DSRIP Implementation Plan

Introduction

This is the DSRIP Implementation Plan Template, which you will use to submit your PPS's implementation plans. The template contains 11 organizational sections, 1 general project implementation section (which applies across all of your DSRIP projects) and separate project implementation plans for each of your chosen DSRIP projects.

Table of Contents

Workforce Strategy

Key Steps and Measurable Milestones

Domain 1 Process Measures - this section is linked to a specific achievement value in the implementation plan & quarterly report process

i. Workforce Strategy Budget Updates

[Note: In response to PPS feedback, the Department of Health has extended the due date for the Domain 1 workforce process measure estimated projections to October 31st, 2015 (with the quarterly report submission). Once you have provided these revised workforce budget numbers, the quarterly reporting process will require you to provide updates on your actual spend compared to this budget.]

Funding Type	DY1 Spend	DY2 Spend	DY3 Spend	DY4 Spend	DY5 Spend	Total Spend
Retraining						
Redeployment						
New Hires						
Other						

ii. Workforce Impact Analysis and Updates

[Note: In response to PPS feedback, the Department of Health has extended the due date for the Domain 1 workforce process measure estimated projections to October 31st, 2015 (with the quarterly report submission). Once you have provided these revised workforce impact numbers, the quarterly reporting process will require you to provide updates on (and evidence of) your redeployment, retraining and new hires compared to these forecasts.]

Workforce Implication	Percent of Employees Impacted (%)	Number of Employees Impacted
Redeploy		
Retrain		
New Hire		

Placement Impact	Percent of Retrained Employees Impacted (%)	Number of Retrained Employees Impacted
Full Placement		
Partial Placement		
No Placement		

iii. New Hire Employment Analysis and Updates

[Note: In response to PPS feedback, the Department of Health has extended the due date for the Domain 1 workforce process measure estimated projections to October 31st, 2015 (with the quarterly report submission). Once you have provided these revised New Hire numbers, the quarterly reporting process will require you to provide updates on (and evidence of) your new hires compared to these forecasts.]

Staff Type	New Hires Net Change
[staff type 1]	
[staff type 2]	
[staff type 3]	
[staff type 4]	
[...]	
[...]	

Key Issues - this section is not linked to the specific workforce achievement value

Workforce Impact Analysis	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Define target workforce state (in line with DSRIP program's goals)***	DY1, Q3	Finalized PPS target workforce state, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap, including any change to your target state.
1. Finalize appointments to Workforce Development Work Group and sub-committees; ensure labor representatives, other key stakeholders, and human resources staff from participating facilities are represented. Develop workforce governance decision-making protocols.	DY1, Q2	

2. For each specific DSRIP project that has a workforce impact, the Workforce Development Work Group will identify specific workforce requirements using facility surveys and interviews with project managers and key stakeholders.	DY1, Q2	
3. The Workforce Development Work Group will perform a project-specific organizational impact assessment using recommended tools to identify level of impact by project, including the anticipated level of impact by role.	DY1, Q2	
4. The Workforce Development Work Group will conduct a project-specific analysis that will identify the various levels of workforce resources required to support the DSRIP projects.	DY1, Q2	
5. The Workforce Development Work Group will aggregate the project-specific analyses to develop an updated PPS-wide Needs Profile.	DY1, Q3	
6. The Workforce Development Work Group will collect and aggregate data into a comprehensive profile of MCC's proposed Target Workforce State.	DY1, Q3	
7. The Workforce Development Work Group will define the structure and content of the initial Target Workforce State report as well as quarterly update reports.	DY1, Q3	
8. The Workforce Development Work Group will finalize the Target Workforce State and submit it to MCC Board of Managers for review and approval.	DY1, Q3	
Milestone 2: ***Create a workforce transition roadmap for achieving your defined target workforce state.***	DY1, Q4	Completed workforce transition roadmap, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap.
1. In partnership with MCC leadership and the Workforce Development Work Group, the Workforce Development Director will establish protocols for implementing and monitoring the workforce transition process, including but not limited to procedures for obtaining and allocating resources, providing training, recruiting and redeploying staff, and reporting.	DY1, Q3	
2. The MCC Workforce Development Director will work with the established sub-committees and other key stakeholders to formulate a project-specific timeline for recruitment, redeployment, and retraining.	DY1, Q3	
3. The Workforce Development Work Group will define the structure and content of the original Workforce Transition Roadmap and provide subsequent quarterly updates to the roadmap.	DY1, Q4	
4. The Workforce Development Work Group will finalize the Workforce Transition Roadmap and submit it to MCC Board of Managers for review and approval.	DY1, Q4	
Milestone 3: ***Perform detailed gap analysis between current state assessment of workforce and projected future state***	DY1, Q4	Current state assessment report & gap analysis, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap.
1. The Workforce Development Director and the Workforce Development Work Group will conduct an assessment of staffing patterns at partner facilities and will analyze certifications, licenses, educational levels, skills, and competencies among a facility's staff through the use of surveys, reports, and interviews.	DY1, Q3	
2. After the current state assessment is complete, the Workforce Development Work Group will compare the Target Workforce State with the current state, identifying specific retraining, redeployment, and new hire needs.	DY1, Q3	
3. The Workforce Development Work Group will identify resources needed (funding, manpower, methods, metrics, partnerships, etc.) and review projected workforce budget and roadmap for each category of impacted staff.	DY1, Q4	
4. Define structure and content of report, conduct gap analyses, and submit quarterly updates.	DY1, Q4	
5. Finalize current state assessment and gap analysis reports and submit them to the Board of Managers for review and approval.	DY1, Q4	

Milestone 4: ***Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.***	DY1, Q3	Compensation and benefit analysis report, signed off by PPS workforce governance body. Subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap, including updates on compensation and benefits.
1. The Workforce Development Work Group will design content and structure for a survey instrument to collect current compensation information from each participating facility; engage labor representatives and other key stakeholders in the process.	DY1, Q2	
2. The Workforce Development Work Group will distribute surveys, collect results, conduct follow-up interviews as needed, and compile aggregate current benefit and compensation information from each participating facility.	DY1, Q2	
3. Using the salary and compensation plan designed in the "Target State" milestone and "Current State" data, the Workforce Development Work Group will analyze and compare data by position, project, roles, employment status (FT, PT) and forecast anticipated impact on targeted employees.	DY1, Q3	
4. Conduct meetings with HR, labor representatives, and key stakeholders to develop and implement policies which affect staff who may be impacted by redeployment or retraining.	DY1, Q3	
5. Finalize Compensation and Benefit Analysis Report and submit to the Board of Managers for review and approval.	DY1, Q3	
Milestone 5: ***Develop training strategy***	DY1, Q4	Finalized training strategy, signed off by PPS workforce governance body. Quarterly reports will require evidence of up-take of training programs, including both individual training and training for new, multi-disciplinary teams. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
1. The Workforce Development Director will work closely with HR staff at participating facilities to conduct a comprehensive customized training needs assessment for targeted staff.	DY1, Q3	
2. Compile a comprehensive project and individual training needs list, including specific skills and certifications required.	DY1, Q3	
3. The Workforce Development Work Group will establish procedures for implementing and monitoring the Workforce Training Strategy, including but not limited to describing procedures for obtaining and allocating resources, providing training, and implementing reporting requirements.	DY1, Q4	
4. The Workforce Development Work Group will define a process for evaluating the effectiveness of training programs.	DY1, Q4	
5. The Workforce Development Work Group will finalize the Workforce Training Strategy and submit it to the Board of Managers for review and approval.	DY1, Q4	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges and risks that you foresee in achieving the milestones set out above, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: There is a possibility that MCC will have difficulty recruiting sufficient numbers of staff needed. This may be a particular issue with lower-paying community-based positions (e.g., community health workers--CHWs) and positions where a high level of education/certification/licensure is required (e.g. Licensed Clinical Social Worker). This is especially problematic since two other PPSs in WNY will be competing for the same resources (not to mention PPSs all over the state with similar opportunities). If we are unable to fill these positions, it will reduce the PPS's ability to achieve implementation and patient engagement targets, and will also adversely affect long-term sustainability of DSRIP-related changes.
Mitigation: Determine appropriate incentives and promote career ladder pathways. Work with local colleges, universities, and other educational resources to build a pipeline of qualified workers. Establish retraining programs to facilitate redeployment. Consider retention bonuses for lower-paying positions in order to reduce costly turnover/churn. Work with Catholic Medical Partners and Finger Lakes PPS to host joint job fairs and/or training/retraining sessions.

Risk #2: Staff, labor representatives, and key stakeholders will resist the workforce changes needed for success. This resistance can take the form of poor morale among workers or bad publicity that extends across the region. Once established, these attitudes can be contagious, ballooning out of proportion from the actual changes that triggered them. Obviously, a negative image will reduce the PPS's ability to recruit qualified employees and redeploy existing workers into productive long-term positions.
Mitigation: Engage staff, labor representatives, and key stakeholders throughout the process. During the application and implementation planning process, MCC sought input from labor unions and workforce development experts. A contract with a workforce development vendor is currently being finalized. The workforce vendor will continue engaging labor representatives while reaching out to employees potentially affected by DSRIP-related changes. These efforts will promote openness and transparency and involve employees in the decision-making process so that they are more invested in the changes.

Risk #3: Managing disparate HR policies across different PPS members. The PPS is composed of multiple organizations across a wide geographical area, and each facility has different HR polices. Managing the differences could become a barrier to inter-PPS movement by staff across the PPS. In particular, employees who may be moved between organizations, even affiliated organizations, could have different in-house HR services available to support the changes.
Mitigation: The Workforce Development Work Group, with support from the workforce vendor and in close collaboration with facility HR departments, will provide clear and consistent protocols to support the changes and address challenges across the PPS. Specifically, the Workforce Development Work Group will facilitate the establishment of protocols for implementing and monitoring the workforce transition process, including but not limited to procedures for obtaining and allocating resources, providing training, recruiting and redeploying staff, and reporting.

Risk #4: Compatible IT systems may not be in place for reporting, and staff at individual organizations may not have the capability to collect and export data as needed.
Mitigation: The current state assessment will include an analysis of each organization's current capabilities/compatibilities. The Workforce Development Work Group will use the results of this assessment to determine the IT support required to facilitate the required data collection. The Workforce Development Work Group will evaluate whether acquisition and use of a centralized learning management software system is required.

Risk #5: There is a risk of negative ramifications for employees who refuse retraining/redeployment. The workforce is large and is comprised of both unionized and non-unionized facilities. It is probable that a segment of the employee population will find the changes untenable. In facilities that are unionized, employees may seek to avoid the changes through grievances and refusal to cooperate.
Mitigation: MCC will make efforts to provide support to transitioning employees which includes a clear, consistent, and PPS-wide set of protocols for managing the workforce changes required. The PPS intends to refer employees to their HR department and/or union pursuant to existing agreements. Following the communication plan, the PPS will engage frontline staff through the Workforce Development Work Group to provide input into the process of addressing staffing gaps, including refusal of retraining/redeployment. It is our hope that this strategy will minimize the need for disciplinary action, which would only be considered as a last resort.

Risk #6: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #7: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #8: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe the major interdependencies between your workforce transformation plans and other workstreams (e.g. cultural competency, clinical integration, financial sustainability, etc.)

The workforce implementation plan is interrelated with every workstream and every DSRIP project. As a general overarching reality, without an effective, comprehensive workforce strategy, no workstream can be successful. Some of the major interdependencies include:

The IT Processes & Systems workstream is dependent upon an effective workforce strategy to recruit staff to build and manage systems, and to train IT staff on the effective use of varied software.

Cultural Competency and Health Literacy need to be integrated into each aspect of the workforce strategy. Whether staff are retained, hired, retrained, or redeployed, it will be necessary for the workforce to be culturally competent.

Financial Sustainability: Adequate resources are key to successful transformation. Funds need to be available to support all aspects of the recruitment, training, and redeployment processes. In addition, financial delays could be detrimental to small partners attempting to participate in workforce transformation if resources are unavailable to provide needed training programs and develop required career and academic pathways.

Governance and Performance Reporting are also critical to the success of the transformation. Each participating partner needs to fully understand and participate in the process. Success is dependent upon active participation and engagement, including responding to required data needs for reporting.

Clinical Integration is dependent upon a successful transformation of the workforce. Training programs and new operational procedures will have a significant impact on successful integration into the care process.

In addition, Practitioner Engagement, through effective integration of communication processes as outlined in the Practitioner Communication and Engagement Plan, is critical for success. Continued transformation of the workforce and the care process requires active participation.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
MCC Workforce Development Director	***New hire***	***Oversee, develop, and implement workforce transformation plans. Oversee development of job descriptions, workflow procedures, recruitment. Provide information and assure continuous communication among employees, labor reps, community-based organizations (CBOs), and MCC.***
Workforce vendor(s)	***Contract pending with Area Health Education Center***	***Provide training and educational services.***
Workforce Development Work Group and project subgroups	***HR designees from participating facilities***	***Facilitate employee data collection; monitor and report to Board of Managers. Assist in development of job descriptions, workflow procedures, recruitment. Promote and manage communication among employees, labor reps, CBOs, and MCC.***

Key Stakeholders

Please identify the key stakeholders involved in your workforce transformation plans, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
Training programs within PPS members	***Training partners***	***Delivery of multiple trainings***
Home care agency training programs	***Home care training***	***Delivery of home care training***

External stakeholders		
Buffalo Niagara HR Associates	***Professional association***	***Support HR activities and leadership***
Training agencies	***Training provider***	***Offer variety of training programs***
1199 SEIU, NYSNA, AFSCME, CSEA, CWA, and others as identified	***Labor representatives***	***Provide communication among employees and workforce team. Provide expertise and insight into effective processes.***
PX 21 Coalition	***Coalition of substance abuse/mental health agencies***	***Provide training (via training committee)***
Community Health Workers of Buffalo	***Training and certification***	***Provide CHW training with emphasis on health education and promotion, community building, and advocacy; offer CHW certificate in partnership with Canisius***
Rural Area Health Education Center (R-AHEC)	***Training***	***Provide training in rural areas***
Staff education departments; nursing in-service education departments	***Education***	***Provide clinical/nursing education; educate staff for DSRIP protocols***
Colleges and universities with certificate/education programs (e.g., D'Youville, Daemen, UB, NU, Medaille, ECC, NCCC, Trocaire, BOCES, Harkness)	***Education***	***Provide workforce education for DSRIP protocols***
UB School of Social Work; Office of Continuing Education	***Training and certification/ credentialing support***	***Support DSRIP policy and procedures***
Millard Fillmore College	***Adult education on practice transformation***	***Offer certificate program (practice transformation based on AHRQ curriculum)***
Empire State College, Jewish Community Center of Greater Buffalo	***Adult education***	***Offer adult education classes***
Infant community programs (e.g., Healthy Babies, Maternal and Infant Community Health Collaborative---MICHC)	***Program-specific training programs***	***Provide training/orientation related to specific programs***
Vocational and Educational Services for Individuals with Disabilities (VESID)	***Training***	***Provide education opportunities to disabled individuals***

IT Expectations

Please describe how the development of shared IT infrastructure across the PPS will support your plans for workforce transformation.

Data around workforce transformation will be collected, analyzed, and reported upon in order to determine the success and progress of the workforce development efforts. Appropriate data controls, collection, and analytical platforms will be needed to support these efforts. Dashboard or report card capabilities will help PPS partners understand current status/progress and highlight issues that need attention. IT support is also required to facilitate required data collection/reporting/export. It will also be important to track staff movement and changes across the PPS. A learning management system may be required to coordinate and record training/educational efforts.

Progress Reporting

Please describe how you will measure the success of this organizational workstream and report on progress against your targets.

Progress reporting will be aligned with the phased approach to implementing the overall Workforce Strategy. As the Workforce Strategy is developed and refined, quarterly project and unit level progress reports will include:

- *A list of Workforce Development Work Group members and key stakeholders*
- *A regular meeting schedule and meeting minutes*
- *A documented assessment of project workforce needs and Target Workforce State*
- *A Workforce Transition Roadmap, submitted to and approved by the Board of Managers*
- *A documented Compensation and Benefit Analysis Report*
- *Comprehensive Training Strategy*
- *A reporting schedule aligned with finance, governance, cultural competency/health literacy, and performance monitoring*

Quarterly reports help partners to gain meaningful status on their own progress towards goals. Overall project and workstream success will be reported to partners and NYS DOH. Reports will include analyses of, but not be limited to, the following:

- *Number of people retrained, redeployed, and hired*
- *Training programs/sessions conducted*
- *Breakdown of full (95–100% of previous compensation) vs. partial (less than 95%) placement*
- *Breakdown of new hires by staff type*
- *Summary of compensation/benefit impacts*

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

Governance

Key Steps and Measurable Milestones

Domain 1 Process Measures

i. Governance structure updates	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Finalize governance structure and sub-committee structure***	DY1, Q2	Governance and committee structure, signed off by PPS Board. Subsequent quarterly reports will require updates on committee structure and memberships (if relevant).
1. Fill remaining open seats of the Board of Managers.	DY1, Q2	
2. Obtain Board of Managers approval of timetable for governance milestones, including identifying committees, populating committees, and finalizing committee charters.	DY1, Q2	
3. Finalize name, role, and reporting structure of each Committee (to be approved by Board of Managers).	DY1, Q2	
4. Populate committees by taking nominations from Board members for committee membership, seeking outside expertise where necessary.	DY1, Q2	
Milestone 2: ***Establish a clinical governance structure, including clinical quality committees for each DSRIP project***	DY1, Q3	Clinical Quality Committee charter and committee structure chart Subsequent quarterly reports will require minutes of clinical quality committee meetings to be submitted.
1. Establish the role, duties, and reporting structure of the Clinical/Quality Committee (to be memorialized in a Committee Charter).	DY1, Q2	
2. Establish work groups of the Clinical/Quality Committee for DSRIP projects that require specific focus of the Committee.	DY1, Q2	
3. Finalize membership of Clinical/Quality Committee.	DY1, Q3	
4. Populate Clinical/Quality work groups.	DY1, Q3	
Milestone 3: ***Finalize bylaws and policies or Committee Guidelines where applicable***	DY1, Q2	Upload of bylaws and policies document or committee guidelines. Subsequent quarterly reports will require PPSs to articulate any updates that have been made to their bylaws, policies or committee guidelines.
1. The Governance Committee will be instrumental in facilitating adoption of PPS bylaws, committee charters, and PPS policies. The Governance Committee will report to the Board regularly during this phase on milestone progress.	DY1, Q2	

2. Legal counsel, in consultation with PPS executive leadership will draft Bylaws for initial review by Governance Committee and Compliance Committee.	DY1, Q2	
3. Governance and Compliance Committee review of draft Bylaws complete.	DY1, Q2	
4. Finalize Bylaws and present to Board of Managers for approval.	DY1, Q2	
5. Prepare Committee organizational chart showing reporting structure, roles, and responsibilities.	DY1, Q2	
6. Committee leaders, legal counsel, and dedicated members of Governance Committee will prepare Committee and Sub-Committee Charters for review by full Governance and Compliance Committees.	DY1, Q2	
7. Finalize Committee Charters and present to Board of Managers for approval.	DY1, Q2	

ii. Governance process updates	***Target Completion Date***	***Supporting Documentation***
Milestone 4: ***Establish governance structure reporting and monitoring processes***	DY1, Q3	Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes Subsequent quarterly reports will require minutes of committee meetings, including evidence of two-way reporting between committees.
1. Draft Governance Operating Model which will define reporting processes and governance monitoring process.	DY1, Q2	
2. Finalize Governance Operating Model.	DY1, Q3	

Key Issues

iii. Community engagement	***Target Completion Date***	***Supporting Documentation***
Milestone 5: ***Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)***	DY1, Q2	Community engagement plan, including plans for two-way communication with stakeholders. Subsequent quarterly reports will require evidence of implementation of community engagement plan, including evidence of community engagement events.
1. Charge the Community-Based Organization (CBO) Task Force with the responsibility of assisting in the development and implementation of a multi-year plan to provide two-way communication and engagement with public and provider organizations.	DY1, Q2	
2. Plan a series of informational and activation forums at three different sites with WNY to elicit input and participation from public and provider organizations in DSRIP project activities.	DY1, Q2	

Milestone 6: ***Finalize partnership agreements or contracts with CBOs***	DY1, Q2	Signed CBO partnership agreements or contracts. Subsequent quarterly reports to require minutes of meetings with CBOs.
1. Issue requests for proposals (RFPs) for services to be performed by CBOS, including (but not limited to) cultural competency and health literacy training, Patient Activation coaching, and other services in connection with specific DSRIP projects.	DY1, Q2	
2. Finalize Charter for CBO Task Force.	DY1, Q2	
3. Finalize charter for "Voice of the Consumer" Sub-Committee.	DY1, Q2	
4. Populate CBO Task Force by conducting outreach at community forums across PPS region and receiving nominations for CBO representatives. Board of Managers will approve membership of CBO Task Force.	DY1, Q2	
5. Populate "Voice of the Consumer" Sub-Committee by conducting outreach at community forums and receiving nominations for Medicaid beneficiaries. Board of Managers will approve membership of Sub-Committee.	DY1, Q2	
6. Circulate Participation Agreement with CBOs.	DY1, Q2	
Milestone 7: ***Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)***	DY2, Q2	Agency Coordination Plan. Subsequent quarterly reports to require updates on implementation of Agency Coordination Plan, including evidence of interaction with local agencies.
1. Develop agency coordination plan for engaging agencies in MCC initiatives.	DY2, Q2	
2. Prepare a comprehensive booklet that describes DSRIP projects, cites specific project locations by municipality, and provides project coordinator contact information for each project.	DY2, Q2	
3. Hold first in a series of workshops with public sector agencies at state, county, and municipal levels to explain how they can connect with DSRIP projects and activities and refer individuals to services.	DY2, Q2	

Milestone 8: ***Finalize workforce communication & engagement plan***	DY2, Q1	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee). Subsequent quarterly reports to require updates on implementation of workforce communication & engagement plan.
1. The MCC PPS will review and update the list of key stakeholders engaged in the development of the workforce strategy and implementation plan. This group includes stakeholders such as management, project team members, employees, AHEC, labor representatives, academic providers, community members and employees.	DY1, Q3	
2. The MCC PPS will, in partnership with the above mentioned stakeholders, review the communication channels available, solicit additional opportunities and conduct a preliminary assessment of effectiveness of each resource for workforce engagement.	DY1, Q3	
3. The MCC PPS will develop a workforce communication and engagement strategy which addresses the vision, objectives, and guiding principles of the strategy as a means for engaging key stakeholders.	DY1, Q4	
4. The MCC PPS will further develop the strategy into a formal Workforce Communication and Engagement Plan which will describe objectives, pinpoint target audiences(s), determine required resources, and serve as a mechanism for measuring the effectiveness of the communication plan.	DY2, Q1	
5. The Board of Managers or its delegate will review and approve the Workforce Communication and Engagement plan and review and respond to subsequent quarterly updates.	DY2, Q1	

iv. Inclusion of CBOs

Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network

MCC PPS will select 12 CBOs to serve as cultural competency and health literacy trainers via RFP process. These CBOs will receive training and be responsible for training other CBOs and providers within the MCC network. An RFP will be used to select CBOs for participation in the Cultural Competency/Health Literacy workstream.

