Project 4.b.ii – Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer

IPQR Module 4.b.ii.1 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Milestone 1: Identify and engage those at high risk for obesity in an effort to decrease the number of Suffolk County Residents who are obese	In Progress	Obesity	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Invite community partners including local health departments to take part in planning program initiatives and formalize Project 4b2 Obesity Prevention Workgroup	In Progress	To ensure adequate representation of the PPS, the 4b2 project manager will recruit PPS partners and content experts to participate in the project planning. Workgroup will be also include representation from local CBO's whose mission is obesity prevention	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 2: Formalize meeting schedule with Project 4b2 Obesity Prevention Workgroup; Track meeting agendas, and attendance on ongoing basis	In Progress	Meeting schedule to be posted on PPS website and sent to all committee members	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 3: Identify current programs in the community which share common objective of reducing the prevalence of obesity in Suffolk County	In Progress	The committee will help to identify the programs through use of a survey tool	06/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 4: Develop specific programs objectives	In Progress	Leveraging the committee's expertise in this field, the PPS plans to refine the program objectives	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Identify and engage with community partners to support project implementation such as PPS Primary Care Practitioners, Hudson	In Progress	There are many under utilized obesity prevention programs in the county - the PPS plans to spread awareness among partners to ensure those at risk are made aware of programs	07/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
River Health Care, and Cornell Cooperative Extension						
Task Step 6: Designated partners implement project initiatives	In Progress	Participating primary care providers and PPS care managers to implement risk assessment and being referral activity	01/01/2017	12/31/2018	12/31/2018	DY4 Q3
Task Step 7: Collect and monitor identified metrics to measure progress of implementation	In Progress	Step 7: Collect and monitor identified metrics to measure progress of implementation	01/01/2019	03/31/2019	03/31/2019	DY4 Q4
Milestone Milestone 2: Promote community based programs which support nutrition and weight loss in an effort to decrease in the number of Suffolk County Residents who are obese	In Progress	Obesity	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Engage Project 4b2 Obesity Prevention Workgroup to develop comprehensive resource guide and calendar of events, educational activities and health fairs highlighting those which share common objectives of reducing the prevalence of obesity in Suffolk County	In Progress	Develop a centralized resource including as many known resources as possible to distribute to care management and provider community	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 2: Suffolk Care Collaborative Obesity Prevention Resource Guide and events calendar is published to PPS website, intermittently highlighted in PPS newsletter, and distributed among PPS partners including Primary Care Providers and Care Managers	In Progress	PPS Care Managers will utilize the resource guide to ensure patients are being provided with accurate, evidence-based information. Resource guide will be used to connect patients who are engaged in PAM project as well when necessary	11/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 3: Resources to be reviewed periodically and updated as information becomes available to connect patients with established programs	In Progress	Step 3: Resources to be reviewed periodically and updated as information becomes available to connect patients with established programs	11/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 4: Collaborate with care management, community based organizations and other members of care team to coordinate care for identified patients	In Progress	Step 4: Collaborate with care management, community based organizations and other members of care team to coordinate care for identified patients	11/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone Milestone 3: Identify and engage Suffolk County	In Progress	Tobacco Cessation	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
residents who may have a desire to quit smoking in an effort to decrease the number of adults 18+ who use tobacco products						
