who will be engaged in patient activation										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	0	0	0	5	5	5	5	5	5	35
Task Step 1: Project Manager engage key project stakeholders to evaluate initial data collected with Project 2di Pilot CBO partnerships to organize Community Navigator strategy needs										
Task Step 2: Community navigator needs and scope of work further defined. To include education regarding health insurance coverage, age-appropriate primary and preventive healthcare										

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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
services and resources.										
Task Step 3: Program materials developed to promote education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. Materials are reviewed by the cultural competency & health literacy advisory group.										
Task Step 4: Project 2di Workgroup to identify key partnerships with CBO's whereby Community Navigators will be readily available to assume direct hand-offs. Will include SCC and Health Home Care managers in the partnerships.										
Task Step 5: Community Navigators trained										
Task Step 6: Contracted CBO's place Community Navigators in key locations (with high visibility) identified "hot spot" areas. Direct handoffs are operationalized based on grass-roots relationships within the contracted CBOs.										
Task Step 7: Project Manager maintain reports from CBO partners as evidence of navigator placement by location										
Task Step 8: Project 2di Committee monitor program logistics and data to ensure project requirements are met										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task Step 1: Evaluation of PPS network yields development of resource pool for populations engaged in this project.										
Task Step 2: Community navigator needs and scope of work further defined. To include education about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Step 3: Program materials developed to promote education regarding health insurance coverage. Materials are reviewed by the cultural competency & health literacy advisory group.										
Task Step 4: Engaged Community Navigators trained educate										

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navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Step 5: Project Manager maintain reports from CBO partners, List of navigators trained by PPS; List of the PPS trainers; Training dates; Written training materials										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task Step 1: Project 2di Workgroup to engage CBO's in a series of planning discussions around Community Navigators access to County-based resources. Objective to ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Step 2: Identify network of healthcare providers, and provide list to Community Navigators as resource to connect members to primary/preventive care services										
Task Step 3: Policies and procedures for intake and/or scheduling staff to receive navigator calls										
Task Step 4: Identify initial set of Community Navigator staff to roll-out strategy										
Task Step 6: Train Community Navigators, initial set will be used as future "trainers"										
Task Step 7: Regional strategy organized for engaged/contracted CBO's across the County										
Task Step 8: Strategy is rolled out across all engaged/contracted CBO's and incorporated into on-boarding of all newly engaged/contracted CBO's and PAM Providers										
Task Step 9: Project Manager manintain policies and procedures for intake and/or scheduling staff to receive navigator calls; director and list of provider intake staff trained by the PPS										
Task Step 5: Key Project Stakeholders engaged to develop program										

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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
strategy outlining how the PPS will monitor and ensure timely access for navigators (eg. What data is being collected, who is reviewing, log, reporting procedures) mange in relation to contractual requirements for engaged/contracted partners										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries 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 as needed for submission of quarterly reports.										
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. (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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data acquisition feeds from all relevant providers for usage within the HealtheAnalytics, HealtheRegistries and HealtheIntent applications.										
Task Step 10: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications. (Roster and DOH claims data subject to the completion of the DOH Opt Out Process.)										
Task Step 11: Reporting system is finalized, patient identification, tracking, and matching algorithms are tested and fully deployed into production.										
Task Step 12: Population Health Platform is capable of identifying targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 13: Meet with project stakeholders to iteratively define and refine project specific patient identification and report filtering requirements.										