Additionally, CBOs will be contracted with to provide patient activation services in connection with the 11 th project (2.d.i., Patient Activation). Since the 11 th project will be organized on a sub-regional basis (North, Central, and South sub-regions), it is projected that a minimum of three CBOs will be selected through an RFP process. These CBOs will, in turn, contract with a to-be-determined number of CBOs to assist in the provision of patient activation services.

CBOs will also be extensively used in projects 3.f.i. and 4.d.i. (Support for Maternal and Child Health, Reduce Premature Births). The team overseeing these projects has earmarked a minimum of 14 CBOs with expertise in serving young mothers and their families to be involved in these projects. Agreements with these CBOs will be executed over the course of DY1.

Additional CBOs will be identified for project-related work. Each DSRIP project team is being charged with the responsibility of identifying key CBOs that will assist with project work. A determination will be made as to the number of such CBOs required and the specific services they will perform. CBO involvement in MCC's projects and activities will be facilitated by the CBO Task Force, which will be responsible for tracking and monitoring such involvement and for pinpointing new and evolving opportunities for CBO engagement.

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing your governance structure and processes and achieving the milestones described above, as well as potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: Given time constraints of Board of Managers members (many of whom administer healthcare facilities), there is a compelling need to ensure that board meetings are run effectively.
Mitigation: Committee reports and reports on process and clinical performance outcomes must be formatted in a manner that will not only allow extensive reporting on all PPS organizational and project components, but also permit board members to readily pinpoint issues that need to be resolved. Use of color-coding, standardized presentation formats, and brief narrative explaining results will grow in importance, particularly as the number of measures to report on increases over time.

Risk #2: A second challenge pertains to maintaining a high level of involvement by board members.
Mitigation: One way to meet this objective is to ensure that participation in board and committee meetings results in learning experiences that can be adapted by board members to their own facilities. It will be important to provide continuing education opportunities to board members both inside and outside the context of structured board and committee meetings.

Risk #3: A third risk involves communications. One of the key challenges confronting a PPS is to educate the entire community about DSRIP. Failure to educate the community will hinder the success of the PPS and dilute outcomes. At present, relatively few people in the community have an understanding of the objectives and desired results of DSRIP.
Mitigation: As community and healthcare activists, board members are best suited to drive the communication plan and evaluate its effectiveness. They can do so by involving board members from PPS partner institutions in the DSRIP process, closely monitoring the extent to which communication activities and timelines adhere to the overall communication plan, encouraging the active involvement of Medicaid beneficiaries in DSRIP proceedings and affairs, and periodically reviewing survey results which aim to measure the community's level of understanding of the wide-sweeping DSRIP initiative.

Risk #4: Another risk involves the potential failure of the board to place the work of regional councils, the "Voice of the Consumer" Sub-Committee, and the CBO Task Force on equal footing with full-fledged board committees.
Mitigation: Reports from and participation by these groups in board proceedings need to be an ongoing focus of the governing board.

Risk #5: The Board of Managers will need to ensure that DSRIP monetary incentives are sufficient to encourage participation in DSRIP projects and to adequately reward providers for meeting metrics. Inadequate incentive payments will stifle participation and limit the scope of Medicaid beneficiaries served.
Mitigation: To address this issue, the board will be responsible for monitoring provider participation in individual projects and, within budgetary limitations, be prepared to make adjustments in the allocation of incentives.

Risk #6: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #7: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #8: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe the key interdependencies between this and other workstreams (e.g. IT Systems and Processes, Practitioner Engagement, Financial Sustainability etc.)

Effective governance of the PPS is dependent upon the success of all other workstreams:

Workforce development will require innovative approaches for retraining inpatient workers for emerging community-based healthcare careers, for filling primary care gaps, and for integrating physical with behavioral health at service sites throughout WNY. All of these workforce development dependencies (among others) must be aligned to meet DSRIP objectives, and the Board of Managers will be responsible for overseeing this work.

An IT infrastructure is the backbone of all DSRIP projects, providing the platform for recording, reporting, and analyzing all process and performance outcome measures that must be monitored by and responded to by the Board of Managers.

Clinical Integration will serve as the foundation for ensuring that standardized evidence-based procedures are used to conduct multiple projects at multiple sites. Clinical integration will drive performance, and the board's effectiveness will be dependent upon it.

Maximizing Practitioner Engagement through training and education is another important dependency. Active participation by clinicians is not only essential for meeting DSRIP objectives, but it is also a prerequisite for spearheading innovation that is instrumental to meeting the Triple Aims of improving the patient experience of care, improving the health of the population, and reducing the per capita cost of care.

Active patient engagement is perhaps the most critical factor that will determine the success of the governing board and the entire DSRIP project in WNY. The overwhelming majority of Medicaid beneficiaries are challenged by poor housing, lack of nutritious food, lack of transportation, and unsafe neighborhoods. Engaging these patients in healthcare in the face of these issues will be the biggest challenge confronted by the MCC PPS. The Board of Managers--and the entire organization--will need to prioritize cultural competency and health literacy training, push for the overwhelming success of the patient activation project (2.d.i.), ensure that Medicaid beneficiaries themselves play a meaningful role in PPS operations, and see to it that CBOs that serve Medicaid beneficiaries are a vital part of the DSRIP agenda.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
MCC Board of Managers members and committee members	***Various individuals***	***Facilitate key decisions; lead, develop, and audit/monitor projects***
Lead entity	***ECMCC***	***Ensure all governance is in place and functioning to support community projects***
MCC executive management	***Led by Al Hammonds, Jr. (Executive Director)***	***Provide overall leadership for PPS partners and activities; ensure governance strategy is established and followed***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS with regard to your governance structure and processes.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal stakeholders		
CBO Task Force	***Advisory***	***Lead and develop meaningful community engagement***
"Voice of the Consumer" Sub-Committee	***Advisory***	***Capture patients' expectations, preferences, and aversions***
External stakeholders		
Attested CBOs	***Advisory***	***Ensure governance supports DSRIP protocols***
Health plans, managed care organizations	***Value-based payment reform***	***Develop committee to support payment reform***
Legislators	***Regulatory waivers***	***Support regulatory change; remove barriers to collaboration***
NYS DOH	***Regulatory oversight***	***Ensure all laws and regulations are adhered to***
NYS Office of Mental Health	***Regulatory oversight***	***Ensure behavioral health regulations are followed; adhere to necessary mandates***
OASAS	***Regulatory oversight***	***Ensure all substance abuse laws are adhered to***
OPWDD	***Regulatory oversight***	***Ensure patients with developmental and intellectual disabilities are represented***
Office of Children and Family Services (OCFS)	***Regulatory oversight***	***Ensure children- and family-related laws are maintained***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream and your ability to achieve the milestones described above.

Committees will communicate utilizing a communication forum developed by IT. Each committee will have dashboards and reporting requirements. A portal on the MCC website will be created for governance, and governance documents will be uploaded as they are approved. The portal will also be used to communicate with the community about the organization of the PPS, and to publish committee meeting schedules and agendas, minutes, and membership rosters as appropriate. A two-way communication system will also be set up for resolving grievances.

We plan to use a cloud-based suite of applications to support communication with, and collaboration among, members of the PPS. This solution includes conferencing and group messaging across the organization. Additional CRM and project management components are currently being evaluated as adjuncts to the existing infrastructure. A cloud-based solution offers the scalability, extensibility, and functionality required for an agile, efficient organization.

Progress Reporting

Please describe how you will measure the success of this workstream.

The Governance Committee will regularly report to the Board of Managers on progress in achieving governance milestones. The progress will be measured against the timetable adopted by the Board. Success will be measured initially by finalizing Board of Manager appointments and staffing the committees and sub-committees. For each committee, charters will be drafted, reviewed, and adopted, and reporting and monitoring processes will be defined.

Quarterly reports will describe (but not be limited to):
- *Changes or updates to committee rosters/charters/by-laws, organizational structure, and policies*
- *Partnership agreements/contracts with CBOs*
- *Agency coordination plan for engaging public sector agencies*

The progress/success of these efforts geared towards community engagement and public sector outreach and education will be measured in terms of:
- *Engagement with the community*
- *Evidence of implementation of the community engagement plan*
- *Community engagement events*
- *Workforce communication and engagement plan*

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

Financial Sustainability

Key Steps and Measurable Milestones

Domain 1 Process Measures

i. Financial Sustainability Strategy Updates

Financial Sustainability Strategy Updates	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Finalize PPS finance structure, including reporting structure***	DY1, Q3	PPS finance structure chart / document, signed off by PPS Board. Subsequent quarterly reports will require PPSs to provide minutes of Finance Committee meetings.
1. Establish the financial structure of the MCC PPS using a detailed workflow/organizational chart and seek and obtain MCC Board of Managers approval of the PPS financial structure.	DY1, Q2	
2. Construct and convey to MCC partners a finance organizational chart depicting MCC financial functions and duties, including those performed internally and those conducted by contracted accounting firm. Duties cover procurement and payables (purchasing and disbursements); treasury (cash and investment management); financial and operational reporting; compliance; contracting; internal auditing; network communications; provider operating agreements; funds flow and distribution; lead value-based payment (VBP) transition; decision support (receipt of data and data analytics); provider financial health assessments; etc.	DY1, Q2	
3. Establish a charter that defines the functions and responsibilities of the Finance Committee and all sub-committees under the charge of the Finance Committee (e.g. VBP Sub-Committee) and obtain Board of Managers approval.	DY1, Q2	
4. Construct a flowchart depicting internal and external reporting requirements of and reporting flow to and from: *a) Finance/Board of Managers* *b) Finance/other governing board committees* *c) Finance/project leads (domain 1 process milestone reporting and domain 2 and 3 reporting)* *d) Finance/workstreams (IT, workforce, clinical integration, etc.)* *e) VBP Sub-Committee* *f) Compliance Officer* *g) MCC partners* *h) Annual/quarterly financial health reporting* *h) NYS DOH* *h) Other stakeholders*	DY1, Q2	
5. Prepare written policies and procedures describing all financial functions and duties of the MCC PPS, its Finance Committee, and all finance-related sub-committees.	DY1, Q2	
6. Prepare written policies and procedures defining all finance-related reporting requirements.	DY1, Q2	
7. Establish a schedule for regular Finance Committee meetings.	DY1, Q2	
8. Conduct re-evaluation of finance duties and responsibilities and reporting requirements; make revisions, as required.	DY1, Q3	

Milestone 2: ***Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.***	DY1, Q4	Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers In subsequent quarterly reports (i.e. between the annual assessment) PPSs will be requires to provide an update on: --the financial status of those providers identified as financially fragile, including those that qualified as IAAF providers; and how their status impacts their ability to deliver services -- the identification of any additional financially fragile providers; and -- the efforts undertaken to improve the financial status of those providers.
1. Develop measurement tool to evaluate financial health of MCC network partners utilizing indicators such as cash on hand, debt ratio, operating margin, and current ratio.	DY1, Q2	
2. Establish financial stability plan which includes policies and procedures to: define what providers are subject to annual financial health assessment; mandate completion of an annual assessment of all such providers; describe metrics and the process to be used for conducting the financial health assessment; explain how annual assessments will be conducted; and require reporting of financial stability plan results to Finance Committee and MCC Board of Managers.	DY1, Q2	
3. Develop distressed provider plans to monitor financially fragile providers. Require that all Interim Access Assurance Fund (IAAF) providers and any provider that does not pass the financial health test be surveyed quarterly using the financial health measurement methodology.	DY1, Q2	
4. In developing a distressed provider plan, MCC will: (a) utilize a standard set of metrics/template for evaluating a financially fragile provider; (b) utilize prescribed procedures to evaluate metrics: (c) implement a Distressed Provider Plan for financially fragile providers; (d) report quarterly to Finance Committee and MCC Board of Managers on providers in the network that are financially fragile (including those that have qualified as IAAF providers); (e) ensure future quarterly reports provide an update on the financial status of those providers identified as financially fragile; (f) make any additions to the Financially Fragile Watch list, as appropriate; (g) describe the efforts undertaken to improve the financial status of these providers.	DY1, Q2	
5. The financial health policies and procedures will be reviewed and approved by the Finance Committee and MCC Board of Managers.	DY1, Q2	
6. Develop matrix of DSRIP projects and identify expected impact on provider costs, patient volumes, revenue, length of stay, and other factors based upon project goals and participation.	DY1, Q3	
7. Review draft of project impact matrix with Finance Committee.	DY1, Q3	
8. Finalize project impact matrix identifying provider participation in projects, expected impact on participating providers, and other provider-specific information.	DY1, Q3	

9. Review and obtain approval of project impact matrix by Finance Committee and MCC Board of Managers.	DY1, Q3	
10. Prepare/update financial assessments and project impact assessments of MCC providers to include required metrics and provider-specific metrics.	DY1, Q3	
11. Distribute current financial assessment and project impact assessment documents to providers.	DY1, Q3	
12. Review results of current state financial assessments and project impact assessments that are returned by MCC providers.	DY1, Q4	
13. Prepare report of MCC provider current financial status for review by Finance Committee and MCC Board of Managers.	DY1, Q4	
14. Based upon the results of the financial assessments and the project impact assessments, identify providers that are (a) not meeting financial plan metrics, (b) undergoing existing or planned restructuring, or will be financially challenged; and (c) place financially challenged providers on initial financially fragile watch list.	DY1, Q4	
15. Obtain approval of the financially fragile watch list by the Finance Committee.	DY1, Q4	
16. Adopt policies and procedures to describe the role of the MCC Project Management Office (PMO) and the measures the PMO will take to manage the financial stability plan and the distressed provider plans on behalf of MCC and ECMCC.	DY1, Q3	
17. Implement PMO oversight for financial stability plan and distressed provider plans.	DY1, Q4	
Milestone 3: *Finalize Compliance Plan consistent with New York State Social Services Law 363-d*	DY1, Q3	Finalized Compliance Plan (for PPS Lead). Subsequent quarterly reports will require an update on ongoing compliance with 363-d.
1. Place compliance functions under the purview of a Compliance Committee.	DY1, Q2	
2. Prepare charter of Compliance Committee duties and responsibilities and obtain approval of Compliance Committee charter by MCC Board of Managers.	DY1, Q2	
3. Appoint members to Compliance Committee.	DY1, Q2	
4. Design MCC Compliance Plan to ensure that it addresses all provisions of Section 363-d.	DY1, Q2	
5. Define operational policies and procedures to implement MCC Compliance Plan requirements.	DY1, Q2	
6. Present Compliance Plan to Finance Committee for approval and subsequently obtain approval by Board of Managers.	DY1, Q3	
7. Establish compliance reporting dashboard and reporting plan and adhere to regular compliance reporting to Finance Committee and MCC Board of Managers.	DY1, Q3	

ii. Progress Reports on the PPS Effort to Transition to Value-Based Payment Systems

Progress reports on the PPS effort to transition to value-based payment systems	*Target Completion Date*	*Supporting Documentation*
Milestone 4: ***Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.***	DY1, Q4	Value-based payment plan, signed off by PPS board Subsequent quarterly reports will require updates on implementation of that plan.
1. Establish VBP Sub-Committee to lead the formulation of a multi-year VBP transition plan: appoint representatives from finance, legal, medical staff, executive leadership, and others to VBP Sub-Committee.	DY1, Q2	
2. Develop comprehensive description of the roles, responsibilities, and functions of the VBP Sub-Committee, including, but not limited to: educate partners; establish and maintain working relationships with Medicaid Managed Care Organizations (MCOs) (monthly meeting schedule, agenda setting, etc.); select external consultant(s) to assist sub-committee; develop multi-year strategic plan to meet 90% VBP contracting goal; determine bi-directional data sharing needs between MCC and MCOs; devise process for tracking performance against guideposts in plan; etc.	DY1, Q2	
3. Finance Committee and Board of Managers will approve a charter outlining responsibilities and functions of VBP Sub-Committee.	DY1, Q2	
4. With assistance from the communication team, develop an easy-to-understand educational tool for explaining NYS DOH's VBP goals, summarizing the state's VBP roadmap, explaining the various types and levels of VBP contract approaches, describing how VBP contracts can drive additional revenues to PCPs, etc.	DY1, Q3	
5. Develop plan for integrating VBP educational tool into MCC's communication plan, including placement of tool on MCC website, direct distribution to PPS providers, etc.	DY1, Q3	
6. Design plan to assess readiness and willingness of providers in PPS network to engage in various levels of VBP contracting, including development of provider assessment instrument; in-person outreach sessions in various communities of WNY to address inquiries from providers; analysis of responses; and presentation of findings to MCOs.	DY1, Q3	
7. Formulate draft assessment instrument which poses a variety of questions to providers that include, but are not limited to: *a) whether provider has previously engaged in some form of VBP contracting;* *b) readiness of provider to engage in VBP contracting* *c) provider's financial ability to assume risk and enter into risk-sharing arrangements* *d) annual Medicaid revenues by provider and by MCO* *e) number of Medicaid beneficiaries served by provider by specific MCO plan* *f) amount of payments providers receive from existing VBP contracts or from preferred compensation modalities* *g) types of VBP Medicaid contracts in effect (e.g. bundled payments, pay for Patient-Centered Medical Home (PCMH) outcome performance, risk-sharing, etc.)* *h) provider preferences for negotiating plan options (e.g., as a single provider negotiating directly with MCO or as a group of providers within the PPS)* *i) whether provider serves any special populations (e.g., developmentally disabled)* *j) providers' concerns and issues relating to transitioning to a VBP system*	DY1, Q3	
8. Have assessment tool reviewed for completeness by external consultant.	DY1, Q3	

9. Distribute assessment survey to provider population along with information explaining the importance of the survey and why provider participation in survey is important.	DY1, Q3	
10. To explain assessment tool and encourage participation in VBP survey, organize and hold provider outreach sessions and conduct informational sessions in connection with medical staff meetings, medical society meetings, professional society meetings, etc.	DY1, Q3	
11. Compile and analyze responses to assessment tool. Among other things, compute what percent of Medicaid costs/revenues attributable to MCC providers are currently covered by a VBP contract. Project the extent to which the 90% VBP goal would be met if all respondents to the assessment survey entered into VBP arrangements.	DY1, Q4	
12. Analyze state's most up-to-date VBP Roadmap and other related materials to determine all elements that need to be included in MCO strategy for transforming to a VBP system.	DY1, Q4	
13. Incorporate assessment and other findings in a written MCO strategy that is presented to and approved by Finance Committee and Board of Managers.	DY1, Q4	
Milestone 5: ***Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest***	DY2, Q3	Value-based payment plan, signed off by PPS board Subsequent quarterly reports will require updates on implementation of that plan.
1. VBP Sub-Committee will compile a set of principles to guide development of multi-year strategic plan to transition to a system that has 90% of Medicaid payment under a VBP system. Such principles shall include but not be limited to: *- Provision of technical assistance to providers* *- Opportunities for both payers and providers to share savings generated if agreed-upon benchmarks are achieved* *- Phased-in three-year approach to permit providers to successfully transition to VBP system* *- Assurance that quality goals of VBP payment plans match those of MCC* *- Rewards for both improved performance as well as continued high performance*	DY2, Q2	
2. PPS will reach out to PPS providers at meetings and conference calls to solicit provider input on the best approach for attaining VBP goal and to build collaboration and consensus among providers for determining strategies for contracting with MCOs.	DY2, Q2	
3. Finance Committee and Board of Managers will approve principles governing VBP transition plan.	DY2, Q2	
4. Working in concert with MCOs, determine VBP options that will be made available to providers. For example, bundled payments for episodic care; payments for continuous care to persons with chronic disease; VBP plans for serving special populations (e.g., developmentally disabled); population health related VBP initiatives that focus on overall outcomes and total cost of care; specific risk-sharing arrangements, etc.	DY2, Q2	
5. Work to secure MCO –provider contract arrangements that follow a similar set of rules and conditions to reduce administrative burden; standardize definitions involving PCMH care, integrated care, care bundles, and risk-adjustment methodologies; outcomes that correspond with DSRIP metrics; standard risk-adjusted measures; and clear definitions of attributed Medicaid lives.	DY2, Q3	
6. Conduct an environmental scan of issues that may impede the transition to VBP system, including, but not limited to: healthcare IT capabilities of both providers and MCOs; availability of systems to monitor providers' VBP performance; lack of experience in VBP contracting by both providers and MCOs; etc.	DY2, Q3	

7. Using assessment data, Salient data, and MCO provider-specific data, identify which providers and PCMHs have the capacity to expeditiously engage in VBP contracting.	DY2, Q3	
8. Place providers and PCMHs in one of three VBP readiness rankings (advanced, moderate, or low) based on results of assessment, Salient data, and MCO provider-specific data.	DY2, Q3	
9. For each provider grouping (advanced, moderate, low), set forth a possible transition plan covering years 3, 4, and 5 of DSRIP. For example, a moderate ranked hospital provider in DY3 could engage in level 1 VBP (FFS with upside only shared savings); transition to level 2 VBP (FFS with upside and downside risk sharing) in DY4 ; and in DY5 enter into global capitation contracts.	DY2, Q3	
10. Facilitate engagement sessions between advanced providers and MCOs to discuss requirements and process of engaging in VBP contracting.	DY2, Q3	
11. Work with moderate and low ranked provider groups to set forth transition pathways and to assist them in contracting with MCOs. Objective is to ensure that all providers are engaged in some level of a VBP contract by DY3.	DY2, Q3	
12. Work in concert with MCOs to provide value-based benefit designs that incentivize patients to engage in wellness programs, stop smoking, follow care plans etc.	DY2, Q3	
13. Finalize VBP transition pathways for DY3, DY4, and DY5 for low, moderate, and advanced ranked providers.	DY2, Q3	
14. Submit VBP Transition plan to MCC providers for their review and to obtain their feedback.	DY2, Q3	
15. Make any necessary amendments to the VBP Transition Plan and submit plan to providers for their adoption.	DY2, Q3	
16. Submit VBP Transition Plan to Finance Committee and Board of Managers for review and approval.	DY2, Q3	
17. Make provisions to update the status of the VBP transition plan on a quarterly basis.	DY2, Q3	
NOTE: PPSs will ultimately be required to set target dates for the following three milestones, as well as the milestones above. However, this will not be required until the VBP Roadmap is confirmed and all milestone targets are finalized. A detailed timeline setting out the due dates for all the elements of the implementation plan that are not required by April 1st will be published shortly.		
Milestone 6: ***Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation***		
Step 1…		
Step 2…		
Milestone 7: ***Contract 50% of care-costs through Level 1 VBPs, and ≥ 30% of these costs through Level 2 VBPs or higher***		
Step 1…		
Step 2…		
Milestone 8: ***≥90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher***		
Step 1…		
Step 2…		

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: Reduction in hospitalizations (overall goal of DSRIP projects) will result in revenue losses for hospitals due to decreased utilization. Skilled nursing facilities will also experience a drop in revenue.
Mitigation: The shift to VBP will be important for the long-term sustainability of these facilities in spite of reduced utilization. MCC will implement bundled payments, shared savings models, and other VBP approaches to ensure providers can continue to operate beyond the five years of the Waiver.