Task Step 1: Invite community partners including local health departments to take part in planning program initiatives and formalize Tobacco Cessation Workgroup	In Progress	To ensure adequate representation of the PPS, the 4b2 project manager will recruit PPS partners and content experts to participate in the project planning	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 2: Formalize meeting schedule with Tobacco Cessation Workgroup; Track meeting agendas, and attendance on ongoing basis	In Progress	Meeting schedule to be posted on PPS website and sent to all committee members	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task Step 3: Develop clinical goals to reflect evidence based tools such as the 5 A's of tobacco control	In Progress	Step 3: Develop clinical goals to reflect evidence based tools such as the 5 A's of tobacco control	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 4: Develop strategy to incorporate 5 A's of tobacco control into EMR of participating PPS providers to identify Suffolk County residents who may have a desire to quit smoking	In Progress	PPS will collaborate with internal IT department to explore how 5 A's will be incorporated	06/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 5: Develop strategy to assist in the adoption of electronic NYS Quitline "opt to quit" protocol by participating PPS providers to engage Suffolk County residents who may have a desire to quit smoking	In Progress	Collaboration from PPS internal IT department and NYS Quitline	06/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Step 6: Connect with the NYS Quitline and patient care team, including care management, to ensure adequate follow up and patient navigation. This may include utilizing Quiline's Trained Quit Coaches to provide cessation counseling.	In Progress	The goal is to partner with NYS Quitline to ensure patient receives adequate but not duplicative care	12/31/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone Milestone 4: Promote community based programs which support smoking cessation in an effort to decrease the number of adults 18+ who use tobacco products in Suffolk County	In Progress	Tobacco Cessation	04/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 1: Engage Tobacco Cessation Workgroup to develop comprehensive resource guide to connect patients to community based smoking cessation resources including group counseling, medication assistance and other evidence based smoking cessation options	In Progress	Resource guide to include all current smoking cessation programs in the county including Suffolk County's "Learn to be Tobacco Free"	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 2: Suffolk Care Collaborative Tobacco Cessation Resource Guide published to PPS website, intermittently highlighted in PPS newsletter, and distributed among PPS partners including Primary Care Providers and Care Managers	In Progress	PPS Care Managers will utilize the resource guide to ensure patients are being provided with accurate, evidence-based information. Resource guide will be used to connect patients who are engaged in PAM project as well when necessary	11/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 3: Resources to be reviewed periodically and updated as information becomes available to connect patients with established screening programs	In Progress	Step 3: Resources to be reviewed periodically and updated as information becomes available to connect patients with established screening programs	11/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 4: Collaborate with care management and community based organizations to coordinate patient navigation utilizing established resource guide	In Progress	Step 4: Collaborate with care management and community based organizations to coordinate patient navigation utilizing established resource guide	11/01/2015	03/31/2019	03/31/2019	DY4 Q4
Milestone Milestone 5: Identify Suffolk County residents who are at risk for Lung Cancer through pre-screening initiatives in an effort to connect more patients who meet screening criteria to available services	In Progress	Lung Cancer	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1: Develop Lung Cancer Screening workgroup to assist in planning project initiatives and objectives	In Progress	To ensure adequate representation of the PPS, the 4b2 project manager will recruit PPS partners and content experts to participate in the project planning	04/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 2: Determine criteria for those at risk and eligible for Lung cancer screening using current evidence based recommendations	In Progress	Workgroup will assist in developing evidence-based Clinical Guidelines for PPS care managers and PCPs	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task	In Progress	The workgroup will collaborate with the PPS practitioner engagement group to target	08/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 3: Determine target areas using hotspot mapping and community needs assessment findings and engage with partners in those areas to begin identifying Suffolk County residents who are at risk and eligible for Lung cancer screening		those providers who serve patients at highest risk. Efforts will continue to be spread across entire PPS.				