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 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task Step 1: Project implementation plan design series calls										
Task Step 2: Suffolk PPS PMO assignment of project manager to project										
Task Step 3: Identify, engage and evolve project stakeholders										
Task Step 4: Confirm adequate representation on project stakeholder groups for initial pilot program										
Task Step 5: Develop project 2D1 project plan										

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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 6: Organize weekly communications and meeting series with key project stakeholders										
Task Step 7: Create baseline assessment for CBO to identify key CBO partnerships to engage target populations using PAM® and other patient activation techniques.										
Task Step 8: Initiate baseline assessment with key CBO partners										
Task Step 9: Aggregate baseline data and evaluation against project requirements										
Task Step 10: Identify CBO Partners to be engaged in project 2.d.i pilot program										
Task Step 11: Schedule weekly project 2.d.i workgroup meetings to plan day 1 of pilot program operations										
Task Step 12: Develop pilot program scope of work outline										
Task Step 13: Request and collect CBO partner budgets, surveys targets and proposals										
Task Step 14: Aggregate CBO partner proposals and engage SCC Executive Director, Project Lead, Director of PMO and Project Analyst to determine CBO patient activation program addendum to the SCC coalition partner participation agreement										
Task Step 15: Execute CBO agreement with CBO partners for project to engage target populations using PAM, the Wellness Coaching program, and initial community navigation program										
Task Step 16: Collaborate with engaged/contracted CBO partners to build the SCC project 2.d.i Patient Activation Program Survey Encounter Decision Tree and list of locations and CBO partners in county to host Community Health Navigators to perform surveys.										
Task Step 17: Collaborate with engaged/contracted CBO partners to determine regional Suffolk County strategy and "hot spotting" for engagement efforts.										
Task Step 18: Announce initial pilot program. Initiate reporting, monitoring procedures by Project 2di Project Workgroup 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
ensure that engagement is sufficient and appropriate.										
Task Step 19: Initiate collaboration with SCC project 2.d.i. workgroup and committee to identify contract and development pilot program by on-boarding additional "locations" and CBO partnerships										
Task Step 20: Update SCC CBO directory with newly on-boarded program partners										
Task Step 21: Ongoing monitoring by Project 2di Project Workgroup of program development on current and future engagement metrics to ensure project requirements are continuously met and oversight to ensure engagements are appropriate										
Task Step 22: Repeat steps 13-21 with each newly contracted/engaged CBO partner										
Task Step 23: Estalish appropriate quarterly reporting template for 2di for NYS DOH reporting. Including MOUs, contracts, letters of agreement or other partnership documentation.										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task Step 1: Engage Insignia to execute license agreement for PAM										
Task Step 2: Identify initial set of staff from CBO engaged partner pilot to establish PAM training team ("Trainers")										
Task Step 3: Engage PPS Workforce Project Lead in training design										
Task Step 4: Develop and engage Insignia representative to organize PAM written training materials to be consolidated into Project 2.d.i education/training handbook										
Task Step 5: Engage Cultural Competency and Health Literacy Project Lead for material review										
Task Step 6: Approval of training materials by Project 2di Workgroup										

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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 7: Determine necessary frequency of training, include training requirements and expectations in partnership agreements with CBO										
Task Step 8: Develop PPS-wide Project 2di Training Attestation to document training for monitoring by Project 2di Project Workgroup										
Task Step 9: Initiate training program and oversight, collect name and roles of team staff who are trained in PAM (maintain in Project 2di Trained Staff Directory)										
Task Step 10: Engage Project 2di Project Workgroup to continuously monitor training in accordance with SCC workforce objectives. Collect names and roles of team staff trained in PAM® or other patient activation methods; Copy of training materials and trainers.										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task Step 1: Engage key project stakeholders to initiate "hot spot" analytics and determine data sources available to support Community Outreach/Navigation Program Development										
Task Step 2: Engage SCC biomedical informatics team to develop hot-spot mapping to support strategy for contracted/engaged CBO's and their respective trained Community Health Workers for fieldwork. Consider output of "hot spot" analytics in the "locations" strategy of CBO Community Health Worker's survey.										
Task Step 3: Share maps with engaged/contracted CBO to collaborate on identify specific "locations" where our program can be delivered with these "hot spot" areas (e.g.. Food pantries, Shelters)										
Task Step 4: Create outreach plan for CBO strategy in each "hot spot" location. To include mechanism to track and quantify outreach at these locations.										