Risk #2: Difficulty in engaging the payers. The Medicaid MCOs seem reluctant to engage with the PPS and are taking a "wait and see" approach since they will reap the benefits of the DSRIP delivery model whether they actively participate or not. Many of the enhanced services described in the projects (e.g., care coordination, peer navigation, crisis stabilization) are not consistently billed, coded, or reimbursed under current models. Without involvement and investment from the major payers and Medicaid MCOs, providers won't be able to afford to offer enhanced and expanded services. This will make it impossible to earn achievement values for implementation and engagement.
Mitigation: Request support from NYS DOH urging payers to participate in DSRIP initiatives. Collaborate with payers on VBP structures, reporting practices, and metrics. The Finance Committee will constantly communicate with the Medicaid MCOs as an attempt to actively engage them in the process. The PPS may require assistance or intervention from NYS DOH with some payers. Several DSRIP projects provide case/care management services to many kinds of patients (e.g., chronic diseases, pregnant women); these services will augment the payers' existing programs, allowing them to benefit from healthier members without adding to their care management staff.

Risk #3: Insufficient DSRIP revenue stream. Lack of revenues could impact project performance and lead to disinterest by providers.
Mitigation: Educate providers that VBP is a long-term solution for achieving financial sustainability that is not dependent on DSRIP revenues.

Risk #4: Partners' inability to provide data or reluctance to share data. Inability to access data or validate analytics.
Mitigation: Constant communication with the partners who are unable or unwilling to provide data. Communications will explain the rationale and necessity for data sharing to meet project goals and metrics, and will ultimately impact or inhibit the flow of funds to PPS partners who are most in need. Appropriate security and privacy policies will be established and enforced across the PPS. Partners will be involved in the establishment of these policies, to encourage widespread buy-in.

Risk #5: PPS providers are not compliant with PPS provider agreements and reporting requirements. Reporting requirements are overwhelming or unclear to providers. If providers do not fulfill their reporting requirements, performance levels across the PPS will suffer.
Mitigation: Provide timely and clear communication with and among PPS stakeholders. Offer simple, easy-to-follow instructions and training sessions. Conduct test runs of reporting and data functions to meet quarterly and semi-annual reporting.

Risk #6: Reports are confusing, and PPS participants don't look at them.
Mitigation: To create a reporting culture throughout MCC, all stakeholders will need an easy, clear means for understanding whether targets are being met or not. Simplify this process for partners.

Risk #6: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #7: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #8: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (IT Systems and Processes, Clinical Integration, etc.)

Finance Committee members will be actively engaged with all PPS committees and project leaders. The finance function will need to understand the requirements and participation level for all projects, project performance measurement and reporting, and project costs and impacts. Finance team members will also actively participate in clinical discussions related to PPS projects.

The IT Systems & Processes workstream is dependent on Financial Sustainability: Once providers have adopted the technologies required under DSRIP, the costs do not go away. It will be important that providers are able to meet the continuing costs of additional and updated IT assets. As security and privacy regulations grow in complexity and scope, the costs of maintaining a secure system that shares data and meets regulatory/confidentiality requirements will only increase. Finance will also support access to data regarding project performance, platform integration, and Rapid Cycle Evaluation.

Governance: Well-defined roles and responsibilities for the PPS lead, partners, and in particular for finance, compliance, and audit, will need to be established. Financial sustainability will be necessary to maintain a governance structure for continued improvements and common goals with the Medicaid populations in the future post-DSRIP transformation.

Workforce: The finance team will need to understand the workforce strategy and plans, as well as related transition costs. Finance will support the tracking of costs and impact on full-time equivalents, compare actual to projected, and define how workforce spending will be tracked/reported to PPS and DOH.

Performance Reporting: The analytics software used for DSRIP needs to be available and maintained by the lead entity. It needs to have software upgrades and be available for continued use by the practices for continued performance reporting and quality needs.

Provider Engagement: Ongoing community-wide provider engagement for the Medicaid population is critical. Financial Sustainability needs to be linked to improvement in outcomes ongoing. Financial sustainability will be affected by continuation of a community-wide forum. With new alliances being formed, the hope is they will continue to expand and flourish with a new sense of purpose.

Population Health Management: Population health management and stratification of registries is not possible without robust clinical analytic software. The financial sustainability of this is tied with performance reporting and ongoing management of the software.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Project managers for each project	***Various individuals***	***Develop implementation and operational budgets necessary for project success***
MCC Director of Finance	***New hire***	***Manage finance functions of the PPS; oversee receipt, distribution, and safekeeping of DSRIP funds; hold responsibility for reporting, both externally to NYS DOH and other regulatory bodies, and internally to the governing committee and work groups***
Accounting Manager	***Initially an outside accounting firm***	***Develop infrastructure for finance office including general ledger, accounts payable, and payroll functions***
Accounts Payable	***Outside firm***	***Day-to-day accounts payable function, including obtaining approval of invoices, processing for payment, check printing, and reporting***
Payroll	***Outside firm***	***Payroll processing function, including timekeeping, obtaining approval for payment, processing payroll, check distribution, and reporting***
MCC Compliance Officer	***Greg Hammer***	***Oversee compliance programs of PPS activities, including adherence to the compliance requirements of the lead entity***
Audit	***Outside firm***	***Perform audits according to standard accounting principles***
Subject matter expertise	***VBP Sub-Committee***	***Develop VBP Transition Plan; oversee implementation of the plan***
Health plans	***Blue Cross Blue Shield, Univera, Fidelis, Independent Health***	***Establish VBP partnership with MCC; submit claims accounting for payment reconciliation***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal stakeholders		
Troncani	***Accounting firm contracted by MCC***	***Financial management and auditing***
Finance Committee	***Oversight and direction***	***Review/approve MCO Strategy for VBP Transition and VBP Transition Plan; ensure VBP initiatives are aligned to DSRIP goals; review, approve and monitor implementation of financial stability plan, distressed provider plan, project impact matrix, and financially fragile watch list***
Board of Managers	***Oversight***	***Review/approve VBP Transition Plan; monitor and audit fiscal operations; resolve conflicts; adopt Finance Committee charter; adopt financial stability plan; adopt distressed provider plan; review and approve project impact matrix; approve financially fragile watch list; adopt MCO Strategy for VBP Transition***
MCC Finance Director	***Lead implementation***	***Management and distribution of project funds; oversee all financial operations of PPS; oversee implementation of financial stability plan, and distressed provider plan; continually update financial status of providers; monitor financially fragile watch list; ensure sound financial reporting***
Executive leadership and board members of provider partners	***Oversight and participation in decision-making***	***Stay involved in financial activities of MCC PPS; actively participate in development of VBP Plan; as appropriate, report on financial status of their institutions and on efforts to improve financial performance***
External stakeholders		
External auditing firm	***External audit***	***Perform audit of PPS financial operation including internal controls and financial reporting***
NYS DOH Liaison	***Liaison***	***Serve as liaison between NYS DOH and PPS; provide updates on NYS DOH expectations and deliverables***
NYS DOH	***Governance***	***Define DSRIP requirements***
Community representatives	***Provider partners and representatives***	***Regular, timely, effective communication with community groups and organizations***
Health foundations/grant coalitions	***Bridge funding***	***Fund MCC initiatives via coalition grants***
Independent Health, Blue Cross Blue Shield, Fidelis, Univera and other health plans	***VBP transformation***	***Establish VBP partnerships with MCC providers; share essential data with MCC to facilitate development of VBP strategies***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

The finance workstream will require a suite of standard accounting applications as well as the ability to pull in data from providers across the PPS. MCC will use existing hardware and software, where possible, for basic financial reporting. It will be critical to be able to bring in progress indicators from other workstreams/projects to convey to finance; this may be done manually at first (similar to the initial financial health assessment), but ultimately we envision a central, integrated repository MCC can use to monitor PPS financial stability. It may be necessary to establish a "reporting portal" for partner organizations to submit financial performance information easily on an ongoing basis. The financial performance of MCC will also be reliant upon IT innovations that support population health and care coordination performance and drive financial results for the MCC PPS.

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

Progress reporting will be aligned with a phased approach to implementing the overall financial sustainability strategy. Success will be measured initially by finalizing appointments, staffing the Finance Committee, completing a financial health current state assessment of providers, adopting distressed provider plans, establishing a financially fragile watch list, and developing an MCO Strategy for VBP Transition as well as VBP Transition Plan. These efforts will culminate into a financial sustainability strategy, which will be used to report quarterly project- and unit-level progress.

The progress of MCC's financial sustainability efforts will be measured by:
- *Finalized finance structure, including reporting structure approved by the Board of Managers*
- *Finalized Compliance Plan consistent with NYS Social Services Law 363-d approved by the Finance Committee and Board of Managers*
- *Development of a VBP Sub-Committee charter to be approved by the Finance Committee and Board of Managers*
- *Development of a set of principles to guide development of multi-year strategic plan to transition to a system that has 90% of Medicaid payment under a VBP system to be approved by the Finance Committee and Board of Managers*
- *Development of a systematic approach to designing and conducting annual provider financial health evaluation policies and procedures approved by the Finance Committee and Board of Managers*
- *A network financial health current state assessment*
- *Provider willingness and readiness assessments within the network to engage in various levels of VBP contracting*
- *Development of communication and education plans explaining NYS DOH's VBP agenda and goals*

The finance structure will at minimum include the following:
- *Organizational chart*
- *Internal and external functions, roles, and responsibilities*
- *Flow chart of internal and external reporting requirements*
- *Identification and development of policies and procedures*
- *A regular meeting schedule and meeting minutes*

Quarterly project- and unit- level reports to mark progress towards financial sustainability will include but are not limited to:
- *Finance Committee charter, meeting schedule, and minutes*
- *Finance structure/organizational chart and reporting flowchart*
- *Number of financial policies and procedures developed*
- *Number and type of changes and updates to charters, schedules, organizational or reporting structure, policies, and procedures*
- *Number/percent of providers in network that are financially fragile*
- *Progress towards the implementation of a finalized compliance plan for NYS Social Services Law 363-d*
- *Progress towards implementation of a finalized MCO strategy for VBP transition and the VBP transition plan*
- *Percent of care costs going through VBPs (Level 1 and Level 2)*
- *Status of the PPS's financially fragile providers (as defined by specific financial indicators including but not limited to days cash on hand, debt ratio, operating margin, and current ratio); how their financial status affects performance; identification of additional financial fragile partners; actions taken to improve these providers' financial status*

Pursuant to Financial Stability Plan, MCC will conduct an annual financial health assessment of MCC providers and assessment results will be reported to the Finance Committee and MCC Board of Managers. Financially fragile providers will be placed on a financially fragile watch list and, as noted above, the financial status of these providers along with all actions taken to improve performance will be reported to the Finance Committee and MCC Board of Managers on a quarterly basis.

All progress reports relating to the Finance workstream will be forwarded to the Finance Committee and the MCC Board of Managers.

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

Cultural Competency and Health Literacy

Key Steps and Measurable Milestones

Domain 1 Process Measures

Progress Reports on the Implementation of the Cultural Competency/ Health Literacy Strategies	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Finalize cultural competency / health literacy strategy.***	DY1, Q3	Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes. Subsequent quarterly reports will require updates on the implementation of your cultural competency / health literacy strategy.
1. Using the Community Needs Assessment (CNA) as a foundation, MCC will work to uncover health disparities among different cultural, socioeconomic, and linguistic groups by extracting profiles of Medicaid enrollees attributed to MCC by race, ethnicity, primary language, and rural/urban status.	DY1, Q2	
2. Based on research findings, determine what factors are causing poor health outcomes among identified population groups (e.g., lack of a regular source of primary care, high emergency department (ED) utilization rates, disease complexity factors). Identify potential reasons for under-utilization of primary care and other services by these populations and define priority communities.	DY1, Q2	
3. Develop and issue a request for proposals (RFP) from qualified agencies to spearhead MCC's cultural competency and health literacy program. Selected contractor will be responsible for development, implementation, and operation of a comprehensive cultural competency and health literacy program.	DY1, Q2	
4. Evaluate RFP responses and select qualified entity to operate cultural competency and health literacy program on behalf of MCC.	DY1, Q2	

5. Selected contractor will survey and canvass community-based organizations (CBOs), both those with a long tradition of serving at-risk communities and those that are emerging (particularly in new/immigrant neighborhoods). Objective is to gain further knowledge of the reasons for under-utilization of healthcare services, obtain suggestions for improving access to primary and behavioral health services, and shed light on the service roles and capabilities of these CBOs.	DY1, Q3	
6. Contractor will interview healthcare practitioners and support staff located within or near targeted communities to assess the cultural competency of providers (e.g., language and composition of provider staff) and uncover barriers to care (e.g., location of offices, operating hours, lack of transportation).	DY1, Q3	
7. MCC will issue a survey instrument requesting practitioners and provider representatives to complete a self-assessment that will help gauge health literacy and cultural competency training needs.	DY1, Q3	
8. Contractor will conduct a gap assessment to: (a) compare health disparities of specific targeted populations with linguistic and other cultural competency determinants among community providers; (b) evaluate accessibility of services at those locations where target populations receive care; (c) identify roles and extent to which CBOs are involved in serving target populations ; and (d) develop findings to spur future action.	DY1, Q3	
9. Working in concert with MCC, cultural competency and health literacy contractor will reach out to Medicaid Managed Care Organizations, local literacy groups , MCC project leaders, behavioral health professionals, agencies serving the developmentally disabled, and others (e.g., P^2 Collaborative of WNY) to obtain recommendations on: (a) language-appropriate patient engagement materials; (b) techniques for engaging patients with low literacy rates; (c) use of teach-back methods in patient-centered medical homes and other settings; (d) assessments and tools to assist patients with self-management of conditions; and (d) other tools for promoting health literacy.	DY1, Q3	
10. Based on canvass, interviews, and assessments, develop literature and material to improve health literacy of targeted populations that cover topics such as when to use the ED, the importance of primary care, overcoming mental health stigma, navigating the health system, and questions to ask your provider.	DY1, Q3	
11. Engage the "Voice of the Consumer" Sub-Committee and CBO Task Force to assist in the health literacy improvement effort. Members of these groups will review patient education materials, make recommendations to improve patient communications, and provide plain language suggestions to enhance patient understanding of written materials (prescriptions, discharge plans, educational materials, treatment orders, etc.).	DY1, Q3	

12. Develop and finalize plan for distributing health literacy materials via the MCC website and at primary care practices, mental health clinics, drug and alcohol treatment centers, EDs, hospitals, and agencies serving the developmentally disabled, etc.	DY1, Q3	
13. Utilizing findings from cultural competency gap assessment, evidence-based cultural competency approaches, and health literacy-related recommendations, contractor will prepare draft Cultural Competency and Health Literacy Strategy, including planned training initiatives and community-based interventions to reduce health disparities and improve outcomes.	DY1, Q3	
14. Submit proposed Cultural Competency and Health Literacy Strategy to Clinical/Quality Committee, CBO Task Force, and "Voice of the Consumer" Sub-Committee for their review. Amend plan to reflect recommendations.	DY1, Q3	
15. Submit Cultural Competency and Health Literacy Strategy, including training plan, to Board of Managers for approval and post approved plan on MCC website.	DY1, Q3	
16. Establish system for issuing quarterly reports to provide updates on Cultural Competency and Health Literacy Strategy.	DY1, Q3	
Milestone 2: ***Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).***	DY2, Q1	Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches Subsequent quarterly reports will require evidence of training programs delivered. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
1. Issue an RFP from CBOs to serve as trainers for MCC's cultural and health literacy program. A minimum of 12 CBOs representative of the three sub-regions of the PPS (North: Niagara and Orleans Counties; Central: Erie, Genesee, and Wyoming Counties; and South: Allegany, Cattaraugus, and Chautauqua Counties) will be selected.	DY1, Q3	
2. Select CBOs responding to survey based on their capabilities and the extent to which they serve under-served population groups and communities that were identified in previous research (milestone #1).	DY1, Q3	
3. Working with IT team, contractor will develop content for web-based cultural competency and health literacy learning platform.	DY1, Q3	
4. Contractor will develop a comprehensive plan for providing in-person and web-based cultural competency and health literacy training to representatives of CBOs.	DY1, Q3	
5. Commence training of CBO representatives who will serve as trainers for the cultural competency and health literacy initiative.	DY1, Q4	

6. Develop and wage an ongoing communication effort to encourage MCC partners to actively engage in training and other programming to improve the cultural and health literacy competency of partners' providers and staff. Work will be led by MCC communication staff with input from health literacy/cultural competency contractor, "Voice of the Consumer" Sub-Committee, and CBO Task Force.	DY1, Q4	
7. Recruit cultural competency champions from MCC-affiliated providers, agencies, and CBOs.	DY1, Q4	
8. Using results of gap assessment and other findings, develop priority target list of providers, agencies, and CBO sites for cultural competency and health literacy training.	DY1, Q4	
9. Working in concert with cultural competency champions, schedule onsite cultural competency and health literacy training that will be provided by trained CBO representatives as well as by contractor.	DY1, Q4	
10. Begin onsite training at MCC partner sites, including primary care practices, behavioral health agencies, addiction treatment centers, CBO service sites, etc. directed to practitioners and staff and focused on the core competencies of delivering culturally competent, health-literate care.	DY1, Q4	
11. Populate cultural competency and health literacy learning platform with lessons learned and continue to build educational resources on the website.	DY2, Q1	
12. Perform an evaluation of cultural competency and health literacy training initiative to pinpoint any gaps and needed improvements to strengthen training before proceeding to the next training phase.	DY2, Q1	
13. Review progress and issue first quarterly report to MCC Board of Managers, "Voice of the Consumer" Sub-Committee, and CBO Task Force on number of partners receiving training, participant-level data, description of training provided, training outcomes, health literacy materials that have been developed and tested by consumer input, and other cultural competency and health literacy activities.	DY2, Q1	

Key Issues

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing your cultural competency / health literacy strategy and addressing the specific health disparities you are targeting (based on your CNA), and achieving the milestones described above - including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: PPS provider receives revenue from MCC without Cultural Competency/Health Literacy training.
Mitigation: Provide classes with continuing education credits and celebrate all providers who complete training in PPS publications and on social media.

Risk #2: CBOs are not compensated or recognized for their participation in training.
Mitigation: Include training compensation and recognition. Create an accreditation (e.g., CBOs of Health Excellence).

Risk #3: Training is considered unnecessary or a waste of time.
Mitigation: The training design is to teach and entertain in order to create memorable moments. We will use the Program to Enhance Relational and Communication Skills (PERCS) model of realistic enactments with professional actors, collaborative learning, reflection, and feedback.

Risk #4: Stability of CBOs. Many CBOs are small, with a small staff who are already multi-tasking, and insecure funding. This project requires stable, experienced CBOs so clients have confidence in them being there when they need them. We also need to know that the trainers we invest in are going to able to attend "train the trainer" sessions and consistently serve as lead trainers.
Mitigation: Include an organizational profile which includes financials and staffing as part of the RFP process for selecting CBOs who will serve as lead trainers. Also consider the number of clients they serve and whether or not they have multiple sites. Identifying these organizations as primary training sites would increase our opportunity to reach the underserved/uninsured population we are seeking.

Risk #5: An individual's literacy level is a highly personal and sensitive area that requires building trust with a nonjudgmental approach.
Mitigation: In addition to the CBOs, we also need to provide in-community health literacy collaborations which include public libraries and faith-based sites to make health literacy a community initiative. The objective will be to reach community members in the diverse environments where they are already comfortable, to maximize consumer engagement.

Risk #6: Overlapping PPSs in WNY.
Mitigation: Work with Catholic Medical Partners and Finger Lakes PPS to coordinate efforts. MCC has met with the other PPSs and with the Population Health Improvement Program grantee in WNY (P^2 Collaborative of WNY) to identify potential areas of collaboration including conducting focus groups; designing training programs; and collecting quality metrics related to race, ethnicity, and language.

Risk #7: Lack of patient engagement. Changes are made "in a vacuum" and do not meet actual patient/caregiver needs.
Mitigation: Community participants play vital roles in the cultural competency and health literacy training development and its successful implementation. Their participation and feedback in assessments, through focus groups, on social media, and in face-to-face meetings will instruct us on what will work, what does not, and how we should change things in order to make this healthcare transformation meet their needs.