Task Step 4: Initiate Project 4b2 Lung Cancer Screening Identification efforts among identified PPS partners including Primary Care Practitioners and Care Management	In Progress	Identified partners will begin to identify Suffolk County residents who are at risk for Lung Cancer through pre-screening initiatives	08/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine feasibility of utilizing tracking system capable of tracking prescreen and referral activity	In Progress	Step 5: Determine feasibility of utilizing tracking system capable of tracking prescreen and referral activity	11/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone Milestone 6: Promote early detection of Lung Cancer through current screening programs in an effort to increase percentage of patients who meet criteria for screening who complete the screening process and decrease time from identification of need to completion of Lung Cancer Screening	In Progress	Lung Cancer	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1: Engage Lung Cancer Screening workgroup to develop comprehensive resource guide to refer patients to current Lung Cancer Screening programs and community screening events	In Progress	Resource guide to include Lung Cancer Screening programs in the county which meet the standards endorsed by workgroup	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 2: Ensure materials are developed and delivered in a culturally sensitive manner by consulting with cultural competency committee for review and approval of materials	In Progress	Cultural competency committee will review resources to ensure unique patient needs are addressed	09/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 3: Suffolk Care Collaborative Lung Cancer Screening Resource Guide and educational materials are published to PPS website, intermittently highlighted in PPS newsletter, and	In Progress	PPS Care Managers will utilize the resource guide to ensure patients are being provided with accurate, evidence-based information. Resource guide will be used to connect patients engaged in PAM project as well	03/31/2016	03/31/2019	03/31/2019	DY4 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
distributed among PPS partners including Primary Care Providers and Care Managers						
Task Step 4: Resources to be reviewed periodically and updated as information becomes available to connect patients with established screening programs	In Progress	Workgroup will be engaged to review and make necessary edits to resources	03/31/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 5: Collaborate with PPS providers, care management and community based organizations to connect patients and coordinate patient navigation	In Progress	Resource guide will be utilized by participating providers and partners	03/31/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 6: Determine feasibility of utilizing tracking system capable of tracking prescreen and referral activity	In Progress	Workgroup and PPS staff along with IT will look into various options for a means to track patient activity	03/31/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone Milestone 7: Identify Suffolk County residents who are at risk for Breast Cancer through pre-screening initiatives in an effort to connect more patients who meet screening criteria to available services	In Progress	Breast Cancer	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1: Develop Breast Cancer Screening workgroup to assist in planning project initiatives and objectives	In Progress	To ensure adequate representation of the PPS, the 4b2 project manager will recruit PPS partners and content experts to participate in the project planning.	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 2: Determine criteria for those at risk and eligible for Breast cancer screening using current evidence based recommendations	In Progress	Workgroup will assist in developing evidence-based Clinical Guidelines for PPS care managers and PCPs	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 3: Determine target areas using hotspot mapping and community needs assessment findings and engage with partners in those areas to begin identifying Suffolk County residents who are at risk and eligible for Breast cancer screening	In Progress	The workgroup will collaborate with the PPS practitioner engagement group to target those providers who serve patients at highest risk. Efforts will continue to be spread across entire PPS.	08/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Initiate Project 4b2 Breast Cancer	In Progress	Identified partners will begin to identify Suffolk County residents who are at risk for Breast Cancer through pre-screening initiatives	08/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Screening Identification efforts among identified PPS partners including Primary Care Practitioners and Care Management						
Task Step 5: Determine feasibility of utilizing tracking system capable of tracking prescreen and referral activity	In Progress	Step 5: Determine feasibility of utilizing tracking system capable of tracking prescreen and referral activity	11/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone Milestone 8: Promote early detection of Breast Cancer through current screening programs in an effort to increase percentage of patients who meet criteria for screening who complete the screening process and decrease time from identification of need to completion of Breast Cancer Screening	In Progress	Breast Cancer	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1: Engage Breast Cancer Screening workgroup to develop comprehensive resource guide to refer patients to current Breast Cancer Screening programs and community screening events	In Progress	Resource guide to include Breast Cancer Screening programs in the county which meet the standards endorsed by workgroup including the NYSDOH Cancer Screening Program Suffolk Contractor	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 2: Ensure materials are developed and delivered in a culturally sensitive manner by consulting with cultural competency committee for review and approval of materials	In Progress	Cultural competency committee will review resources to ensure unique patient needs are addressed	09/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 3: Suffolk Care Collaborative Breast Cancer Screening Resource Guide and educational materials are published to PPS website, intermittently highlighted in PPS newsletter, and distributed among PPS partners including Primary Care