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Task Step 5: Contract with CBO's to perform outreach within the identified "hot spot" areas										
Task Step 6: Develop master Project 2di PAM outreach locations and calendar for community engagement of targeted populations.										
Task Step 7: Assure "locations" which are identified for outreach are incorporated into the "Appendix" of the Project 2di CBO Participation Agreement for Project 2.d.i Patient Activation Measures										
Task Step 8: Engage Community Engagement key stakeholders to support grass-roots efforts in "hot spot" locations. To include opportunities for PAM outreach at specific community events and forums.										
Task Step 9: Initiate recurring strategy sessions of the Project 2di Project Workgroup to continue to evaluate, determine new locations and monitor programs based on "hot spot" mapping strategy										
Task Step 10: Engage Project 2di Project Workgroup to monitor outreach at designated locations, collect recurring reports demonstrating strategy by engaged/contracted CBOs. Collect "Hot spot" map delineated by UI, NU, LU types; Evidence of CBO outreach within appropriate "hot spot" areas; Outreach lists for UI, NU, and LU populations.										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task Step 1: Identify a SCC Community Engagement Lead										
Task Step 2: Orient Community Engagement Project Lead to Project 2di requirements, program objectives and all key internal and external project stakeholders										
Task Step 3: Project 2di Community Engagement opportunities are brainstormed. List of community events and CBO partners engagement opportunities is developed										

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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 5: Community Engagement opportunities are added to the outreach locations and calendar for Project 2di. Program agenda, marketing and promotional plan, speakers options are organized.										
Task Step 6: Other information-gathering mechanisms are brainstormed with Project 2di Workgroup and Community Engagement Project Stakeholders										
Task Step 4: Survey tool is developed to understand healthcare needs in Suffolk County. Other ways to obtain data about the health care needs of Suffolk County is considered.										
Task Step 7: Cultural Competency & Health Literacy Advisory Group is engaged in milestone and review of survey tool										
Task Step 8: Initiate surveys (or other options to collect data) and begin aggregating data and maintain data base of responses. Community engagement forums and other information-gathering mechanisms established and performed.										
Task Step 9: Present data to Project 2di Committee and other key project stakeholders										
Task Step 10: Engage Project 2di Project Workgroup to collect and monitor list of community forums held, detailing locations, agenda, and presenters; Documentation surveys or other information- gathering techniques										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task Step 1: Engage Project 2di Workgroup, key internal project stakeholders to coordinate plan to develop written training materials and techniques										
Task Step 2: Engage Insignia representative to collect PAM Tool training materials										
Task Step 3: Training Materials developed for PAM survey outrach										

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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
activities for community engagement, includes other training components such as motivational interviewing and other social work techniques, soft skills, PAM survey scripts/talking-points and a PAM survey Decision Tree										
Task Step 4: Training Materials, Agenda and program designed is shared with Cultural Competency & Health Literacy Advisory Group, Project 2di Workgroup and Committee, Key internal and external project stakeholders for review and comment.										
Task Step 5: Trainees identified in "hot spot" areas by Project Manager, Project Lead and Contracted/Engaged CBO partners.										
Task Step 6: Identify Project 2di PAM Trainers from SCC CBO engagement to support training of additional PAM providers. Project Manager to support coordination of training sessions.										
Task Step 7: Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency. Use Project 2di Training Attestation to document training.										
Task Step 8: Project Manager to engage with Trainers following training sessions to collect lessons learned, risks, risk mitigation strategies and additional feedback to continue to support program developments.										
Task Step 9: Project Manager to collect and maintain list of PPS providers trained in PAM®; Training dates; Written training materials										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials,										

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which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 1: Engage VBP Team to orient on Project 2di Project Requirement and Objective to engage partnering MCO's within the program. Purpose to engage MCO's into Project 2di Community Navigation Program.										
Task Step 2: Develop scope of work for MCO integration into program										
Task Step 3: Partnership and arrangements organized with partnering MCO's for Project 2di. This shall include procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 4: Obtain list of PCPs assigned to NU and LU enrollees from engaged MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP.										
Task Step 5: Initiate discussions with engaged MCOs and key PPS PCPs partners to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Step 6: Engaged CBO's engaged and oriented to new procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task Step 7: Engage Practitioner Engagement Project Lead to review procedures and design. PCP communication and engagement plan for procedures are developed and promoted.										
Task Step 8: Appropriate consent is in place for new procedures.										