Risk #8: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #9: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #10: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe any interdependencies between this and any other workstreams (IT Systems and Processes, Practitioner Engagement, Financial Sustainability, etc.)

There are several interdependencies between the cultural competency and health literacy workstream and other workstreams and project initiatives:

Cultural competency and health literacy training will be a key element of clinical integration activities. The aim is to give providers the training they need to be sensitive and responsive to the cultural needs of their patients, a key element for promoting ongoing patient engagement with the healthcare system.

The cultural competency and health literacy program will buttress the project 2.d.i. (Patient Activation). All patient activation coaches will be required to complete cultural competency and health literacy training as a means for improving their effectiveness in motivating patients and making sure they understand medication and plan of care instructions.

The effectiveness of the cultural competency and health literacy program will be dependent upon a supportive governing body that elevates the importance of this work.

The cultural competency and health literacy effort will be dependent upon the strength of CBOs. At least 12 CBOs will serve as cultural competency and health literacy trainers, and the CBO community will be tapped to promote participation in this essential training.

The effectiveness of the PPS's communication strategies will be dependent upon the use of health literate educational materials and other communications that can be readily understood by diverse cultural and ethnic communities across WNY.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
MCC Workforce Development Director	New hire	Advise, develop, train, implement, monitor, and plan implementation team; identify cultural competency topics and implementation plan
MCC Director of Community-Based Initiatives	Catherine Lewis	Solicit and engage CBOs; secure master agreements; coordinate "Voice of the Consumer" Sub-Committee and CBO Task Force
Director of MCC Operations	Juan Santiago	Manage CBO RFP/procurement process
Cultural competency champions	CBOs, PPS partners	Attend "train the trainer" classes; coordinate and deliver cultural competency/health literacy activities to community members at their respective sites
Minority business relations	Janique Curry	Facilitate inclusion of Minority- and Women-Owned Business Enterprises (MBE/WBEs); support organizations seeking MBE/WBE certification

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal stakeholders		
Providers	Patient care	Ensure office practices are sensitive to cultural diversity and health concerns of their population; deliver culturally sensitive care
MCC Continuing Education Manager	Training oversight	Ensure all training is conducted with cultural sensitivity; develop training necessary for raising awareness on cultural diversity and health literacy; consider a dissemination plan for education developed

Staff	***Consumer and patient administrative support***	***Ensure staff conducts business with astuteness for cultural diversity and various health literacy levels; delivery culturally sensitive care***
External stakeholders		
Patients, caregivers	***Care seekers***	***Remove barriers to effective care due to cultural sensitivities; strive towards personal success goals***
Community participants	***Patients, patient support***	***Encourage awareness of cultural norms; support diversity***
211 information referral line	***Consumer resource information***	***Provide links to and information about culturally aware and health literacy-appropriate services***
Literacy Volunteers of Buffalo	***Educational resource***	***Include topic of health and cultural diversity in literacy education***
Centers for Disease Control and Prevention	***Resource for patients and caregivers***	***Provide free educational materials for varied cultural ethnicities and languages***
Jericho Road	***PCP/FQHA***	***Provide medical care in a transcultural, diverse, and culturally sensitive medical home especially for refugees and low-income community members***
International Institute; Journey's End; Jewish Family Services; Hispanics United of Buffalo (HUB); Native American Community Services; area Indian reservations; Olmsted Center for the Blind; Deaf Access Services; St. Mary's School for the Deaf; Gay/Lesbian Youth Services (GLYS); Pride Center of WNY; Autism Services Inc. of WNY; etc.	***Support, outreach, advocacy***	***Provide support and outreach services tailored to specific populations and groups; ensure services are offered in culturally sensitive and linguistically appropriate formats; promote community awareness and understanding of specific populations/groups***
UB Educational Opportunity Center	***Literacy and workforce development***	***Literacy for adults; culturally sensitive workforce development services***
Local school districts, BOCES	***Education resources***	***Literacy for adults and children***
Catholic Charities	***Social determinant of health support services, i.e., counseling, housing, etc.***	***Offer supportive guidance services with cultural diversity and literacy sensitivity***
Community health workers	***Care coordination***	***Provide care coordination/navigation services in culturally and linguistically appropriate formats/settings***
Lakeshore Behavioral Health	***Behavioral health services***	***Work with refugee population***
Retired Peace Corps Volunteer Group	***Speakers for community forums***	***Assist with cultural awareness discussions, forums, and roundtables***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support the development and implementation of your cultural competency / health literacy strategy and the achievement of the milestones described above.

A shared IT infrastructure will be used to store and disseminate standardized health education and sample conversation scripts that will be used by providers throughout the PPS. This information will be pre-authorized with respect to meeting cultural competency and health literacy standards. A shared IT structure will also be used to track and monitor partner engagement in cultural competency and health literacy training.

Progress Reporting

Please describe how you will measure the success of your cultural competency / health literacy strategy, including reference to specific health disparities.

Progress reporting will be aligned with the phased approach to implementing the overall cultural competency strategy. Establishment of project- and unit-level reporting frequency will be based on the internal and external reporting requirements to ensure the success of the PPS-wide cultural competency strategy which will be consistent with cultural and linguistic needs of the population.

The progress of MCC's cultural competency and health literacy efforts will be measured by:
- *Finalizing the makeup of various committees/groups (CBO Task Force, etc.)*
- *Designing and administering stakeholder and health literacy assessments*
- *Aggregating and analyzing responses to identify gaps and areas of focus*
- *Communicating the results*
- *Developing a comprehensive training strategy to address drivers of health disparities to be approved by the Board of Managers*

Progress towards these overall goals will be reported quarterly based on several indicators, such as:
- *Percentage of assessments completed*
- *Health disparities relating to access to care among uninsured and low/non-utilizing Medicaid patients*
- *The percentage of uninsured and low/non-utilizing Medicaid patients who completed a patient activation screen and are connected to care*

The progress of the MCC cultural competency training plans will be analyzed and reports will be developed to assess the following:
- *Number of training programs delivered each quarter*
- *Geographical locations of trainings*
- *Number of CBOs serving as cultural competency/health literacy trainers*
- *Number of CBO staff trained to serve as trainers*
- *Percentage of total PPS partners who participated in cultural competency/health literacy training*
- *Percentage of partner staff who completed training*
- *Training outcomes*
- *Training satisfaction rate*

Monthly and quarterly reports will track development of materials/programs/publications and the status of efforts to test these materials in pilots or focus groups.

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

IT Systems and Processes

Key Issues

Current state analysis	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).***	DY1, Q4	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment. Subsequent quarterly reports will require updates on the key issues identified and plans for developing the PPS's IT infrastructure.
1. Establish an IT governance structure including a charter, goals and objectives, reporting structure, budget, and reporting responsibilities. IT governance will engage representatives from all entities in the MCC corporate structure to participate in the IT governance process.	DY1, Q2	
2. Define requirements to provide IT solutions to meet the goals and objectives outlined in MCC IT needs, including but not limited to: EHR, care management, direct messaging, patient portal, patient activation, telehealth, HEDIS, grouping (3M), security tools, and back office tools including project management and finance software.	DY1, Q2	
3. Determine approach to assessing the capabilities of MCC participants and their ability to meet the requirements defined in Step 2. MCC participants to include all providers of services (medical, behavioral, post-acute, long-term care, and community-based service providers as well as payers and social service organizations). Approach will leverage existing data sources and direct interviews and surveys as appropriate.	DY1, Q2	
4. Assess capabilities from HEALTHeLINK (Qualified Entity) against defined requirements. Review HEALTHeLINK proposal to support DSRIP organizations.	DY1, Q2	
5. Roll out initial communication and education to all PPS members via electronic means and workshops.	DY1, Q2	
6. Conduct current state assessment utilizing the approach identified in Step 3. Gathered data should focus on vendors/systems/applications, interoperability capabilities, capabilities of staff, and planned or current data sharing activities. Key data points should include Meaningful Use (MU) status and plan as well as current use of Direct secure data sharing protocol.	DY1, Q3	
7. Develop Gap Analysis against defined requirements. Prioritize the defined gaps against the potential impact of the gap and required timeline for delivery.	DY1, Q3	

8. Develop strategy and approaches to closing or remediating identified gaps. Potential strategies include leveraging existing capabilities, selecting/procuring new solution sets, and/or providing services and capabilities to MCC participants directly. In addition, document MCC's intentions to leverage technology to support its business and strategic vision through development of the IT Target Operating Model (TOM). The TOM plan will include business operations model and IT systems model deliverables which include working, outcomes, access, care coordination, and prevention views.	DY1, Q4	
9. Develop implementation plan based upon the identified gaps. Include capabilities, intended organizations, technical approach, capital, and resources required for successful implementation.	DY1, Q4	
10. Obtain Board of Managers approval for IT strategy and IT implementation plan.	DY1, Q4	

IT Governance	***Target Completion Date***	***Supporting Documentation***
Milestone 2: ***Develop an IT Change Management Strategy***	DY1, Q4	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes Subsequent quarterly reports will require an update on the implementation of this IT change management strategy.
1. Develop the PPS plan for IT Change Management Strategy, including oversight and governance processes and interaction/monitoring by appropriate entities.	DY1, Q3	
2. Communicate change management policies to all stakeholders for management of high-impact changes that affect the entire PPS.	DY1, Q3	
3. Assign responsibility for driving the IT Change Management Strategy to members of the IT Data Committee and other key stakeholders as appointed by the Board of Managers.	DY1, Q3	
4. Establish change management procedures including the following tasks: review, approve/reject, communicate, and monitor including tracking and reporting.	DY1, Q4	
5. Develop or procure a tool or technology to assist in management of the change management system.	DY1, Q4	
6. Coordinate and communicate all activities to stakeholders including PPS members to leverage the change management system.	DY1, Q4	
7. Build an appropriate change management culture throughout the MCC community.	DY1, Q4	

8. Develop the impact analysis processes for change requests. These processes should address contingencies, allow stakeholders to communicate concerns, identify and establish a specific maintenance window, and include an adequate fallback plan.	DY1, Q4	
9. Define processes and workflows including but not limited to documentation of information related to high-level testing, communication and resource plans, required meetings, timely decisions, change management work processes, and post-change analysis for process improvements.	DY1, Q4	
10. The Board of Managers will review/approve the IT Change Management Strategy.	DY1, Q4	
11. Conduct quarterly audits of the change control process, ensuring its effectiveness and modifying the IT Change Management Strategy as needed.	DY1, Q4	

Data Sharing	***Target Completion Date***	***Supporting Documentation***
Milestone 3: ***Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network***	DY1, Q3	Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing). Subsequent quarterly reports will require updates on your implementation of this roadmap and an an update on any changes to the contracts / agreements in place.
1. Determine the need for data sharing agreements between MCC and all participating PPS providers. Review the applicable law and assess agreements for data sharing currently in use by Qualified Entity (HEALTHeLINK) and MCC providers.	DY1, Q2	
2. Establish and obtain approval of an MCC data governance plan, including requirements of the PPS members and project data sharing needs.	DY1, Q2	
3. Create policies and procedures for data sharing, including data sharing requirements between PPS members and external entities.	DY1, Q3	
4. Establish data formatting, nomenclature, and data schema policies for all interfaces.	DY1, Q3	
5. Based on legal analysis, the DEAAs will incorporate PHI, BAAs, and other elements and will be finalized and executed within the PPS network.	DY1, Q3	

6. Complete the execution of all required data sharing agreements within the PPS network.	DY1, Q3	
7. Verify two-way data flow, where approved and appropriate, to all systems identified. Data flows need to be secure, logged, and monitored.	DY1, Q3	
8. Begin providing quarterly reports to the Board of Managers detailing the status of the signing and execution of the DEAAs.	DY1, Q3	
Milestone 4: ***Develop a specific plan for engaging attributed members in Qualifying Entities***	DY2, Q1	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities. Subsequent quarterly reports will require updates on your progress in implementing this plan.
1. Develop high-level strategy engaging PPS members and any community RHIO or data exchange (Qualified Entities) entity which are identified as critical to the success of this initiative. IT TOM will be utilized to identify requirements and IT systems required to assist in the enablement of patient engagement and RHIO/data exchange.	DY1, Q2	
2. Identify gaps for engagement with PPS members and Qualified Entities, including analysis and determination of outreach strategies, patient portals, patient communications, and call centers.	DY1, Q2	
3. Identify remediation for gaps in engagement with PPS members and Qualified Entities.	DY1, Q2	
4. Define patient engagement goals and objectives; include metrics and monitoring processes to verify adherence to goals and objectives.	DY1, Q2	
5. From Steps 1-4, develop plan to implement and maintain engagement. This includes workflows, processes, procedures, and tools.	DY1, Q3	
6. As part of the development of the Engagement Strategy and Plan, identify the different communication methods and techniques including objectives and proposed tools. *- Provider-to-Provider* *- Provider-to-MCC* *- Provider-to-Home Care* *- Patient-to-Provider* *- External Entity-to-Caregiver*	DY1, Q3	
7. As part of the analysis for the creation of the Engagement Strategy and Plan, identify the linguistic requirements of the region.	DY1, Q3	
8. Incorporate any linguistic requirements into the IT portion of the Engagement Strategy and Plan as needed.	DY1, Q3	
9. Finalize Engagement Strategy and Plan including milestones, workflows, processes, procedures, objectives, and proposed tools.	DY1, Q3	
10. MCC Governance Committee with Clinical Integration Officer reviews and approves Engagement Strategy and Plan.	DY1, Q3	

11. Identify and design tools to address the engagement plan. Identify business/technical requirements including final architecture and downselection of solutions. Determine whether to develop the system internally or leverage a third party. Develop RFP for engagement plan/communication tool.	DY1, Q3	
12. Select vendor from the RFP.	DY1, Q4	
13. Acquire and customize tools for the Engagement Strategy and Plan.	DY1, Q4	
14. Develop and implement the workflows, processes, and procedures to support the Engagement Strategy and Plan.	DY1, Q4	
15. Communicate to PPS members and deploy to MCC the Engagement Strategy and Plan including tools.	DY2, Q1	
Milestone 5: ***Develop a data security and confidentiality plan.***	DY1, Q3	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network. Subsequent quarterly reports will require an update on progress on implementing this plan.
1. Develop a Data Security and Confidentiality Plan.	DY1, Q2	
2. Develop Security Charter and IT Security Program and Management Processes. Obtain Board of Managers approval of program.	DY1, Q2	
3. Coordinate definition and establishment of IT Security Policies and Protocols including data usage policies, data handling policies, and sanctions and penalties policies. Obtain IT Data Committee approval of program.	DY1, Q3	
4. Perform risk analysis of Information security risks, regulatory requirements, and design of controls to mitigate risk. The results of this assessment will be integrated into the IT Security Policies and Protocols to mitigate the identified risk.	DY1, Q3	
5. Provide IT Security Policies and Protocols to be integrated by the IT Data Committee for implementation in all infrastructure, applications, and back office and communications tools deployed.	DY1, Q3	

6. Establish requirements for monitoring data misuse by PPS partners and staff *- Establish logging and monitoring requirements and the support system to deliver* *- Establish IT Security testing tools of IT Security controls to monitor data misuse* *- Design IT Security testing controls* *- Establish automated monitoring and alerting of PPS member and partner adherence to security policies; include reporting and remediation protocols* *- Implement IT security testing controls* *- Monitor interfaces and data exchanges for appropriate use* *- Establish a risk assessment and analysis program* *- Annual risk assessment performed* *- Establish contract with third-party entity(s) to perform vulnerability scanning, penetration testing, security audits, and incident monitoring and response* *- Utilize the Capability Maturity Model as baseline for all assessments and analysis*	DY1, Q3	
7. Establish reporting mechanisms to IT Data Committee and Board of Managers	DY1, Q3	

Major Risks to Implementation and Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in creating and implementing your IT governance structure, your plans for data sharing across your network, your approach to data security and confidentiality, and the achievement of the milestones described above, including the potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: Establishing a PPS-wide IT system and process strategy will be challenging due to the fragmentation of services that are delivered in the market. Additional challenges exist due to the wide geographic distribution of the MCC PPS. This poses a risk to successful and timely deployment of required deliverables to support the development of an IDS. The fragmentation of services and geographic distribution can cause issues in one-on-one and in person communications with providers and community-based organizations. One-on-one interactions are critical to appropriate education and in-servicing to providers and their staff.
Mitigation: Clearly define goals and requirements up front, have a strong program management office/capability, and have a timely and clearly defined communication plan to address at-risk activities. Include videoconferencing and other electronic communication methods.

Risk #2: Attributed members (patients) do not provide the necessary consents to allow sharing of clinical data throughout our PPS. Without a sufficient amount of patient consents, data analytics and population health information will be inaccurate since there would be statistically an insufficient amount of data to perform accurate analysis. Without accurate analysis, the PPS cannot provide quality care and meet the projected community goals.
Mitigation: Develop materials to outline the benefits of sharing clinical data and require all patient access points to educate and capture patient consent documents.

Risk #3: Gap analysis for EHR and data exchange connectivity is not completed in a timely manner. If the gap analysis is delayed, the remaining IT implementation steps will be delayed. This would result in significant delays to meaningful data analysis and thus the improvement of care and desired outcomes.
Mitigation: Develop a strong Program Management Office (PMO) which will clearly define goals and requirements at the beginning of the project, including timelines and key milestones. The PMO will provide reports directly to Board of Managers on a weekly basis. If there are issues identified concerning meeting deadlines, resources will be applied to verify targets are met.

Risk #4: MCC IT leadership and staff are not assigned. Without a dedicated, supporting IT department, there will be a significant delay in deployment of the infrastructure, IDS, HIE, and data analytics systems including the population health and coordination of care applications. Without these systems, the required analytics and clinical data and information required to improve quality of care for patients and obtain desired community outcomes will not be achieved within the identified timeframe.
Mitigation: Engage MCC IT resources by the middle of DY1, Q2.

Risk #5: Local community HIE cannot meet the requirements of the MCC HIE. If the local community HIE cannot support and deliver the contracted services, the MCC will need to build duplicate provider/community organization data interfaces and data normalization, and execute an external HIE network which will take significant time and delay any meaningful action towards delivering desired outcomes and improved community services.
Mitigation: Complete local community HIE gap analysis by MCC IT Data Committee by DY1, Q2. Approach the local community HIE entity with a contract to deliver on specific requirements with hard deadlines and milestones. If deadlines and milestones are not met, penalties and sanctions will be executed.

Risk #6: Responsibility for IT privacy/security is not assigned. MCC needs to create the IT security and privacy charter and security/privacy policies and procedures. Without these policies and procedures, the IT infrastructure might be built non-compliant with HIPAA and NYS regulations. Without compliance, the MCC will not be able to activate their systems thus delay services.
Mitigation: A member of the MCC staff will be assigned the duties of Privacy/Security Officer to ensure MCC's systems and interfaces meet all federal and state regulations. This individual will also be responsible for developing and obtaining the consensus on the security controls in use by all PPS members so that all members freely exchange and utilize data.

Risk #7: PPS members cannot agree to appropriate IT security controls required for data exchange. Since there is an extensive and diverse membership to the PPS, a lack of confidence in the MCC PPS could cause providers and organizations to either exit the PPS program or not become fully committed.
Mitigation: Establish openness, direct engagement, and strong communications between MCC and its partners' representatives. Achieve consensus on security controls and connectivity requirements. Make decisions above board and communicate them. Initiate Active Monitoring of systems and make reports available to all PPS members.

Risk #8: Expense of EHR solution for each provider is not affordable by providers. Without an EHR or access to one, providers will not be able to leverage the information delivered by the IDS, HIE, and data analytics since this information is collected electronically. This would cause the PPS program to fail because the PPS will not be able to enact and deliver on desired outcomes.
Mitigation: Secure value-based performance contracts which provide bonus payments for use of EHR system.

Risk #9: IT security tools cannot be designed until EHR adoption and IDS solution is implemented. IT security tools need to be implemented first so that they are imbedded in the architecture of the IT solutions. This will assist in providing assurance to PPS members that their patient data is secure. Without this assurance, PPS members might not fully participate in the PPS, thus diluting any desired outcomes.
Mitigation: Those with duties/roles related to MCC privacy and security will be involved with all architecture and design solutions for the EHR and IDS solutions. Security solutions should include two-factor authentication, encryption, access management, and active monitoring.

Risk #10: EHR and IDS solution cannot be completed until gap analysis concerning EHR data capabilities and connectivity requirements gathering is completed. Any delay in completion of the gap analysis will cause a delay in the architecture and design of the EHR and IDS solutions. It is a cascade effect. If the EHR and IDS systems design and implementation are delayed, the data analytics, population health and coordination of care systems are delayed. Since privacy/security are overlaid and integrated into all systems, security tool design and architecture will be delayed.
Mitigation: Develop a strong PMO which will clearly define goals and requirements at the beginning of the project including timelines and key milestones. The PMO will provide reports directly to MCC Governance on a regular basis. If there are issues identified concerning meeting deadlines, resources will be applied to verify targets are met. Conduct member gap analysis as soon as possible.

Risk #11: Security policies cannot be completed until PPS members' gap analysis is completed. IT security policies need to be established and consequently imbedded in the architecture of the IT solutions. This will assist in providing assurance to PPS members that their patient data is secure. Without this assurance, PPS members might not fully participate in the PPS, thus diluting any desired outcomes.
Mitigation: The security policies are consensus documents based on agreement among PPS members. The required security controls cannot be designed until the state of security is accessed via the gap analysis. Also, the scope and cost of the security tools and program cannot be determined until a complete PPS member gap analysis is completed. This could delay deployment and connectivity if extensive security tools have to be deployed.

Risk #12: Disparate IT systems being used by partners could cause a delay in the connectivity to the integration of the MCC IDS. A delay in the connectivity of all PPS member data sources could have a negative impact on the ability of the PPS to deliver on the quality of care and desired patient outcomes in a timely fashion.
Mitigation: The IT solution has to include components and capabilities to address multiple EHRs and provider data repositories. This includes a tiered approach to deployment of connectivity and integration of provider EHR and data repositories, which is dependent upon individual capabilities.