Providers and Care Managers	In Progress	PPS Care Managers will utilize the resource guide to ensure patients are being provided with accurate, evidence-based information. Resource guide will be used to connect patients engaged in PAM project as well	03/31/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 4: Resources to be reviewed periodically and updated as information becomes available to connect patients with established screening programs	In Progress	Workgroup will be engaged to review and make necessary edits to resources	03/31/2016	03/31/2019	03/31/2019	DY4 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 5: Collaborate with PPS providers, care management and community based organizations to connect patients and coordinate patient navigation	In Progress	Resource guide will be utilized by participating providers and partners	03/31/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 6: Determine feasibility of utilizing tracking system capable of tracking prescreen and referral activity	In Progress	Workgroup and PPS staff along with IT will look into various options for a means to track patient activity	03/31/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone Milestone 9: Promote early detection of Colorectal Cancer through education about the importance of screening and about current screening options and programs available in the Suffolk County Community in an effort to help increase prevalence of early detection of Colorectal Cancer	In Progress	Colorectal Cancer Screening Education	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Develop Colorectal Cancer Screening Education workgroup to assist in planning project initiatives and objectives	In Progress	To ensure adequate representation of the PPS, the 4b2 project manager will recruit PPS partners and content experts to participate in the project planning	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task Step 2: Engage Colorectal Cancer Screening Education workgroup to develop accurate resource guide to connect patients to current Colorectal Cancer Screening programs	In Progress	Resource guide to include Colorectal Cancer Screening programs in the county which meet the standards endorsed by workgroup including the NYSDOH Cancer Screening Program Suffolk Contractor	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 3: Develop or adopt evidence based patient and provider education materials to educate patients about Colorectal Cancer Screening importance and screening options as well as available screening resources	In Progress	Step 3: Develop or adopt evidence based patient and provider education materials to educate patients about Colorectal Cancer Screening importance and screening options as well as available screening resources	07/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 4: Ensure materials are developed and delivered in a culturally sensitive manner by consulting with cultural competency committee for review and approval of materials	In Progress	Step 4: Ensure materials are developed and delivered in a culturally sensitive manner by consulting with cultural competency committee for review and approval of materials	09/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 5: Publish resource guide to PPS website	In Progress	Step 5: Publish resource guide to PPS website and distribute among PPS partners including Primary Care Providers and Care Managers	11/01/2015	03/31/2019	03/31/2019	DY4 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and distribute among PPS partners including Primary Care Providers and Care Managers						
Task Step 6: Resources to be reviewed periodically and updated as information becomes available to connect patients with established screening programs	In Progress	Workgroup will be engaged to review and make necessary edits to resources.	11/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 7: Collaborate with PPS providers, care management and community based organizations to connect patients and coordinate patient navigation utilizing resource guides	In Progress	Step 7: Collaborate with PPS providers, care management and community based organizations to connect patients and coordinate patient navigation utilizing resource guides	11/01/2015	03/31/2019	03/31/2019	DY4 Q4

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
Milestone 1: Identify and engage those at high risk for obesity in an effort to decrease the number of Suffolk County Residents who are obese	
Milestone 2: Promote community based programs which support nutrition and weight loss in an effort to decrease in the number of Suffolk County Residents who are obese	
Milestone 3: Identify and engage Suffolk County residents who may have a desire to quit smoking in an effort to decrease the number of adults 18+ who use tobacco products	
Milestone 4: Promote community based programs which support smoking cessation in	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
an effort to decrease the number of adults 18+ who use tobacco products in Suffolk County	
Milestone 5: Identify Suffolk County residents who are at risk for Lung Cancer through pre-screening initiatives in an effort to connect more patients who meet screening criteria to available services	
Milestone 6: Promote early detection of Lung Cancer through current screening programs in an effort to increase percentage of patients who meet criteria for screening who complete the screening process and decrease time from identification of need to completion of Lung Cancer Screening	
Milestone 7: Identify Suffolk County residents who are at risk for Breast Cancer through pre-screening initiatives in an effort to connect more patients who meet screening criteria to available services	
Milestone 8: Promote early detection of Breast Cancer through current screening programs in an effort to increase percentage of patients who meet criteria for screening who complete the screening process and decrease time from identification of need to completion of Breast Cancer Screening	
Milestone 9: Promote early detection of Colorectal Cancer through education about the importance of screening and about current screening options and programs available in the Suffolk County Community in an effort to help increase prevalence of early detection of Colorectal Cancer	

IPQR Module 4.b.ii.2 - IA Monitoring

Instructions :

Milestone 1: The IA recommends the PPS describe in more detail the project steps, as opposed to just repeating the step, in the description section. This pertains to each Milestone and step.