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Including Information-exchange agreements between PPS and MCO										
Task Step 9: Collect documented procedures and protocols, Information-exchange agreements between PPS and MCO for SCC records										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task Step 1: Operationalize process for setting baselines and intervals towards improvement for each PAM activation level. Baselines and intervals towards improvement set for each cohort at the beginning of each performance period.										
Task Step 2: Engage key project stakeholders to identify method developed by state for baselining each beneficiary cohort										
Task Step 3: Agreement of method for data collection of baseline for each cohort and appropriate intake intervals towards improvement										
Task Step 4: Identify workflow and plan to set baseline for each beneficiary cohort.										
Task Step 5: Prepare baseline, periodic and annual cohort reporting calendar										
Task Step 6: Educate key project stakeholders for baseline metric reporting										
Task Step 7: Project 2di Project Workgroup to monitor monthly engaged stakeholders for baseline and interval metric reporting for periodic and annual reports										
Task Step 8: Collect and maintian baseline, periodic and annual PAM® cohort reports and communicate results via presentations to key project stakeholders										

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Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task Step 1: Engage Project 2di workgroup to develop Community Navagation Program for post-PAM operations to include the promotion of preventive care and community-based resources.										
Task Step 2: identify beneficiaries in development team to organize the Project 2di Community Navigation Program to promote preventive care. Beneficiaries to be used as a resource in program development and awareness efforts, communication efforts, health literacy efforts.										
Task Step 3: Document participation of beneficiaries in program development. Utilize creative engagement opportunities such as focus groups. Document participate of beneficiaries in awareness efforts.										
Task Step 4: Collect & Maintain list of contributing patient members participating in program development and on-going awareness efforts										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect										

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with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 1: Engage Project 2di Workgroup to organize the Project 2di PAM Tool Performance Measurement Program										
Task Step 2: Ensure Project 2di PAM Tool Performance Measurement Program includes how to operationalize the PAM Tool. Including: screening patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM® survey and designate a PAM® score.										
Task Step 3: Ensure Project 2di PAM Tool Performance Measurement Program highlights how member's score must be averaged to calculate a baseline measure for that year's cohort.										
Task Step 4: Identify a method with Insignia to follow cohorts for the entirety of the DSRIP program. To include determining specifications for unique identifiers.										
Task Step 5: Following the initiation of the PAM pilot program, initiate										

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a calendar to follow cohorts annually.										
Task Step 6: Develop program procedures for training whereby on an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.										
Task Step 7: Engage partnering MCOs to develop procedures for determining if the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.										
Task Step 8: Project Manager to organize method to provide the current contact information to the beneficiary's MCO for outreach purposes.										
Task Step 9: Project Managers to provide member engagement lists to engaged/relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Step 10: Performance measurement reports established, including but not limited to: Number of patients screened, by engagement level, Number of clinicians trained in PAM® survey implementation, Number of patient: PCP bridges established, Number of patients identified, linked by MCOs to which they are associated, Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, Member engagement lists to DOH (for NU & LU populations) on a monthly basis, Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 11: Collect output of the Project 2di PAM Tool Performance Measurement Program, to include, performance measurement reports and presentations; Annual reports; Member engagement lists, by PAM® cohort										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										