Risk #13: There might be cost constraints by PPS members and partners to purchase needed technology or connectivity to the MCC IDS, the local community RHIO, and/or the preferred MCC EHR solution.
Mitigation: Any IT solutions for providers' EHRs and connectivity to the MCC IDS must have a low cost per patient charge. Also, provider and PPS partners incentives must be structured to compel providers and PPS partners to implement the proposed solutions.

Risk #14: The lack of PPS member and partner understanding of the PPS change management program and the IT security/privacy policies requested by the MCC PPS could cause delays in deployment and IDS integration. Confusion and misinformation could derail the MCC PPS program timelines and result in missed deadlines.
Mitigation: The MCC will provide detailed education and in-servicing to providers, partners, and their staff about the change management, IT security/privacy policies, and other compliance and operational policies and programs.

Risk #15: MCC and the DSRIP program are at risk of not delivering on quality of care, desired outcomes, and improving patient results because of possible conflicts from administration of services from overlapping WNY PPSs.
Mitigation: MCC will provide as part of the IDS solution verification that all basic clinical patient data is flowing appropriately to and from the local community RHIO so that the patient data will be available to any provider or organization in WNY regardless of their PPS affiliation. Since patients will obtain services from entities in any and possible all PPSs, the ability to have basic clinical patient information available for all PPSs will be required for success of the overall DSRIP program. If all WNY PPSs follow this model, delivery of the required and relevant information will benefit all PPS organizations and assist in the delivery of desired goals and outcomes.

Risk #16: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #17: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #18: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe the main interdependencies with other organizational workstreams (e.g. Performance Reporting, Clinical Integration, Financial Sustainability, etc.)

All workstreams are impacted by IT. Performance reporting and population health management in particular are nearly impossible without the technology in place to support them. In addition, all projects require participating providers to track patients using electronic systems. Many of the projects also require providers to not only have an EHR system in place, but to achieve MU and/or Patient-Centered Medical Home (PCMH) status. This will require extensive support and infrastructure from the central PPS IT organization.

Workforce: While technology can enable change, it is essential that the workforce strategy is defined and in place to support PPS membership through the required change. In addition, the clinical advisory committee will provide oversight and guidance in the design and development of the IDS, HIE, and data analytics systems and programs. This is to verify the IT solutions will be able to assist providers, partners, and organizations deliver on their desired outcomes and goals.

Clinical integration: Providers will need help in their offices to make this transformation, as well as receive ongoing support to sustain changes and deliver results.

Governance: The MCC leadership and governance structure has to be in place before IT processes and security/privacy policies can be finalized and approved.

Financial sustainability: Following initial implementation, it will be imperative that the PPS become financially sustainable so that the continuing costs of additional and updated IT assets can be met.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
MCC Administrative Director	***Greg Turner***	***Set current and future MCC IT strategy; oversee MCC IT operations***
MCC Chief Information Officer	***Leslie Feidt***	***Deliver on a day-to-day basis; remediate identified IT risks and elevate to IT Data Committee and MCC governance where appropriate***
MCC Compliance Officer	***Greg Hammer***	***Implement compliance controls and compliance program; oversee MCC privacy/security and IT change management platform***
MCC IT personnel (various titles)	***New hire(s)***	***Architect and design data exchange and interface topologies and strategies within MCC partners and members and with external entities; develop database architecture and environment for MCC; provide operational support, integration, and interoperability with MCC partners and external data sources; manage infrastructure teams; support IT architecture and systems***
MCC IT privacy/security staff	***To be assigned***	***Implement privacy/security controls and standards; monitor security controls including data security and confidentiality plans and strategy; monitor security controls; manage IT change management program; report to MCC Compliance Officer***
IT Data Committee	***Various individuals***	***Oversee IT program including approval of IT strategy and verification of appropriateness of vendor relationships; develop and adopt IT strategies; monitor progress and delivery to IT systems project deadlines; provide assistance if deadline or timelines are in jeopardy; remediate identified IT risks and elevate where appropriate; oversee IT Change Management Strategy***

IT TOM Development Team	***Various individuals***	***Ensure IT initiatives align with MCC's IT TOM plan and support MCC's business and strategic vision***
Clinical/Quality Committee	***Various individuals***	***Provide input and guidance to IT strategy and development and design of IDS, HIE, and data analytics systems***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
Board of Managers	***Executive governance***	***Address risks identified by IT Data Committee***
PPS member IT security representatives	***Varies by organization***	***Verify and approve security controls and data exchange requirements***
All participating organizations	***Full participation***	***Connect to other MCC providers in order to coordinate care across the region, support ongoing interconnectivity enhancements***
Data analysis tool vendors/staff (e.g., patient activation, HEDIS, population health, 3M, Coordination of Care, etc.)	***Data analytics***	***Support use of data analysis tools at the central PPS level as well as at individual practices (as appropriate), ensure software is tested and meets MCC needs***
External stakeholders		
RHIOs (HEALTHeLINK, Rochester, etc.)	***Data sharing, connectivity***	***Provide community-wide exchange of patient data, facilitate patient consent, provide connectivity to the SHIN-NY; assigned as guests to IT Data Committee; assist Clinical Integration Officer in an advisory capacity***
Specialized software user groups (e.g., EHRs)	***Support***	***User support***
External consulting groups	***Technical support***	***Provide technical expertise, staff, and services as needed to assist in meeting MCC objectives***
NYS Health Commerce System/MAPP	***Reporting***	***Provide consistent reporting capabilities***
SHIN-NY	***Connectivity***	***Provide secure network for exchange of information across the state***
WNY Rural Broadband Network	***Telemedicine***	***Ensure rural communities are able to connect to broadband to facilitate telemedicine needs***
Payers	***Data communication***	***Share claims and provider data with MCC to assist in meeting and measuring project objectives***
Network connectivity providers	***Connectivity***	***Ensure all members are able to connect to broadband to facilitate telemedicine needs***
NY e-Health Collaborative	***Strategic direction, IT tools***	***Provide continued support for IT initiatives (e.g., patient portal, statewide provider directory), establish statewide technical standards/policies that enable secure exchange of patient data***
External databases (e.g., health homes, MAPP)	***Data***	***Advance their systems to ensure appropriate connectivity to MCC activity and dashboards***
Salient	***Data***	***Provide clean, consistent Medicaid provider data***

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

Progress reporting will be aligned with the phased approach to implementing the overall IT systems and processes strategy. Success will be measured initially by finalizing appointments, staffing the IT Data Committee, and completing an IT current state assessment. These efforts will culminate into an EHR/IDS strategy; an implementation plan; an engagement strategy/plan; a data security and confidentiality plan; and an IT infrastructure development plan for interoperability, clinical integration, and population health management which will be used to report quarterly project- and unit-level progress.

The progress of MCC's IT system and processes efforts will be measured by:

- *Determining the current state assessment approach*
- *Performing risk analysis and current state assessment of IT capabilities across MCC network*
- *Aggregated, analyzed results of the assessment identifying gaps and areas of focus in the strategic plan*
- *Establishing an IT governance structure representative of the entities in MCC, including reporting structure approved by the Board of Managers*
- *Development of data security, confidentiality, IT strategy, IT implementation, and data governance plans approved by the Board of Managers*
- *Development of IT communication/education plans*
- *Development of a change management strategy and culture approved by the Board of Managers*
- *A roadmap for achieving clinical data sharing and interoperable systems approved by the Board of Managers*
- *Development of a plan for engaging attributed members in qualifying entities approved by Governance Committee and Clinical Integration Officer*
- *Execution of legal requirements/documents for data sharing agreements*
- *A regular meeting schedule and meeting minutes*
- *Identification and development of policies and procedures*
- *A comprehensive training plan to support the implementation of new platforms*
- *IT requirements for initializing/maintaining/communicating risk stratification across settings with electronic interfacing to the participating provider community*

- *IT requirements and specifications for key data sharing across the IDS during transitions*
- *Establishing reporting mechanisms to IT Data Committee and Board of Managers*

The IT systems and processes structure(s) will at minimum include the following:

- *Organizational chart*
- *Governance charter*
- *Roles and responsibilities*
- *Reporting structure*
- *Identification and development of policies and procedures and workflows*
- *A regular meeting schedule and meeting minutes*

Quarterly project- and unit-level reports will mark progress towards IT systems and processes strategy. These reports will include but are not limited to:

- *Reporting structure document*
- *Deployment of the IT requirement document*
- *Regular audits of the change management process*
- *MCC IT gap analysis results*
- *Approved implementation plan*
- *Approved change management strategy*
- *Finalized/approved engagement strategy and plan*
- *Approved plan for engaging attributed members in Qualifying Entities*
- *Approved MCC data governance plan*
- *Data sharing policies and procedures document*

- *Clinical interoperability system is in place for all participating providers*
- *Approve roadmap with overarching rules of the road for interoperability and clinical data sharing*
- *Approved plans for establishing data exchange agreements between all providers within the PPS*
- *IT communication, education, and training plans*
- *Equipment specifications (meeting certified standards for interoperability and communications) and rationale documented*
- *Percent of all legal required documents with providers/partners*
- *Risk assessments results*
- *Number of signed/executed DEAAs*

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

Performance Reporting

Key Issues

Reporting Structure	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Establish reporting structure for PPS-wide performance reporting and communication***	DY2, Q3	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation Subsequent quarterly reports will require updates on your progress on implementing this strategy and evidence of the flow of performance reporting information (both reporting 'up' to the PPS Lead and 'down' to the providers throughout the network)
1. MCC executive leadership will identify project leaders/managers for each project who will be responsible for progress and performance outcomes and program development.	DY1, Q2	
2. The Finance Committee and Workforce Development Work Group develop reporting plans that meet mandatory reporting and Rapid Cycle Evaluation (RCE) program goals.	DY1, Q2	
3. Complete interim plan for collecting performance and process data—including self-reported data from providers—and establish data quality standards and submission processes.	DY1, Q2	
4. An interdisciplinary RCE support team will establish the goals and objectives of the RCE program and work hand in hand with provider champions, the Physician Performance Sub-Committee, and the Clinical/Quality Committee.	DY1, Q3	
5. Develop system for reporting early elective deliveries for project 3.f.i. Reduce Maternal Births.	DY1, Q3	
6. Establish an initial strategy for communicating baseline performance data available from existing DSRIP data sources (MAPP, Salient Interactive Miner) to partners via reports and scorecards.	DY1, Q4	
7. Define a minimum data set required to support mandatory reporting as prescribed by the DOH and perform a comprehensive gap analysis of available and required data sources and reporting processes.	DY1, Q4	

8. Develop comprehensive and audience-specific approaches to the phased implementation of internal reporting (between MCC and partners)	DY2, Q1	
9. Finalize initial policies and procedures for continuous and systematic data collection and rapid feedback including remediation strategies. These policies and procedures will be approved by the IT Data Committee and will comply with MCC's PPS-wide data governance and security plan.	DY2, Q2	
10. Develop specifications for data collection, iterative reports, dashboards, scorecards, and other key deliverables.	DY2, Q3	
11. Finalize data exchange agreements with Medicaid Managed Care Organizations (MCOs), RHIOs, and other participants with access to relevant data. These agreements will align with RCE, quality improvement, and care management/population health program goals.	DY2, Q3	

Performance Reporting Culture	***Target Completion Date***	***Supporting Documentation***
Milestone 2: *Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting*	DY2, Q4	Finalized performance reporting training program. Subsequent quarterly reports will need to demonstrate up-take of training. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
1. Identify performance monitoring champions who will help lead and coordinate the dissemination of continuous messaging and facilitate the communication of feedback between individuals in the field and PPS leadership.	DY1, Q2	
2. Provide initial pilot training to project team leads and project managers.	DY1, Q2	
3. Perform a comprehensive assessment to identify key staff in compliance, reporting, training, and other roles.	DY1, Q3	
4. Form a training team responsible for developing performance monitoring and continuous quality improvement-specific training within the PPS's workforce training programs.	DY1, Q3	
5. Include training materials and dissemination of performance monitoring information (on processes, outcomes, best practices, etc.) in PPS-wide communications plan.	DY1, Q4	
6. Define the training requirements required to develop and sustain a culture of performance reporting and quality improvement.	DY2, Q2	
7. Evaluate and select evidence-based, best practice, and industry standard training materials as part of a coordinated training program.	DY2, Q3	
8. Provide pilot training to project team leads and project managers.	DY2, Q3	
9. Create roll-out schedule for training to be held at various locations, including provider sites.	DY2, Q3	

10. Roll out PPS-wide training sessions.	DY2, Q4	
11. Collect feedback using formal and informal surveys to assess training and messaging effectiveness.	DY2, Q4	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing performance reporting structures and processes and effective performance management within your network, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: Performance data cannot be obtained from partner organizations because of technical (IT) roadblocks. If partner organizations lack the technical and human resources to accurately collect and transmit the required performance data in a timely manner, blind spots will form where we cannot measure our RCE metrics with confidence.
Mitigation: This is mitigated at the earliest stages by identifying the data collection and sharing capabilities of PPS members. Once identified and a gap analysis is performed, we can begin our implementation with partners already sharing or prepared to share data. Concurrently, we will work with the overall Clinical Integration strategy to prioritize their inclusion in implementation plans.

Risk #2: Performance data cannot be obtained and normalized in a timely manner due to the implementation timeline and, therefore, reports cannot be submitted to the DOH on time.
Mitigation: Early and aggressive efforts to enlist partners who can be champions for this effort. Also, the Physician Steering Committee and Physician Performance Sub-Committee will play key roles in establishing the need for timely reporting. Lastly, remediation strategies consistent with PPS bylaws will be implemented.

Risk #3: Performance data is obtained but is incorrect, incomplete, or corrupted.
Mitigation: If data is delivered in non-standardized formats, the effort needed to acquire relevant data could surpass existing human and IT resources and lead to data with significant gaps and quality concerns. This may require additional resources for data extraction, transformation, and loading. Data reporting standards and practices must be defined in the policies and procedures and addressed in any project participation agreements with providers. A comprehensive data specification that aligns with data normalization and integration processes identified in the IT infrastructure strategy will be developed. Lastly, best practices for data extraction, transmission, and loading will be included in training and information materials developed to enrich a culture of performance monitoring.

Risk #4: Culture is resistant to change.
Mitigation: A culture resistant to change or inundated with training requirements is less likely to deliver quality data, take the time to process findings from analyses, and implement continuous quality improvement projects. We will coordinate with the Workforce Development Work Group to streamline or better integrate performance improvement training into other education efforts, particularly those aimed at new staff. We will solicit input from provider organizations and project leads on how to better integrate performance reporting processes into existing workflows. Our communication and provider outreach teams will continuously reinforce the relationship between performance monitoring, funds flow, patient outcomes, and process improvement.

Risk #5: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #6: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #7: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (e.g. IT Systems and Processes, Practitioner Engagement, Financial Sustainability, etc.)

IT systems & processes: IT will serve as the backbone for data collection and reporting. IT systems must be designed to accommodate performance reporting.
Clinical integration: Clinical integration facilitates the coordination of patient care across the PPS and drives improved outcomes that must be collected, analyzed, and reported through an effective performance reporting system.
Population health management: Performance reporting will provide for monitoring and assessment of population health performance, using outcomes to guide population health improvement activities.
Governance: The Board of Managers will be the ultimate entity responsible for ensuring that outcome data is used to determine incentive rewards.
Patient activation: Performance outcomes that will be reported from project 2.d.i. (Patient Activation) will determine the extent to which patient activation and motivation techniques leads to primary care connections for the uninsured and low and non-utilizing Medicaid beneficiaries.
Finance: The flow of funds provides immediate and irrefutable evidence of one key benefit of continuous quality measurement and improvement: the ability to see real dollar amounts attached to specific outcomes and goals. Funds flow also plays a significant role in dictating the speed and scale of project implementation, the ability to hire and retrain staff required to monitor and report on quality data, and the PPS's ability to meet the overall DSRIP goals.
Clinical quality: Performance reporting is closely linked with clinical quality in terms of both its goals and processes. Evidence-based medicine will guide the establishment, evaluation, and analyses of key performance metrics. These metrics will be established and approved through close coordination with the Chief Medical Officer, Physician Performance Sub-Committee, project leads, and other subject matter experts.

Roles and Responsibilities

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals driving/managing the workstream, whereas the 'Key Stakeholders' table is for the people/organizations with a stake in the workstream, but who are not responsible for driving it.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
MCC Chief Reporting Officer	John J. Bono	Oversee development and operation of an effective system for reporting and responding to process and performance outcomes
MCC IT staff	Various individuals	Implement reporting and communication technologies
MCC Clinical Integration Officer	Michele Mercer	Establish performance goals; integrate population health and data tools into performance metrics
Physician Steering Committee	Various individuals	Advise Board of Managers on clinical and quality issues
IT Data Committee	Various individuals	Identify sources of data
MCC Compliance Officer	Greg Hammer	Audit and monitor network to ensure objectives are being met
Physician Performance Sub-Committee	Members of the Physician Steering Committee	Review provider metrics, determine remediation approach for under-performing providers
MCC Chief Medical Officer	Anthony Billittier	Define clinical metrics, liaise between medical community and MCC leadership
Rapid Cycle Evaluation (RCE) support team	Various individuals	Establish the goals and objectives of the RCE program
MCC Population Health Manager	Priti Bangia	Assist with development of population health metrics; monitor data and statistics necessary to prove outcomes
Community reporting	Catherine Lewis	Ensure community network has adequate access to computer systems to support reporting of results
Clinical/Quality Committee	Various individuals	Detect and address IT issues that may impede quality analysis

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal stakeholders		
MCC Executive Director	Oversight	Ensure all reporting and measurement is meeting DSRIP objectives; ensure timely submission of all reporting

Physician Steering Committee Chair	***Physician engagement***	***Ensure physician community is represented and reports accurately reflect physicians and practices***
Governance Committee	***Oversight***	***Approve proposed goals and objectives of MCC RCE program***
Partner organizations	***Engagement, reporting, acting on reports***	***Provide feedback on the effectiveness of training and reports; provide input on reporting needs relevant to their particular area of practice***
External stakeholders		
Patients	***Data owner***	***Consent to exchange of data to facilitate accurate reporting across PPS***
Local government	***Regulatory body***	***Support PPS reporting by considering regulatory waivers where needed***
Professional associations	***Subject matter expertise***	***Provide input on reporting needs relevant to their particular area of practice***
Medicaid MCOs	***Data, expertise***	***Provide data on attributed recipients; advise on population health best practices; supply baselines for their population***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support your approach to performance reporting.

It is expected that the shared IT infrastructure will form the backbone of the performance reporting effort. As the central conduit for data flow both from and to the providers, it is essential that IT projects be coordinated with requirements for collecting performance data.
IT will be required for:
• Data collection and transmission: Electronic health record, claims, and other data will have to be communicated securely and in a timely manner in adherence to the PPS data governance plan. Leveraging the RHIO to facilitate the exchange and delivery of encounter information will be crucial.
• Data warehousing: Data, once collected, will have to be aggregated in a central location for analysis. This will require hardware, software, and technical expertise.
• Data normalization and acquisition: Data acquisition across types and sources are all dependent on the IT infrastructure. Collaboration and coordination with other area PPSs as well as the local RHIO will further enhance performance improvement, regionally.
• Communications infrastructure for transmitting reports to providers, the DOH, and key stakeholders: This includes the ability to host dynamic dashboards and, eventually, real-time streaming analytics. This will require resources such as web hosting, platform selection and acquisition, technical expertise from web services, or other development efforts.
• Extract, transform, and load (ETL) processes and data integration: Effectively leverage data sources provided by NYS DOH via Salient Interactive Miner and the MAPP. Define ETL processes for making best use of that data and integrating it into internal PPS analytics, reports, and dashboards.

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

Progress reporting will be aligned with the phased approach to implementing the overall performance reporting strategy. Establishment of project- and unit-level reporting frequency will be based on the internal and external reporting requirements to ensure the success of MCC-wide performance reporting strategy. Success will be measured initially by finalizing appointments, staffing the Clinical/Quality Committee, and completing a comprehensive network assessment. The progress of MCC's performance reporting and communications efforts will be measured by a performance reporting and communications strategy approved by the Board of Managers. The strategy will at minimum include the following:

- *Roles and responsibilities*
- *Creation of clinical and quality dashboards*
- *Defined RCE approach*
- *Creation of RCE support team*
- *Policies and procedures for continuous and systematic data collection and rapid feedback including remediation strategies approved by Board of Managers*
- *A reporting schedule aligned with finance, governance, and cultural competency/health literacy*
- *A comprehensive training program*

Overall project- and unit-level reports to mark progress towards performance reporting and communication will include but are not limited to:

- *RCE support team meeting schedule and minutes*
- *RCE goals*
- *Gap assessment results*
- *Data collection policies and procedures*
- *Reporting guidebook*
- *Sample scorecard and report templates; examples of deliverables presented to partners*
- *Training curriculum including materials*
- *Participant/attendance record*
- *Training outcomes*

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

Practitioner Engagement

Key Issues

Practitioner engagement / involvement in the DSRIP program	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Develop practitioner communication and engagement plan***	DY2, Q4	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee Subsequent quarterly reports will require evidence of ongoing communication and engagement, in line with plan, evidence of active professional peer groups and performance reporting to these groups.
1. Hire practitioner engagement liaison to implement; direct; manage; monitor; and improve practitioner communication, engagement, empowerment, and ongoing relations.	DY1, Q2	
2. Create a comprehensive practitioner network registry to identify all potential practitioners (contact information, communication preferences, practice demographics, areas of expertise).	DY1, Q4	
3. Develop communication strategy utilizing technology (e.g. website, social media, etc.) to allow bi-directional, effective information sharing including provider feedback and recommendations to MCC.	DY2, Q2	
4. Establish professional advisory groups/communities as needed based on project initiatives and subject matter expertise (e.g., cardiovascular, diabetes, behavioral health). Identify and leverage professional peer groups/communities already active in the region.	DY2, Q2	
5. Draft Practitioner Communication and Engagement Plan.	DY2, Q3	
6. Submit draft plan to MCC governance for review.	DY2, Q3	
7. Obtain approval of Practitioner Communication and Engagement Plan.	DY2, Q4	
8. Begin distribution of performance reports to professional groups as appropriate. Maintain records of communications sent and other evidence of active engagement.	DY2, Q4	
9. Begin ongoing process of obtaining feedback on reports provided to professional groups.	DY2, Q4	

Milestone 2: ***Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda***	DY2, Q2	Practitioner training / education plan. Subsequent quarterly reports will require evidence of training. PPSs will need to provide: a description of training programs delivered and participant-level data, including training outcomes.
1. Provide initial, introductory training to MCC partners and the community.	DY1, Q2	
2. Leveraging the training needs list compiled in the Workforce workstream (milestone #5), identify additional educational needs for DSRIP practitioners related to quality of care, standards of care, and other healthcare delivery.	DY1, Q3	
3. Define requirements and process for initial and ongoing practitioner education programs. Programs may be purchased, developed internally, and/or created (in partnership with clinical experts, healthcare educational institutions, and education subject matter experts).	DY1, Q4	
4. Begin development of DSRIP program-specific educational initiatives.	DY1, Q4	
5. Begin implementation of DSRIP program-specific educational initiatives.	DY2, Q1	
6. On an ongoing basis, collect, collate, and prioritize educational needs from MCC staff and practitioners.	DY2, Q1	
7. Begin ongoing process of obtaining feedback on education.	DY2, Q2	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the current level of engagement of your practitioner community in the DSRIP program and describe the key challenges or risks that you foresee in implementing your plans for practitioner engagement and achieving the milestones described above. Describe any potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: Practitioners receive continuous and extensive external personal and professional communications from multiple sources; addition of DSRIP communications could further overwhelm these already busy individuals. DSRIP communications could become lost in all the noise.
Mitigation: Uniquely engage, incentivize, and provide value-add to help ensure meaningful and effective engagement. Consider small financial incentives, free Continuing Medical Education (CME) credits, office detailing used by pharmaceutical and medical equipment representatives, dinners, and other innovative methods. Engage other entities similarly trying to engage and influence practitioner behaviors (e.g., payers). Partner/collaborate with like-minded entities to leverage strength in numbers, share costs and resources, and ultimately achieve more effective interaction.

Risk #2: Practitioners may disagree and/or take offense with, and perhaps actively resist DSRIP initiatives (e.g., established standards of care and quality of care reporting) which could be viewed as encroachment in the doctor-patient relationship.
Mitigation: Make every effort to ensure inclusivity, transparency, evidence-based justification, and other consensus-building techniques to maximize practitioner buy-in and ownership of DSRIP efforts and the DSRIP program itself.

Risk #3: The MCC network includes a wide range of types of practitioners and participants, and serves a diverse patient population across a large and varied geographical area. There is potential fragmentation among physicians and between community resources and physicians. Providers in other areas feel this is an Erie County initiative and their voices are not being heard.
Mitigation: Provide incentives. Maintain a physical and virtual presence. Maximize provider participation in DSRIP projects. Engage geographic councils to ensure the Southern Tier and Niagara/Orleans counties are represented.

Risk #4: MCC practitioners vary greatly in terms of the level of resources available to them. For example, practices that have already achieved Patient-Centered Medical Home (PCMH) certification will be in a much better position to meet DSRIP project requirements (e.g., exchange patient data via EHR) than those practices that are understaffed, and those located in areas without robust community-level resources available. These disadvantaged practices will struggle to implement the same strategies in the time allowed.
Mitigation: Allocate resources to fill in gaps. Offer meaningful incentives (cash, workforce, or equipment). Provide IT support, software, hardware, and/or videoconferencing capability. Provide onsite outreach. Engage practitioners virtually via social media, EHR alerts, virtual CME, and videoconferencing. Provide resources through HEALTHeLINK.

Risk #5: There is considerable county overlap with two adjacent PPSs in WNY. Some clinical practices are in more than one PPS. Among these practices there are varying degrees of clinical standards, especially in outpatient/primary care. Goal is to standardize clinical protocols, strategies, etc. The patient experience should be relatively uniform regardless of PPS.
Mitigation: Ultimately it would be ideal across the PPS (and the region) to achieve consensus on clinical guidelines/protocols. Minimally we want to ensure uniformity to create a seamless experience for the patient, regardless of where he or she seeks care. Catholic Medical Partners publishes the current clinical guidelines its providers follow. MCC will review these guidelines (and those of Finger Lakes PPS if available) to assure to the maximum possible extent standardization of clinical guidelines. PPSs will agree to share registry information, use standardized referral protocols, utilize uniform tracking and reporting systems and procedures, and maintain common messaging to educate/communicate with patients. MCC will work with Finger Lakes PPS and Catholic Medical Partners to establish common protocols for referrals (inside or outside the PPS).

Risk #6: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #7: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #8: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (e.g. Clinical Integration, Population Health Management, Financial Sustainability, etc.)

IT Systems & Processes: IT capabilities will be central to the achievement of major practice/workflow transformations related to PCMH. Specific to practitioner engagement, we will need a technical solution (platform) to engage physicians and share PPS-wide and practice-specific information/messaging. This may involve utilizing existing channels (such as social media) and developing new ones that meet the participants' needs. We will establish two-way communication and use a virtual presence to share information about different workstreams within the PPS. We will host regularly scheduled virtual meetings. To communicate and share lessons learned with physicians across the state, we will encourage practitioners to use MIX (or other state-provided venues, as appropriate).

Performance Reporting: It will be critical to implement dashboards for monitoring at a central level as well as self-monitoring at the practice level.

Governance: Make certain physicians are involved in decision-making. Have physicians in different specialties (e.g., pulmonary, cardiology, etc.) review clinical guidelines. These could be ad hoc or limited-time sub-committees, formed as required.

Finance and Flow of Funds: Performance is tied to finance/flow of funds. Reduced funds flow due to lackluster or nonperformance will be passed through from PPS to practitioners, potentially resulting in practitioners not getting paid.

Workforce: Workforce redevelopment strategy involves significant redeployment and retraining.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
MCC Chief Medical Officer	***Anthony Billittier***	***Ensure policies affecting physicians are evidence-based guidelines selected with sound medical judgment; serve as provider liaison***
MCC Clinical Integration Officer	***Michele Mercer***	***Ensure providers and their support staff are aware of DSRIP policies and clinical workflows***
Physician Steering Committee	***Various individuals***	***Ensure MCC physicians are represented and support decisions***
Geographic councils	***Niagara Orleans Healthcare Organization, Southern Tier Council***	***Implement practitioner engagement strategies in the Northern and Southern Tier counties of the PPS; report progress, challenges, and appropriate solutions to the Physician Steering Committee***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		

All MCC practitioners	***Participants***	***Engage in MCC projects, deliverables, and action plans***
Primary care safety net practices (including SNAPCAP, VAP)	***Participants***	***Engage safety net practices in the MCC projects, deliverables, and action plans***
Primary care private practices	***Participants***	***Engage in MCC projects***
"Voice of the Consumer" Sub-Committee	***Advisory***	***Ensure patients' voices are heard in relation to all MCC activities***
Community-Based Organization (CBO) Task Force	***Advisory, training***	***Ensure community action plans are in line with community needs; ensure selected CBO institutions are appropriate for MCC initiatives***
Regional Perinatal Center of WNY	***Education/training***	***Education of OB/GYN on use of progesterone etc.***
External stakeholders		
Local chapters of national professional societies and associations (e.g., Buffalo Chapter of National Association of Black Social Workers)	***Training, outreach***	***Education to members regarding MCC initiatives***
ASAP and NYS Council for Community Behavioral Healthcare	***Regulatory***	***Regulatory waivers***
Rural health networks	***Outreach***	***Ensure rural physicians' communication and action plans are aligned with MCC initiatives***
NY Care Coordination Program (Rochester), Departments of Mental Health	***Training***	***Regional training***
Nursing organizations	***Training***	***Nursing education***
Labor partners	***Outreach***	***Encourage buy-in and engagement from nurses and other practitioners***
Patients (via groups like the Parent Network of WNY)	***Advocacy***	***Help providers understand importance of DSRIP initiatives***
HEALTHeLINK	***RHIO***	***Ensure providers in network are gathering consent and information is flowing across network***
Physician groups/clubs (e.g., P^2 Collaborative of WNY, HEALTHeLINK Physician Committee)	***Outreach***	***Encourage buy-in and engagement from physicians***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

• IT capabilities to achieve major practice/workflow transformations related to PCMH
• Physician participation in the development of the IT strategy and implementation plan
• Technical platform to engage physicians and share PPS-wide and practice-specific information/messaging; this may involve utilizing existing channels (such as social media) and developing new ones that meet PPS needs
• Easy-to-use reporting systems for practices to submit quality data; dashboard technology to share/display performance data
• Patient and provider portals to facilitate communication and data sharing among providers and between providers and patients
• Teleconferencing, videoconferencing, and other technology capabilities to support effective two-way communication with providers dispersed across a broad geographical area, including those with limited access to broadband
• Connectivity through HEALTHeLINK, integration with EHR systems to support sharing of data across the region
• Technical support and training for practices related to use of PPS-specific tools (e.g., reporting interface), RHIO connectivity/capabilities, data collecting and reporting practices, EHR/Meaningful Use, PCMH certification

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

Progress reporting will be aligned with the phased approach to implementing the overall practitioner engagement strategy. Project success and governance will be measured by the penetration within the provider community.

As the practitioner engagement strategy is developed, quarterly progress reports will include:
- *Hiring of a practitioner engagement liaison responsible for practitioner communication, engagement, empowerment, and ongoing relations*
- *Development of a comprehensive practitioner network registry*
- *A Practitioner Communication and Engagement Plan to be reviewed and approved by MCC governance*
- *A regular meeting schedule; meeting minutes*
- *Comprehensive practitioner training strategy to address MCC quality improvement agenda and continuing DSRIP education*

Quarterly reports will track the progress of practitioner network development, implementation, and education against project goals. Reports will include analyses of, but not be limited to, the following:
- *Number of practitioners in the network*
- *Primary care capacity for both safety net and non-safety net organizations*
- *Number of practitioners by groupings (e.g., cardiovascular, diabetes, behavioral health)*

The progress of the practitioner engagement training/education plans will be analyzed and reports will be developed to assess the following:
- *Number of training programs delivered each quarter*
- *Geographical locations of trainings*
- *Number of participants per training session*
- *Percentage of practitioners who completed training*
- *Training satisfaction rate*

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

Population Health Management

Key Issues

Population health roadmap	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Develop population health management roadmap***	DY3, Q1	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities. Subsequent quarterly reports will require an update on the implementation of this roadmap.
1. Finalize requirements for population health management and other business intelligence tools.	DY1, Q3	
2. Identify data sources and inputs required to appropriately collect and process data for analytics.	DY1, Q3	
3. Establish IT requirements for initializing, maintaining, and communicating risk stratification across settings with electronic interfacing to the participating provider community.	DY1, Q4	
4. IT requirements for key data sharing across the integrated delivery system (IDS) during transitions including interface with overlapping PPSs in the WNY region.	DY1, Q4	
5. Develop request for proposals (RFP) for population health tools.	DY1, Q4	
6. Select evidence-based care management model(s).	DY2, Q1	
7. Evaluate RFP responses and select qualified entity to provide population health and data analytics tools.	DY2, Q1	
8. Award population health and data analytics RFP.	DY2, Q2	
9. Develop strategy for primary care transformation (PCMH 2014 level 3 certification) as outlined in project 2.a.i. (requirement #7).	DY2, Q2	
10. Define risk stratification methodology (high risk, moderate risk, low risk, and well) and pilot test risk criteria.	DY2, Q3	
11. Produce patient registries based on risk stratification methodology.	DY2, Q3	
12. Define priority target population, building upon PPS project requirements and the Community Needs Assessment.	DY2, Q3	
13. Compile information from steps above into Population Health Roadmap draft.	DY2, Q4	

14. Submit draft Population Health Roadmap draft to MCC Board of Managers for review/approval.	DY2, Q4	
15. Identify priority practices to work with based on readiness.	DY2, Q4	
16. Operationalize population health IT infrastructure, processes, and procedures based on requirements.	DY2, Q4	
17. Implement and deploy population health strategy and tactical plan, including clinical resources and data analytics tools and environment leveraging data from the MCC integrated EHR and data exchange/HIE environments.	DY2, Q4	
18. Measure, improve, and refine population health management processes.	DY3, Q1	
19. Track and monitor progress of implementation of the Population Health Roadmap to verify continuous improvement.	DY3, Q1	

Bed Reduction Plan	***Target Completion Date***	***Supporting Documentation***
Milestone 2: ***Finalize PPS-wide bed reduction plan***	DY2, Q4	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings. Subsequent quarterly reports will require updates on bed reductions across the network and updates on the delivery of your bed reduction plan.
1. Complete bed-review (fact-based data collection) of excess bed capacity in hospitals and skilled nursing facilities (SNFs).	DY1, Q4	
2. PPS-wide Bed Reduction Work Group analyzes current state, DSRIP impact on capacity, and bed redesign by sub-region.	DY2, Q1	
3. Develop recommendations for excess bed reduction.	DY2, Q2	
4. Obtain Board of Managers approval on bed reduction plan.	DY2, Q4	
5. Begin quarterly reporting on bed reductions and delivery of bed reduction plan.	DY2, Q4	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: Excess bed capacity. MCC hospitals have an occupancy rate of 71% that translates into 511 beds not in use, and the NYS DOH projected (2016) 499 excess beds for residential healthcare facilities in WNY.
Mitigation: Resolve excess bed capacity in inpatient and SNF facilities by in-depth fact-finding (regarding the nature of each facility's occupancy, physical plant, options for reuse, and future impact of system change) followed by a collective recommendation process and phased-in implementation.

Risk #2: Gaps in RHIO interoperability. Enhanced communication and care management data sharing among primary care and specialists, mental health, health homes (HHs), and community support agencies does not exist, and the interoperability among hospitals and pharmacies needs to be enhanced. There is a lack of universal protocols across settings. We lack an interoperable HIE to make care management data accessible in real time.
Mitigation: Activate a continuum of providers in the IDS including medical, behavioral, and community to increase HIE use and area-wide patient consent along with massive RHIO enhancements to support population health management in the PCMH connected across settings. Achieve clinically interoperable care management and community support across the system.

Risk #3: Gaps in primary care infrastructure. PCMH/APCM status is low within MCC, with only 36% of primary care locations (85 out of 235) currently NCQA recognized as PCMH facilities.
Mitigation: Achieve PCMH/APCM standards and MU requirements in all safety net primary care locations. Achieve EHR connectivity to RHIO's HIE for all safety net primary care locations. Achieve health IT integrated population health management in all safety net primary care locations.

Risk #4: Gaps in PCP settings. There are virtually no PCP personnel devoted exclusively to care management of the high-risk complex population associated with avoidable admissions and readmissions.
Mitigation: Establish risk stratification built into the IDS. Embed new care management teams in safety net locations that provide care management services across settings between office encounters with the highest risk population. Engage patients in the IDS at all levels. Achieve real service integration with HHs.

Risk #5: Workforce competency gaps. A crucial component of population health management to achieve DSRIP goals will be establishing PCMH teams devoted exclusively to care management of the high-risk complex population associated with avoidable admissions and readmissions. The roles, responsibilities, skills, and competencies for this have not yet been defined.
Mitigation: We will address these gaps by building training into the practice transformation process used by the primary care locations in the MCC network to achieve PCMH 2014 recognition. The role, responsibilities, workflow, protocols, and performance evaluation inherent in complex patient population health management will be imbedded in each office to address standard 4 of the 2014 PCMH NCQA requirements.

Risk #6: Barriers to patient engagement in population self-management.
Mitigation: Broadly, we will engage patients in the IDS at all levels. Operationally, we will embed patient engagement and activation into the practice transformation process used by primary care locations in the MCC network to achieve PCMH 2014 recognition. Specifically, new roles, responsibilities, and workflows will assess the diversity and language needs of patient population (Standard 2C- Culturally and Linguistically Appropriate Services -- CLAS); involve patients on the practice's advisory council (Standard 2D); incorporate patient preferences and lifestyle goals into care planning and self-care support (Standard 4B); and use the PCMH version of the CAHPS survey to obtain feedback on experiences of vulnerable patient groups (Standard 6C).

Risk #7: Failure of the multiple PPS organizations in WNY to cooperate through the use of common protocols, standardized reporting requirements, and sharing lessons learned will negatively impact the primary care transformation process because providers will become confused by inconsistent or even contradictory instructions that will impede their performance.
Mitigation: MCC, Catholic Medical Partners, and the Finger Lakes PPS will hold routine meetings and share information and ideas. Wherever possible, the three PPS organizations will develop standards and procedures that will guide implementation of the population health roadmap in a unified way.

Risk #8: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #9: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #10: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (IT Systems and Processes, Clinical Integration, Financial Sustainability, etc.)

Population health management that is capable of reducing avoidable admissions and readmissions is highly dependent on all elements of the PPS.

Population health management is dependent upon PPS-wide clinical integration and protocol for defining risk stratification so that care management intensity and scope is stepped according to level of patient need.

Interoperability across settings for population health is dependent upon massive IT/HIE systems and processes enhancements.

Population health management of high-risk panels must be high-touch and active across settings using new roles and responsibilities that are not found in encounter-based, office-based care. To be effective, the new high-risk care management must function outside the office under the direction of the PCMH. This new out-of-office intensive care management is not currently covered by encounter-based reimbursement, so it is highly dependent upon financial sustainability through value-based payments.

Population health management is dependent upon a trained primary care, behavioral health, and HH workforce and, therefore, must rely on the expertise, planning, and work of the workforce workstream.

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
IT Data Committee	***Various individuals***	***Identify sources of data***
MCC Clinical Integration Officer	***Michele Mercer***	***Establish performance goals, integrate population health and data tools into performance metrics***
Physician Steering Committee	***Various individuals***	***Oversee strategy for ensuring physician engagement***
Chief Medical Officer	***Anthony Billittier***	***Oversee strategy for ensuring physician engagement***
Physician Performance Sub-Committee	***Members of Physician Steering Committee***	***Review provider metrics, determine remediation approach for under-performing providers***
MCC Administrative Director, data analysts, IT resources	***Gregory Turner and various individuals***	***Implement reporting and communication technologies, risk stratification, and data sharing across PPS***
Governance Committee	***Various individuals***	***Establish goals and objectives of MCC Rapid Cycle Evaluation (RCE) program with assigned representation from Physician Performance Subcommittee and Clinical/Quality Committee***
Clinical/Quality Committee	***Various individuals***	***Develop clinical metrics and processes to support accountability for population outcomes***
MCC Population Health Manager	***Priti Bangia***	***Develop clinical and community metrics for projects, support the community in education and implementation of population health techniques, work closely with clinical integration and IT business owners, monitor/ensure all metrics from the community are uploaded in a clean, secure manner allowing for accurate reporting and data collection***
Other MCC staff/population health team	***To be designated***	***Support/educate community providers on conducting and uploading population health data for successful reporting***
MCC care transition coordinators	***To be designated***	***Support outreach to patients and complete necessary metrics to measure effectiveness***
Population health vendor(s)	***To be selected by RFP***	***Supply systems that support population health management, execution, and measurement***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal stakeholders		

Primary care practices	***Care providers***	***Reduce avoidable admissions, ensure high-risk patients are monitored according to care plan, prevent patients from entering high-risk populations by deploying prevention and medicine based on EBG***
Hospital/emergency department (ED) discharge staff	***Care transition***	***Follow approved policies and procedures, especially when discharging high-risk patients; link all patients to PCPs and secure appointments***
ED care coordinators/navigators	***Care coordination***	***Intercept high-risk patients, follow approved protocols to identify and remove barriers to care***
Community-Based Organization (CBO) Task Force	***Patient outreach***	***Coordinate medically-appropriate and culturally-sensitive interventions with high-risk patients***
External stakeholders		
Urgent care centers	***Care access, care coordination***	***Ensure communication to PCPs, contribute to coordination of care***
HHs (adult and pediatric)	***Care coordination***	***Document interventions and care coordination activities for sharing among HHs to manage populations holistically and enhance reporting***
Health plans and Medicaid managed care organizations	***Risk management***	***Risk stratification***
CBOs	***Patient outreach***	***Deploy resources to intervene with high-risk patients, follow approved protocols to identify and remove barriers to care***
P^2 Collaborative of WNY	***Education***	***Educate patients and providers***
Rural health networks	***Patient outreach, care coordination***	***Ensure rural populations are supported by MCC and care is rendered***
Pharmacies	***Education***	***Educate patients and providers***
School-based health services	***Care access, care coordination***	***Provide improved access to care for school-aged population to prevent them from entering high-risk groups, connect students (and families) with primary care***
All health service providers and community-based services	***Community services***	***Community support of population health***
Retail-based medical services ("minute clinics")	***Care access***	***Provide medical services (including vaccinations) especially for uninsured or low utilizing patients in the community***
HEALTHeLINK	***Connectivity***	***Provide communication platform for essential clinical data to manage populations***
FQHCs	***Population health***	***Support impoverished and uninsured populations to decrease risk and improve health***

IT Expectations

Please describe the current Population Health Management IT capabilities in place throughout your PPS network and what your plans are at this stage for leveraging these capabilities and/or developing new IT infrastructure.

Maturation of the existing HIE. The HIE (HEALTHeLINK) is well developed in terms of its capability to collect data from hospitals, laboratories, and radiology facilities. Hospital data about admissions, discharges, and transfers is critical for identifying target populations and is available from every hospital in the region. However, population health interventions across an integrated delivery system, especially for high-risk patients, require bi-directional HIE in primary care, long-term care, and home care settings. While many primary care settings have access to read data from HEALTHeLINK, very few have the ability to feed data in so that it can be accessed in other settings. Long-term care settings currently have little connectivity. WNY was one of the first communities in the nation to establish HIE connections with home care but the data shared is limited. If these connections cannot be made in a timely fashion, there is a risk that coordination of care across the system for population health will be impaired. This will limit the ability to reduce hospitalizations. To mitigate this risk, we will encourage and support the use of Direct communication, which provides a means of secure clinical communication among organizations without the use of an HIE and therefore does not depend on the ability to create the bi-directional connections to the RHIO outlined above.

EHR implementation across the system is particularly problematic in long-term settings where EHR adoption has been slower than in other settings.