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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 1: Engage Project 2di Workgroup to brainstorm the Project 2di Community Navigator Program										
Task Step 2: Engage key primary, behavioral and dental care providers in Community Navigation Program, to include planning the handoffs for individuals surveyed, through Wellness Coaching then navigated to a community-based resource										
Task Step 3: Track the number of referrals made by PAM Providers into the Community Navigation Program (as new PAM Providers are on-boarded the number of referrals are expected to increase)										
Task Step 4: Determine how SCC and Health Home care management staff will be involved in the patient activation process.										
Task Step 5: Engage Project 2di Workgroup to monitor the referrals made across the County for individuals who receive the PAM survey, receive Wellness Coaching though the CBO partnership and then receive a handoff/referral into the Community Navigation Program.										
Task Step 6: Engage SCC biomedical informatics key project stakeholders to monitor the ED usage of these cohorts. Monitor the usage of non-emergent care by the captive cohort.										
Task Step 7: Enage SCC biomedical informatics team to develop a baseline of non-emergent volume. Develop in collaboration with the Project 2di Workgroup a method of periodic reports to demonstrating increase/trends in visits (specific to UI, NU, and LU patients)										
Task Step 8: Project Manager to monitor, collect and report ongoing data acquisition to enhance program design and development										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	185	235	285	350	350	350	350	350	350	350

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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 Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	85	135	220	350	350	350	350	350	350	350
Task Step 1: Begin Executing initial CBO agreements (pilot program) with CBO partners for project to engage target populations using PAM, the Wellness Coaching program, and initial community navigation program.										
Task Step 2: Collaborate with engaged/contracted CBO partners to build the SCC project 2.d.i Patient Activation Program to include a Community Navigator Program. This shall include FTE roles, responsibilities and staffing guidelines based on the project scale and speed schedule.										
Task Step 3: PPS to identify CBO's with an interest in partnering to develop a group of community navigators (community health workers, wellness coaches and navigators) who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Step 4: Project 2di Workgroup and key project stakeholders reviews and provides feedback on the Project 2di Community Navigator Program.										
Task Step 5: Orient potential CBO partners on the term and scope of the Project 2di CBO partnership agreements, which defines roles of Community navigators										
Task Step 6: Identify communication requirements for program										
Task Step 7: Engage Cultural Competency & Health Literacy Project Lead in program development										
Task Step 8: Engage SCC Workforce Project Lead in development processes.										
Task Step 9: Project 2di Workgroup to develop training curriculum and procedures for Community Navigation Program. Assure participating members are subject matter experts in workgroup with experience in community-based services in Suffolk County.										

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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: Determine necessary training program, including frequency of training, re-training and competency evaluations, training dates, schedule training sessions.										
Task Step 11: Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.										
Task Step 12: PPS to collect and maintain lists of contracted/engaged CBO's and community navigator credentials (by designated area) detailing navigator names, location, and contact information										
Task Step 13: PPS to collect list of training dates along with number of staff trained; Written training materials, and Project 2di Training Attestations										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task Step 1: Engage key project stakeholders to develop process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Step 2: Draft protocols for customer service complaints and appeals.										
Task Step 3: Determine staffing requirements and modes for customer service to be engaged to support project requirement										
Task Step 4: Engage Compliance Officer to review protocols for complaints. Add protocols to SCC enterprise complaints procedures.										
Task Step 5: Begin communicating protocols to key internal, external project stakeholders including posting to the SCC website										
Task Step 6: Project Manager to initiate a method to monitor the effectiveness of the protocols for customer service complaints and appeals.										

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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
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	350	350	350	350	350	350	350	350	350	350
Task Step 1: Begin Executing initial CBO agreements (pilot program) with CBO partners contract includes Train the Trainer responsibilities to educate future PAM providers in how to appropriately assist project beneficiaries using PAM.										
Task Step 2: SCC to identify additional CBO partnerships and county-based resources to be engaged as Community Navigators and trained in PAM										
Task Step 3: Project 2di Workgroup to develop training curriculum and procedures for Community Navigation Program. Assure participating members are subject matter experts in workgroup with experience in community-based services in Suffolk County.										
Task Step 4: PPS to organize a training strategy with engaged/Contracted CBO partners, listing a schedule, logistics and a trainer directory										
Task Step 5: Community navigators trained in including how to appropriately assist project beneficiaries using the PAM®.										
Task Step 6: PPS to collect and maintain lists of contracted/engaged CBO's and community navigator credentials (by designated area) detailing navigator names, location, and contact information										
Task Step 7: PPS to collect description including the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy of training agenda materials, and team staff roles who will be engaged in patient activation										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										