Integration of primary care and behavioral health: if it is not in place then population health efforts for patients with mental health and chronic disease will be much more difficult.

Progress Reporting

Please describe how you will measure the success of this organizational workstream.

Progress reporting will be aligned with the phased approach to implementing the overall population health management direction. Project success and governance will be measured by the establishment of a population health roadmap which identifies the IT infrastructure necessary to support data analytics for MCC including targeted patient registries and their care management which supports primary care transformation.

Progress towards the development and approval of this roadmap will be reported quarterly (projected timeline versus actual implementation timeline/percent complete of implementation of the approved roadmap). Quarterly reports will describe progress at the project and unit level including development of the population health management roadmap approved by the Board of Managers.

The roadmap will at minimum include the following items:
- *Development of physician and patient communication and education plans*
- *RFP process for selection of vendor*
- *Implementation and deployment of population health management data analytics tools*
- *Development of business intelligence and other data analytics reporting at the project and unit levels*
- *Communicating results of population health management to appropriate committees and sub-committees*

Population health management project- and unit-level progress reports will measure the status of the following:
- *Population health roadmap designed to meet PCMH 2014 requirements and reduce avoidable utilization*
- *Risk stratification criteria: definition of priority target population; rubric for risk stratification; pilot test of risk stratification criteria*
- *Patient registries for risk stratification, pushed electronically to physicians*
- *Percent of primary care offices submitting NCQA application for 2014 PCMH recognition*
- *Percent of primary care offices obtaining NCQA 2014 PCMH level 3 recognition*

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

Clinical Integration

Key Issues

Clinical Integration	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Perform a clinical integration 'needs assessment'***	DY1, Q4	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration
1. Assess MCC's capability to perform clinical integration (CI) needs assessment. If necessary, develop RFP and/or select vendor.	DY1, Q3	
2. Identify validated CI needs assessment tool, such as: *a. Clinical Integration Self-Assessment Tool v. 2.0 by Gosfield and Reinertsen* *b. Physician Alignment and Integration Readiness Assessment by The Chartis Group* *c. Clinical Integration Readiness Assessment by Dye and Sokolov*	DY1, Q3	
3. Present CI needs assessment tool and proposed distribution process to the Clinical/Quality Committee for review and approval.	DY1, Q3	
4. Establish provider distribution list (practices).	DY1, Q3	
5. Establish response rate goal.	DY1, Q3	
6. Define distribution process and implementation plan.	DY1, Q3	
7. Disseminate CI needs assessment.	DY1, Q3	
8. Gather, aggregate, and analyze responses to identify gaps and CI focus areas.	DY1, Q3	
9. Leveraging key data points, identify opportunities for shared access and the key interfaces that will have an impact on clinical integration.	DY1, Q3	
10. Establish CI roll-out strategy informed by the data to support requirements for clinical integration (including clinical providers, care management providers, and other providers impacting on social determinants of health).	DY1, Q4	

Milestone 2: ***Develop a Clinical Integration Strategy***	DY2, Q4	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools Subsequent quarterly reports will require an update on the implementation of this strategy.
1. Develop CI Strategy based on needs assessment and MCC projects, including protocols, procedures, processes, guidelines that will be used across the projects (e.g., Million Hearts, INTERACT, PAM).	DY1, Q4	
2. Present CI Strategy to the Clinical/Quality Committee for review and approval.	DY1, Q4	
3. Identify all relevant data sources for clinical integration by all PPS members, RHIO, and SHIN-NY, e.g., EHR systems, population health and care coordination modules, data analytic tools.	DY1, Q4	
4. Catalogue existing programs MCC-wide to leverage best practices and identify gaps.	DY1, Q4	
5. In compliance with HIPAA security protocols, develop and test/verify clinical data sharing process for all relevant clinical interfaces (as defined in IT Systems & Processes, milestone #1).	DY1, Q4	
6. Implement/establish clinical data sharing process.	DY1, Q4	
7. Convene MCC's geographic councils (Niagara Orleans Healthcare Organization, Southern Tier Council) to review and discuss CI plan implementation.	DY1, Q4	
8. Roll-out plan to implement a consistent use of efficient and effective evidence-based approaches to care and coordination.	DY2, Q1	
9. Implement Care Transitions Strategy developed in 2.a.i. including protocols for hospital admission/discharge coordination, care transitions, and communication among primary care, mental health, and substance use providers.	DY2, Q1	
10. Develop provider-specific/program-specific metrics and reports. Establish transparent program and reporting plan.	DY2, Q2	
11. Implement Training/Education Plan outlined in Practitioner Engagement (milestone #2) including providers and operations staff.	DY2, Q3	
12. Measure and track participation rates.	DY2, Q3	
13. Measure and report on participation and training topics quarterly to Clinical/Quality Committee.	DY2, Q4	

Major Risks to Implementation & Risk Mitigation Strategies

Please describe the key challenges or risks that you foresee in improving the level of clinical integration throughout your network and achieving the milestones described above. Describe potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk #1: Over-reliance on hospital-employed physicians makes it difficult to achieve full CI across the community; they lack the breadth to serve as a foundation for building the clinically integrated, performance-focused platform.
Mitigation: Include/engage a cross-section of both independent community-based and hospital-employed physicians in all programming.

Risk #2: Independent (community-based) physicians have limited availability, staff, and financial resources to implement changes in workflow to accommodate new care coordination processes and other DSRIP requirements.
Mitigation: Provide centralized support/resources (e.g., physician assistance, care management, PCMH expertise, IT support) for CI efforts.

Risk #3: Stakeholders (e.g. ancillary providers, community-based organizations (CBOs), faith-based organizations, etc.) are too diffuse for organized performance achievements.
Mitigation: Develop organized approach for connecting these stakeholders to hospital-based and independent primary care practices (e.g., by leveraging and automating the 211 resource directory). Promote collaboration among these stakeholders via the CBO Task Force. Review progress reports; identify "problem areas" and low-performing organizations for additional support/intervention.

Risk #4: Failure to engage contracted physician groups. Some physician groups may be resistant to the changes proposed.
Mitigation: Include contracted physician groups in all clinical implementation strategies. Implement a comprehensive practitioner engagement strategy. Represent a variety of provider types on the Physician Steering Committee to ensure a wide range of voices are heard.

Risk #5: Technology/data integration is not available/ready for deployment in a timely manner.
Mitigation: Develop interim technology and data strategies to communicate data to practitioners. For example, leverage existing hospital admission, discharge, and transfer data and push to primary care offices. Work with IT Data Committee on interim steps to integration.

Risk #6: Funding received is insufficient to achieve the PPS' stated achievement goals.
Mitigation: MCC will have a streamlined administrative structure to minimize unnecessary overhead costs. To address funding constraints, all projects will utilize flexible, phased project plans that can be adjusted as needed. Whenever possible, MCC will engaging no-cost training provided by community experts. Many of MCC's projects overlap in terms of clinical skillsets and activities. It will be possible to share resources across projects (e.g., INTERACT coaches who could be used for projects 2.b.vii. INTERACT and 2.b.viii. Hospital Home Care Collaboration). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

Risk #7: The IT infrastructure for data sharing, reporting, communication, or other areas does not emerge quickly enough to meet the PPS' needs and goals.
Mitigation: A phased approach to project rollout, IT development, reporting, and rapid cycle evaluation creates a resilient system which can adapt quickly to change. Our early reliance on free, open source solutions for data collection and analysis provides us with a "fallback" option for maintaining continuity of operations in the event gaps in IT begin to affect the organization. Additionally, we are working to mitigate this risk through close partnerships with our core stakeholders in IT and partners at ECMC. Moving from an IT infrastructure wholly hosted by ECMC to one that we control directly has enabled us to grow our internal capacities and help direct the development of IT resources across the region. Our strategy allows for systems to fail gracefully by creating a scaffolding of solutions that can meet immediate or interim goals and then building continuously toward integrated, regional solutions for interconnectivity.

Risk #8: Prior experience, geographic diversity, and the scope of organizational change required to achieve the PPS' goals indicate that resistance to change will impede the deployment of process, workforce, and other aspects of system integration and redesign. Likewise, imbalances in the adoption of new approaches to care delivery that arise from a resistance to change can cause inconsistency across different locations implementing the same project.
Mitigation: Early analyses of the workforce and other stakeholders will provide a better understanding of the specific barriers that may arise from resistance to change. These analyses, coupled with audience-specific training programs developed by the Workforce Development Work Group and others will ensure open, transparent conversations about the degree of change required and the best ways of achieving change among specific groups of stakeholders. Partnerships with labor and administration will further help us define and deliver the messages necessary to ensure buy-in across the PPS. As part of our governance strategy, we also stipulate assessment and remediation strategies for addressing specific partner organizations where change is slow or non-existent.

Major Dependencies on Other Workstreams

Please describe any interdependencies with other workstreams (IT Systems and Processes, Practitioner Engagement, Financial Sustainability, etc.)

Practitioner engagement: Successful CI implementation is dependent on active practitioner engagement
Population health strategy: CI is a means to population health
IT systems and processes: Data integration and interoperability are essential components of CI
Performance reporting: CI progress is informed by accurate performance reporting
Financial sustainability: CI transformation depends on financial sustainability for such items as interoperability and practitioner incentives
Workforce strategy: CI resources, such as care coordinators, are essential to successful CI implementation
11 projects: An interdependency exists between CI and the MCC clinical projects

Roles and Responsibilities

Please list the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
Clinical/Quality Committee	***Various individuals***	***Oversight and approval of CI Strategy and CI Work Plan***
IT Data Committee	***Various individuals***	***Ensure that the IT infrastructure meets the needs of the clinically integrated network***
CBO Task Force	***Various individuals***	***Provide advisory feedback on CI Strategy and CI Work Plan***
Geographic councils	***Niagara Orleans Healthcare Organization, Southern Tier Council***	***Implement CI strategies in the Northern and Southern sub-regions of the PPS; report on progress, challenges, and appropriate solutions***
Clinical integration liaisons	***Representatives from primary care, specialties, behavioral health, CBOs, care coordination, hospice/palliative care, and population health***	***Act as liaisons between their respective disciplines and the CI process***

Key Stakeholders

Please identify the key stakeholders involved, both within and outside the PPS.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals and organizations responsible for driving/managing the workstream, whereas the 'Key Stakeholders' table is intended to capture the people/organizations with a stake in the project, but who are not directly responsible for driving it.

Key stakeholders	*Role in relation to this organizational workstream*	*Key deliverables / responsibilities*
Internal stakeholders		
Chief Clinical Integration Officer	***Lead development and implementation of CI Strategy and Work Plan***	***Develop CI Strategy and Work Plan; present to oversight committees and work groups for feedback and approval; oversee implementation of work plan; report on progress of implementation***
Chief Medical Officer	***Medical oversight; input into CI Strategy and Work Plan***	***Work with Chief Clinical Integration Officer to develop CI Strategy and Work Plan; present to oversight committees and work groups for feedback and approval; oversee implementation of Work Plan; report on progress of implementation***
Chief Reporting Officer	***Development of clinical metrics***	***Develop and implement mutually agreed-upon CI metrics; provide input into measurement criteria and development of reports to the Clinical Quality/Committee, Board of Managers, and NYS DOH.***
Representatives from each partner hospital	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***
FQHCs	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***
Behavioral health providers	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***
Health homes	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***

Post-acute providers	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***
Physician networks	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***
External stakeholders		
Departments of Health from each MCC PPS county	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***
Patients	***Beneficiary of care improvements driven by CI***	***Response to consultation on CI Strategy***
Family members	***Communication with practitioners, particularly on behalf of children, the elderly, or those without mental capacity***	***Response to consultation on CI Strategy***
Hospice/palliative care providers	***Buy-in/support of new pathways, lines of accountability, responsibilities, and communications***	***Engagement in the process, including consultation and training***
CBOs	***Buy-in and support of CI Work Plan including new pathways, lines of accountability, responsibility, and communication***	***Engagement in the process, including consultation and training***

IT Expectations

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

Effective CI will require relevant information to be readily accessible for all providers across the patient care spectrum. For some providers this will mean integration into new or expanded clinical data systems. For other providers in our network, effective CI is likely to rely more heavily on the coordinated use of patient registries and risk stratification. A core element of our CI needs assessment will be identifying where new or expanded data-sharing systems are required and where a different approach is required. The involvement of the IT Data Committee will be important in ensuring that our plans for developing IT infrastructure across the PPS support better CI.

The following areas that will require IT assessment and requirement definition for CI include:
--The architecture of the PPS to support a clinically integrated system
--The data sharing and confidentiality protocols in place for the PPS
--What platforms are being used to support the PPS (EHRs, etc.)
--How will the PPS integrate manual processes
--Data reporting and performance monitoring
--Secure messaging and alerts
--Patient and physician portals

Achieving the buy-in from our large community of downstream providers to the new ways of working that fall under the CI workstream will greatly depend on the providers and the individual practitioners having easily accessible methods of communicating with one another.

Progress Reporting

Please describe how you plan to measure the success of clinical integration in your PPS network over time.

Progress reporting will be aligned with the phased approach to implementing the overall CI Strategy. Project success and governance will be measured by the completion of a clinical IT needs assessment, current state assessment of the PPS network, and establishment of a best practice data model flow. Quarterly reports at the project level will include the following:
• A validated CI needs assessment tool approved by the Clinical/Quality Committee
• Aggregated analyzed results of the responses to identify gaps and CI focus areas

Results of the CI needs assessment will be utilized in the development of the CI Strategy. The strategy will include, but not be limited to, the following items:
• Inventory of all data sources
• A comprehensive training program
• A reporting schedule aligned with finance, governance, cultural competency/health literacy, and performance monitoring

Quarterly project- and unit-level reports will mark progress towards full implementation of the IT infrastructure development plan for interoperability, CI, and population health management.

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

DSRIP Budget Table

In the table below, please detail your PPS's projected DSRIP budget allocation for the next five years.

NOTE:

- This table requires your budget forecast on an annual basis. The quarterly reports will require you to submit your actual spend against these budget categories on a quarterly basis.

- This table contains three budget categories. Please add rows to this table as necessary in order to add your own additional categories and sub-categories. The budget categories used in this table should reflect the budget categories you used in your application.

- In the 'Waiver Revenue' row, you should enter your expected waiver revenue, based on your project valuations

If the budget you set out here deviates from the approach you articulated in your application (where you expressed your budget in percentage terms) you must explain this variance below.

Budget approach has significantly changed due to the lower than anticipated total valuation award. The approach is to ensure success, thus project implementation and administration is funded first then revenue loss and internal PPS provider bonus payments. Contingency is comprised of potential lost funding if there is a state penalty from CMS in DY3-5 and MCC's exclusion from the high performance fund. Should these funds become available MCC will look to fund budget items consistent with execution of the PPS's goals.

Budget Items	DY1	DY2	DY3	DY4	DY5	TOTAL
Waiver Revenue	34,271,285	44,212,090	64,149,642	58,168,377	42,218,334	243,019,728
Cost of Project Implementation & Administration	30,665,487	29,171,610	27,926,881	23,570,359	23,098,173	134,432,510
Cost of services not covered	-	-	-	-	-	-
Internal PPS Provider Bonus Payments	1,505,798	1,426,488	15,420,019	13,177,594	1,750,000	33,279,899
Revenue Loss	2,100,000	9,373,744	13,950,059	12,553,434	7,066,440	45,043,678
Contingency fund	-	4,240,249	6,852,682	8,866,989	10,303,721	30,263,641
Miscellaneous	-	-	-	-	-	-
Total Expenditures	34,271,285	44,212,090	64,149,641	58,168,377	42,218,334	243,019,728
Undistributed Revenue	0	0	0	0	0	0

DSRIP Flow of Funds

Designing your funds flow	*Target Completion Date*	*Supporting Documentation*
Milestone 1: ***Complete funds flow budget and distribution plan and communicate with network***	DY1, Q3	***Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.*** ***Subsequent quarterly reports will require updates to the budget and funds flow tables contained in this template.***
1. Distribute assessment of DSRIP project impacts (prepared in connection with current state financial assessments) to MCC partners along with an explanation of the purpose of the matrix and how it will be used to finalize funds flow in determining expected impacts of DSRIP projects.	DY1, Q3	
2. Complete preliminary PPS budget for administration, implementation, revenue loss, and cost of services not covered.	DY1, Q3	
3. Review provider-level projections of DSRIP impacts and costs submitted by MCC providers. During provider-specific budget processes, develop preliminary-final provider-level budgets including completion of provider-specific funds flow plans.	DY1, Q3	
4. Review the funds flow approach and distribution plan with drivers and requirements for each of the funds flow budget categories.	DY1, Q3	
5. Distribute funds flow approach and distribution plan to Finance Committee and MCC providers for review and input.	DY1, Q3	
6. Amend plan to reflect input and obtain approval of plan by Finance Committee.	DY1, Q3	
7. Prepare PPS, provider, and project funds flow budgets based on budget review sessions with providers and submit said budgets to Finance Committee for approval. Incorporate these budgets into the Funds Flow Budget and Distribution Plan.	DY1, Q3	
8. Forward approved Funds Flow Budget and Distribution Plan to MCC partners and incorporate said plan and requirements to receive funds into MCC provider partner operating agreements.	DY1, Q3	
9. Distribute Funds Flow Budget and Distribution Plan; schedule DSRIP period close requirements; and forward expected funds distribution schedule to MCC provider partners.	DY1, Q3	
10. Provide training sessions on Funds Flow Budget and Distribution Plan, related administrative requirements, schedules for reporting, and distribution of funds.	DY1, Q3	

Funds Flow

In the table below, please detail your PPS's projected flow of DSRIP funds for the next five years, splitting out the flow of funds by provider type. The provider types used here match the categories used for the Speed & Scale portion of your Project Plan Application.

NOTE:

- This table requires your funds flow projections on an annual basis. The quarterly reports will require you to submit your actual distribution of funds to these provider categories on a quarterly basis.

- These quarterly submissions of actual funds distribution will ultimately be required at the provider level (as opposed to the provider type level required here)

- In the 'Waiver Revenue' row, you should enter your expected waiver revenue, based on your project valuations

If the forecast funds flow that you set out here deviates from the approach to the distribution of DSRIP funds that you articulated in your application you must explain this variance below.

Forecast of funds flow follows the revised budget adjustment for the lower than anticipated total valuation award. Forecast includes MCC qualifying for the high performance fund and assumes no state penalty in DY3 - DY5.

Funds Flow Items	DY1	DY2	DY3	DY4	DY5	TOTAL
Waiver Revenue	34,271,285	44,212,090	64,149,642	58,168,377	42,218,334	243,019,728
Primary Care Physicians	1,054,059	998,542	10,794,013	9,224,316	2,770,558	24,841,487
Non-PCP Practitioners	451,739	427,946	4,626,006	3,953,278	1,555,372	11,014,342
Hospitals	2,100,000	8,436,370	12,555,053	11,298,091	9,966,098	44,355,612
Clinics						-
Health Home/Care Management			530,031	856,585	1,108,374	2,494,990
Behavioral Health			2,120,125	3,426,341	6,494,239	12,040,705
Substance Abuse			1,060,062	1,713,171	2,216,748	4,989,980
Skilled Nursing Facilities/Nursing Homes		937,374	1,395,006	1,255,343	2,252,202	5,839,926
Pharmacies						-
Hospice						-
Community-Based Organizations			530,031	856,585	1,623,560	3,010,176
All Other	15,332,744	44,504,354	27,926,881	23,570,359	23,098,173	134,432,510
Total Funds Distributed	18,938,542	55,304,586	61,537,208	56,154,069	51,085,324	243,019,728
Undistributed Revenue	15,332,744	4,240,248	6,852,682	8,866,990	-	-

General project implementation section

This General Project Implementation section will apply across all of your DSRIP projects. In this section you describe your PPS's overall approach to the implementation of your DSRIP projects, as well as some of the factors that will apply to all projects – such as your PPS's approach to project performance monitoring. You will be required to provide an update on these headings in each quarterly report, although there will be no specific achievement value attached to these updates.

Overall approach to implementation

Please summarize your intended approach to the implementation of your chosen DSRIP projects, including considerations around how this approach will allow for the successful development of concurrently implementing DSRIP projects

The MCC PPS intends to operate under a hybrid of the Delegated Governance and Collaborative Contracting models. All community initiatives begin with strong shared community governance that is representative of the communities and Medicaid beneficiaries they serve. The MCC Board of Managers is representative of PPS partners, stakeholders, and geographic regions. The standing committees of the Board of Managers will support the projects by directing PPS activities at a high level and coordinating policies, processes, and functions that span all 11 projects (e.g., Finance, IT Data, Clinical/Quality, Compliance, and Governance).

Open, frequent communication is key to successful projects, and MCC is dedicated to a transparent communication process across the PPS. Project activities to improve the healthcare of the targeted population while decreasing overall admission rates will not only affect Medicaid patients attributed to MCC, but the overall health of WNY. As MCC conducts training/education and implements care improvements throughout the community, it will have a secondary effect across all segments of the population. Providers will become more educated in the use of population management metrics and "Plan, Do, Study, Act" (PDSA) cycles, causing a transformation in healthcare. Communication strategies will be critical to all projects, but are particularly important in those that span multiple disciplines or require collaboration among a broad group of stakeholders. This would include projects such as 2.b.iii. (ED Care Triage), 2.b.viii. (Hospital/Home Care Collaboration), 3.a.i. (Integration of Primary Care and Behavioral Health Services), 3.f.i. (Maternal and Child Health), and 4.a.i. (Improve Mental, Emotional and Behavioral (MEB) Well-Being in Communities).

The 11 projects selected by MCC will require major changes—broad, systemic changes at the network level as well as specific alterations in the day-to-day lives of patients and providers. The disruptions caused by these changes, however minute, will be felt throughout the PPS. Eventually, the results (such as improved health outcomes) will stimulate increased patient buy-in and provider involvement. But as these outcomes may take a long time to observe, community-based organizations (CBOs) will be mobilized immediately to help promote the practices and principles of DSRIP. Through community-based organizations the PPS will conduct outreach education, networking, and PCP coordination to ensure patients outside of the PPS will be engaged and linked to a PCP. The CBOs are an essential link to the serving the patients on the outside of care to bring them into a medical home (2.d.i., Patient Activation).