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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 Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	85	155	240	350	350	350	350	350	350	350
Task Step 1: Project Manager engage key project stakeholders to evaluate initial data collected with Project 2di Pilot CBO partnerships to organize Community Navigator strategy needs										
Task Step 2: Community navigator needs and scope of work further defined. To include education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Step 3: Program materials developed to promote education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. Materials are reviewed by the cultural competency & health literacy advisory group.										
Task Step 4: Project 2di Workgroup to identify key partnerships with CBO's whereby Community Navigators will be readily available to assume direct hand-offs. Will include SCC and Health Home Care managers in the partnerships.										
Task Step 5: Community Navigators trained										
Task Step 6: Contracted CBO's place Community Navigators in key locations (with high visibility) identified "hot spot" areas. Direct handoffs are operationalized based on grass-roots relationships within the contracted CBOs.										
Task Step 7: Project Manager maintain reports from CBO partners as evidence of navigator placement by location										
Task Step 8: Project 2di Committee monitor program logistics and data to ensure project requirements are met										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task Step 1: Evaluation of PPS network yields development of resource pool for populations engaged in this project.										

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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 2: Community navigator needs and scope of work further defined. To include education about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Step 3: Program materials developed to promote education regarding health insurance coverage. Materials are reviewed by the cultural competency & health literacy advisory group.										
Task Step 4: Engaged Community Navigators trained educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Step 5: Project Manager maintain reports from CBO partners, List of navigators trained by PPS; List of the PPS trainers; Training dates; Written training materials										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task Step 1: Project 2di Workgroup to engage CBO's in a series of planning discussions around Community Navigators access to County-based resources. Objective to ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Step 2: Identify network of healthcare providers, and provide list to Community Navigators as resource to connect members to primary/preventive care services										
Task Step 3: Policies and procedures for intake and/or scheduling staff to receive navigator calls										
Task Step 4: Identify initial set of Community Navigator staff to roll-out strategy										
Task Step 6: Train Community Navigators, initial set will be used as future "trainers"										
Task Step 7: Regional strategy organized for engaged/contracted CBO's across the County										

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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 8: Strategy is rolled out across all engaged/contracted CBO's and incorporated into on-boarding of all newly engaged/contracted CBO's and PAM Providers										
Task Step 9: Project Manager manintain policies and procedures for intake and/or scheduling staff to receive navigator calls; director and list of provider intake staff trained by the PPS										
Task Step 5: Key Project Stakeholders engaged to develop program strategy outlining how the PPS will monitor and ensure timely access for navigators (eg. What data is being collected, who is reviewing, log, reporting procedures) mange in relation to contractual requirements for engaged/contracted partners										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries 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 as needed for submission of quarterly reports.										
Task Step 6: Iteratively develop, test and deploy Enterprise Data Warehouse (EDW) HealtheRegistries, HealtheAnalytics, HealtheIntent in accordance with applicable DOH domain requirements.										

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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 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. (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: Load Patient Roster into the HealtheEDW for usage within HealtheAnalytics, HealtheRegistries and HealtheIntent applications. (Roster and DOH claims data subject to the completion of the DOH Opt Out Process.)										
Task Step 11: Reporting system is finalized, patient identification, tracking, and matching algorithms are tested and fully deployed into production.										
Task Step 12: Population Health Platform is capable of identifying targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 13: Meet with project stakeholders to iteratively define and refine project specific patient identification and report filtering requirements.										

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
Contract or partner with community-based organizations (CBOs) to engage target populations	

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

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	
Survey the targeted population about healthcare needs in the PPS' region.	
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	
Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	
Baseline each beneficiary cohort (per method	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	
Include beneficiaries in development team to promote preventive care.	
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant	

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	

IPQR Module 2.d.i.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.d.i.6 - IA Monitoring

Instructions :