The development of a shared IT infrastructure and data sharing ensures the patient information is shared and securely transferred to referring providers and members of the PPS. The ability to share data among care rending groups will enhance the care coordination and decrease risk for the patient for readmission and enhance positive outcomes. Through the IT infrastructure, notifications of care transitional protocols will be established. Data sharing and notifications will support improved care transitions, which are critical to projects 2.a.i. (Integrated Delivery System), 2.b.iii. (ED Care Triage), 2.b.vii. (Implementing the INTERACT Project), 2.b.viii. (Hospital/Home Care Collaboration), and 3.a.ii. (Crisis Stabilization).

MCC, through the Clinical/Quality Committee, will standardize clinical and operational flows to support Patient-Centered Medical Home (PCMH) and patient-focused models. The activities will drive the foundational steps for moving towards a value-based model through improved outcomes. Through PCMH and NYS Advanced Primary Care Model principles the PPS will set standards for identifying high-risk patients, addressing barriers for compliance, and initiating activities to effect change. These activities will be measured and shared across the PPS. PDSA cycles will be initiated to evaluate improvement activities set forth from the practice to meet the quality measures and quickly revise as necessary to continue positive growth. All projects are intended to support the transition to value-based payment and improved outcomes, but some in particular that relate to this are 2.a.i. (Integrated Delivery System) and 3.b.i. (Evidence-Based Strategies for Disease Management).

MCC will work with neighboring PPSs Catholic Medical Partners and Finger Lakes PPS to create comprehensive healthcare transformations in the region. Close coordination will be assured by encouraging the use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to patients, and sharing lessons learned. MCC and Catholic Medical Partners selected six core projects in common and are jointly sponsoring and co-funding projects 4.a.i (Promote MEB Well-Being) and 3.f.i (Maternal and Child Health).

Major dependencies between work streams and coordination of projects

Please describe how your approach will handle interdependencies between complementary projects, as well as between projects and cross-cutting PPS initiatives - for example, an IT infrastructure upgrade, or the establishment of data sharing protocols.

FINANCIAL
Financial concerns across all projects, as practices and facilities are dependent upon financial sustainability. MCC will work with payers to enhance reimbursement strategies to provide sustainability to providers within the PPS. (all projects, Financial Sustainability).

EDUCATION
Education for patients, as well as providers, is key to empowering patients to drive their own healthcare needs as well as instilling confidence in medical staff to utilize new programs/strategies/procedures (2.d.i., Practitioner Engagement, 2.b.iii., 2.b.viii., 3.a.i.)
Gaps in knowledge could hinder outcomes of programs, such as INTERACT (2.b.vii.)
Educating Medicaid beneficiaries on established alternatives to ED will reduce non-emergent ED visits. (2.b.iii., 2.b.vii., 2.b.viii., 3.a.ii.)
Culturally, Linguistically Appropriate Services (CLAS) are very important in patient engagement. (Cultural Competency and Health Literacy, all projects but particularly 2.d.i., 3.b.i., 3.f.i., 4.a.i., 4.d.i.)

STAFFING
This PPS will be seeking highly educated and skilled resources within the PPS area to staff key support roles for all projects and workstreams. (all projects, Workforce Strategy)
The PPS is dependent upon well trained, funded staff availability, and primary physicians trained in areas with current shortages, especially in behavioral health. (2.b.iii., 2.d.i., 3.a.i., 3.b.i., Practitioner Engagement)

PATIENT COORDINATION WITHIN PPS
All providers are highly dependent upon increased levels of communication and coordination for their patients. This is especially challenging due to the current highly fragmented delivery system, the target population's size, and the region's large geographical area. (2.a.i., IT Systems & Processes, Population Health Management)
Connectivity with health home (HH) and ACO population management systems will impact ED triage. (2.a.i., 2.b.iii., Population Health Management)
Hospitals must help coordinate safe and successful discharges, while passing along all crucial information when patients return to skilled nursing facilities (SNFs) or other facilities. (2.b.iii., 2.b.vii., 2.b.viii.)
Crisis Stabilization is dependent upon ED triage to identify patients who do not need urgent care. (2.b.iii., 3.a.ii.)

IT INFRASTRUCTURE
Connectivity is the backbone for which all providers will be dependent. The ability to safely and easily access patient records is key to improving patient outcomes. (2.a.i., IT Systems & Processes)
All projects are dependent upon the PPS's ability to define data gaps, and implement data quality and content standards at the practice level. This directly impacts the PPS's practice clinical transformation and EHR utilization activities at the practice level. In particular, defining data rules and standards around Continuity of Care Documents (CCDs) as these tend to have a high rate of variability across practices and EHR vendors. This will directly impact the ability to perform population analytics across many practices. (2.a.i., IT Systems & Processes)
Cardiac project is dependent upon project 2.a.i. (Integrated Delivery System) requirement to establish disease registries. (2.a.i., IT Systems & Processes, 3.b.i.)

Overview of key stakeholders and how influenced by your DSRIP projects

In the below table, please set out who the key stakeholders are that play a major role across multiple DSRIP projects. Please give an indication of the role they play and how they impact your approach to delivering your DSRIP projects.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals driving/managing the projects, whereas the 'Key Stakeholders' table is for the people/organizations with a stake in the projects, but who are not responsible for driving them.

Key stakeholders	Role in relation to your DSRIP projects	Key deliverables / responsibilities
Legislators	**Regulatory waivers**	**Waive regulations that prevent project from achieving objectives**
HIE	**HEALTHeLINK and other RHIOs**	**Integration, connectivity, consent [especially project 2.a.i., Integrated Delivery System]**
County health departments	**(varies by county)**	**Assist in implementation of community health improvement strategies, provide region-specific support and services [especially 3.a.i. (Integration of Behavioral Health and Primary Care), 3.a.ii (Crisis Stabilization)]**

Home care providers	*Participating home health agencies*	*Provide/promote home healthcare as alternative to hospitalization/SNF admission*
Health plans and Medicaid managed care organizations	*Reimbursement*	*Provide appropriate reimbursement based on project strategies and objectives, streamline authorization processes to facilitate project success, support value-based payment*
Finger Lakes PPS	*Coordination*	*Collaborate on standardized cross-PPS protocols and policies*
Community-based and faith-based organizations	*Service providers*	*Provide culturally appropriate services to various populations to support patient engagement/activation and adherence to care plans*
Health home care managers	*Care management*	*Connect and keep high-risk Medicaid beneficiaries linked to care*
CBO Task Force	*Coordination of community resources*	*Coordinate services provided by CBOs to prevent gaps or unnecessary duplication of services*
"Voice of the Consumer" Sub-Committee	*Patient advocacy and engagement*	*Obtain direct input from Medicaid recipients*
Patients	*Care seekers*	*Care seekers*

Roles and responsibilities

Please outline the key people & organizations that play a role in the delivery of your PPS's DSRIP projects, as well as what their responsibilities are regarding governance, implementation, monitoring and reporting on your DSRIP projects.

To clarify, the 'Roles & Responsibilities' table is intended to capture those individuals driving/managing the projects, whereas the 'Key Stakeholders' table is for the people/organizations with a stake in the projects, but who are not responsible for driving them.

Role	*Name of person / organization (if known at this stage)*	*Key deliverables / responsibilities*
IT Data Committee Chair	*Leslie Feidt*	*Technical oversight/direction/coordination [all projects as needed]*
MCC Clinical Integration Officer	*Michele Mercer*	*Achieve clinical integration through the use of best practices and techniques by healthcare facilities and primary care practices throughout WNY*
MCC Director of Community-Based Initiatives	*Catherine Lewis*	*Cultural competency, health literacy, collaboration with CBOs [especially 2.b.iii. (ED Care Triage), 2.d.i. (Patient Activation), 3.a.ii. (Crisis Stabilization), 3.f.i. (Maternal and Child Health), domain 4 projects]*
MCC Continuing Education Manager	*New hire*	*Devise strategies to meet training needs through cooperative arrangements with community partners*
Project co-sponsor	*Catholic Medical Partners PPS*	*Provide joint funding; collaborate on standardized cross-PPS protocols and policies; participate in open, frequent communication about project status and objectives [4.a.i. (Promote MEB Well-Being), 3.f.i. (Maternal and Child Health)]*
All active project participants (e.g., SNFs implementing INTERACT, individuals being trained on PAM, PCPs offering Million Hearts)	*Per project*	*Meet project requirements according to established timeline, follow any protocols agreed to at PPS level, accept performance-based incentives, use electronic systems to track patients as required [all projects]*
MCC Chief Reporting Officer	*John J. Bono*	*Develop and implement plan specifying process and performance metrics to be reported, manner in which data will be reported, designating entities which will receive data, systems for analyzing and responding to data and reporting date to committees and governing board.*
MCC Project Management Office	*Led by Tammy Fox*	*Ensure workstreams and projects are coordinated, meet objectives, and contribute to the overall success of the PPS [all projects]*

IT requirements

IT will play a crucial role in the development of an effective, integrated PPS. It is likely that most projects will require some level of supporting IT infrastructure. Please describe the key elements of IT infrastructure development that will play a role in multiple projects.

Below is a list of major IT requirements for the various DSRIP workstreams and projects, identified by key stakeholders and partners during DSRIP planning meetings. In summary, there is a wide disparity of IT need and core competencies across the spectrum of participants in the PPS. A detailed survey will be required to fully understand and document the details of those requirements.

SOFTWARE AND FUNCTIONALITY
Messaging: Messaging capability between care delivery services, integrated with current systems; ability for a practice/provider to configure specific patient event notification rules and provide the ability to issue alerts for events other than just admission/discharges; growth of population health management tool with alerts sent to PCPs and other practitioners when a patient has a sentinel event

Interoperable, real-time EHR within each PPS partner practice, including:
- *HL7 interface for receipt of clinical results where the provider is a physician of record*
- *Direct enabled exchange of patient data*
- *Bi-directional exchange of CCD/Consolidated Clinical Document Architecture data*
- *From the patient record within a practice or hospital EHR, allow the user to perform a direct query for that patient's data in the RHIO. Returned result should also display if the patient is in a PPS or health home and name of PCP.*
- *Query a patient's RHIO consent from within a practice/hospital EHR; update the patient's consent directly into the RHIO*
- *SNF facilities should have INTERACT functionality within EHR to improve performance*
- *Enable doctors/nurses to remotely access resident chart to assess patients within SNF and treat in place, preventing readmission*
- *Ability for home health agencies and SNFs to view hospital discharge records from central location or within their EHR*
- *Cross-bridge all partner EHRs with central population health management tools*

Data Analytics Services: Working from the community-wide clinical and claims data repositories, provide a means to perform population health analytics

Patient Portal: Provide a community-level patient portal that provides each patient a means to access any clinical records contained in the SHIN-NY.

DATA
Clinical Data: Aggregate patient data from all WNY sources of patient clinical data and secure it in a community-level repository from which data can be extracted to support local PPS analytics or used within the community analytics service. Expedited hospital discharge summaries available through HIE or other system.

Claims Data (preferably from the state): Aggregate patient data from all WNY sources of patient claims data and secure it in a community level repository from which data can be extracted to support local analytics or used within the community analytics service

Patient Data: Allow data subject to special disclosure rules (42 CFR Part 2) to be uploaded to the RHIO and segregated from other data not subject to those rules. Build/acquire software to allow access to this data in a manner consistent with Substance Abuse and Mental Health Services Administration rules. Having this capability will allow the uploading and query of data sourced at the Part 2 facilities and the sharing of care plans for patients that contains this data.

Provider Directory: With the assistance of the "211" Resource Directory, provide an electronic and streamlined means for primary care practices to connect patients to community-based services in their own neighborhoods and communities . This provides a means for PPS partners to effectively exchange patient information directly with other PPS partners and supports care coordination efforts

HARDWARE
Laptops, tablets: A general need for better means of access to systems and information was expressed by multiple parties (e.g., laptops for home visits for capacity building)
Mobile devices: smart phones with sufficient data capacity to improve communication and documentation

PEOPLE
Training: Responsive IT training and troubleshooting for practices
IT support staff person: Support for leveraging technology for the purpose of reporting and tracking

Performance monitoring

Please explain how your DSRIP projects will fit into your development of a quality performance reporting system and culture.

A work group composed of members of the Physician Performance Sub-Committee, IT/Data Committee, Clinical/Quality Committee, and Finance Committee, with input from the Governance Committee and Chief Reporting Officer, will develop a performance measurement program, including incentive payment provisions. The work group will direct the IT Data Committee in implementation of project-specific performance dashboards. These dashboards will be populated with internal and external data, including measures identified in the DSRIP Measure Specification and Reporting Manual. The work group will develop additional measures and milestones to measure project implementation, quality, and integration and milestones/measures that will be tied to financial incentives. MCC will establish and identify quality standards using NYS DOH metrics as a starting point, and adding additional metrics that the PPS deems necessary to successfully meet provider adoption and patient engagement targets for each of the 11 projects.

Community engagement

Please describe your PPS's planned approach for driving community involvement in the DSRIP projects, how you will contract with CBOs for these projects, how community engagement will contribute to the success of the projects, and any risks associated with this.

MCC will build a CBO network that is representative of all of WNY, and that will play a vital role in engaging the Medicaid population in the delivery and implementation of DRSIP goals. During the first quarter of 2015, MCC conducted a major outreach campaign to urge CBOs to join the network. MCC directly contacted organizations by telephone and email and encouraged CBO involvement through its website. A total of 280 CBOs were added to the MCC PPS as a result of these outreach efforts.

Bringing CBOs on board is a crucial component of MCC's strategy to build a broad CBO network that will support DSRIP projects and provide direct community input to MCC's Board of Managers. MCC will determine the adequacy of its CBO network as part of the additional community needs assessment work it will conduct to identify health disparities and factors causing poor health outcomes. The plan is to identify additional CBOs which currently exist or which are emerging, particularly in immigrant neighborhoods. As additional CBOs are identified, MCC will enroll them as partners and seek to involve them in PPS work.

MCC PPS will select CBOs to serve as Cultural Competency and Health Literacy trainers via request for proposals (RFP) process. These CBOs will receive training and be responsible for training other CBOs and providers within the MCC network. An RFP will be issued to select CBOs for participation in the Cultural Competency/Health Literacy workstream.

Additionally, CBOs will be engaged to provide patient activation services in connection with the 11th project (2.d.i., Patient Activation). Since the 11th project will be organized on a sub-regional basis (North, Central, and South sub-regions), it is projected that a minimum of three CBOs will be selected through an RFP process. These CBOs will, in turn, contract with a to-be-determined number of CBOs to assist in the provision of patient activation services.

CBOs will also be extensively used in projects 3.f.i. and 4.d.i. (Support for Maternal and Child Health, Reduce Premature Births). The team overseeing these projects has earmarked a minimum of 14 CBOs with expertise in serving young mothers and their families to be involved in these projects. Agreements with these CBOs will be executed over the course of DY1.

Additional CBOs will be identified for project-related work. Each DSRIP project team is being charged with the responsibility of identifying key CBOs that will assist with project work. A determination will be made as to the number of such CBOs required and the specific services they will perform. CBO involvement in MCC's projects and activities will be facilitated by the CBO Task Force.

MCC will utilize the RFP process as the mechanism for evaluating the capacity of CBOs to provide services. The evaluation criteria and tools used to evaluate CBO capacity include, but are not limited to: (a) experience providing services to the community served; (b) ability to begin project at identified start date; (c) references from past engagements; (d) leadership and administrative capacity to perform requested service; (e) financial viability as demonstrated in IRS Form 990; and (f) cultural and linguistic capabilities appropriate to the community served.

CBOs will also provide advice and counsel to MCC's Board of Managers and committees. A total of 23 CBO representatives will be appointed to MCC's CBO Task Force. Among other things, the Task Force will be responsible for tracking and monitoring CBO involvement in project work and pinpointing new and evolving opportunities for CBO engagement.

2.a.i - Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management

1. Measurable milestones and implementation risks

Sub-section 1. Major risks to implementation and mitigation strategies

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

Risk #1: Data is not consistent across practices and EHR vendors. This affects providers trying to interpret Continuity of Care Document (CCD) data from another practice and impedes the ability to perform analytics across a population whose data is sourced from many practice settings.
Mitigation: Practice clinical transformation staff must include EHR data standards implementation in their practice support services integrated with data upload and aggregation capabilities. Implement a data standardization function to validate CCDs from practices at go-live (this could be done at the RHIO level). Feedback to practice clinical transformation staff for intervention.

Risk #2: EHR vendors may not support interoperability with the RHIO at a reasonable cost, slowing the pace of implementation of interoperability.
Mitigation: Have MCC representatives from the IT Data Committee participate in regional, state, and national conversations on this issue; apply pressure to the industry to actively support the free flow of patient data.

Risk #3: HEALTHeLINK (RHIO) training staff and PPS practice support staff operate independent of each other. Practices receive multiple, uncoordinated, outreach related to practice workflow transformation, causing confusion or distrust.
Mitigation: Active, up-front coordination of activities to embed engagement of HEALTHeLINK services into the broader PPS practice transformation service as practices are engaged. Include HEALTHeLINK as part of the broader PPS activities.

Sub-section 2. Project Implementation Speed (for Project 2.a.i. only)

For Project 2.a.i, which involves all providers in a PPS's network, setting out progress per provider would be overly onerous. For this project, PPSs will therefore be required to set out in the table below a work plan that sets out the (non-provider-specific) steps that underpin each of the PPS-wide project requirements.

Project 2.a.i	
Project Requirements/sub-steps	***Target Completion Date***
<u>Requirement 1.</u> All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy.	DY2, Q4
1. Assess any gaps in the PPS network, particularly among community-based organizations (CBOs), pharmacists, dentists, and key primary care providers (PCPs).	DY1, Q2
2. To maximize participation of all PPS partners in MCC projects and activities, conduct quarterly touchpoints to connect them to projects and educate them on techniques for referring patients to other MCC partners.	DY1, Q2
3. As part of governance structure, establish a process to conduct periodic assessments of provider network in geographic areas throughout WNY to ensure that Medicaid beneficiaries have access to service providers.	DY1, Q3
4. Perform gap analysis of PPS providers' capabilities for EHR and data exchange (possess full EHR system, possess some EHR capabilities, or no EHR capabilities).	DY1, Q3
5. Develop comprehensive PPS partner database to house all data for readiness, implementation, and ongoing reporting. Partner database will have the capability to produce the provider network list and demonstrate changes to the network list (required in domain 1 metrics).	DY1, Q4
6. Develop ongoing review procedures to ensure that all network partners have completed the necessary privacy and participation agreements to serve as a provider in the MCC network. Establish contractual agreements with partners (required in domain 1 metrics).	DY1, Q4

7. Use these gaps, along with results of the Clinical Integration Needs Assessment, to develop a high-level roadmap for inclusion and integration of all partner organizations in the integrated delivery system (IDS).	DY1, Q4
8. Finalize design; draft request for proposals (RFP); implement and deploy EHR SaaS/subscription solutions: *- EHR subscription instance: MCC EHR SaaS for PPS partners with no EHR capabilities* *- EHR integration: PPS partners' existing EHR integrated with MCC EHR SaaS* *- EHR data interfaces and exchanges*	DY2, Q1
9. Finalize design; draft RFP; implement and deploy data exchange/MCC HIE solution. Analyze local community HIE/RHIO capabilities (i.e. HEALTHeLINK). Define requirements of a community HIE/RHIO. Identify gaps of a community HIE/RHIO. Work with community HIE/RHIO to close any gaps.	DY2, Q1
10. Finalize design; draft RFP; implement and deploy data exchange alerts and messaging environment.	DY2, Q1
11. Identify payers and ancillary social service organization connectivity requirements; build data interfaces for these entities (if applicable).	DY2, Q2
12. Establish reports and secure dashboards so providers and stakeholders can monitor success and quality of data exchange and integration and make recommendations to the MCC IT Data Committee and individual providers to improve data exchange and integration.	DY2, Q3
13. IT Data Committee monitors reports and dashboards to identify trends and makes recommendations for improved data access, exchange, integration, and use. Recommendations are reported to the Board of Managers.	DY2, Q4
Requirement 2. Utilize partnering HH and ACO population health management systems and capabilities to implement the strategy towards evolving into an IDS.	DY2, Q4
1. Produce and maintain list of participating health home (HH) organizations and any ACOs in WNY.	DY1, Q2
2. Finalize and maintain written agreements with protocols for coordinating care (required in domain 1 metrics).	DY2, Q1
3. Assess HH and ACO population health management systems and capabilities. Implement evidence-based models to establish linkages with HH and ACO population health and care management services. Create system for informing PPS partners of availability of these services.	DY2, Q2
4. Meet regularly with leadership from HHs and ACOs to continue to refine collaborative care practices and integrated service delivery. Discuss how and the extent to which their care management services are connected to EDs, hospital discharge planning, home care services, and safety net PCPs and develop care management linkage recommendations. Maintain evidence of interaction (required in domain 1 metrics).	DY2, Q3
5. Conduct gap analysis to identify gaps in HH and ACO members' data exchange and data access capabilities. Verify MCC IDS and EHR solution appropriately addresses these outliers, safety net organizations, and patient support members.	DY2, Q3
6. Begin providing periodic progress reports to demonstrate service integration; incorporate a population management strategy towards evolving into an IDS (required in domain 1 metrics).	DY2, Q4
Requirement 3. Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	DY2, Q4
1. Recruit and appoint qualified individual to oversee care management across PPS, enable development and dissemination of consistent information/processes, manage care management process, and promote integration and coordination among entities delivering care management.	DY1, Q2
2. Develop Care Transitions Strategy, as required in Clinical Integration, including process flow changes required to successfully implement IDS. Develop process flow diagrams demonstrating IDS processes (required in domain 1 metrics).	DY1, Q3

3. Work with project directors, Workforce Development Work Group, and others to determine the knowledge, competencies, and licensures required for care management to effectively work with patients to ensure they receive appropriate healthcare and community support.	DY1, Q4
4. Using CNA and other inputs, finalize inventory of WNY agencies providing care management services, including HHs, WNY Care Management Coalition, etc. Identify PPS partners and hospitals that must be linked for effective transitions of care.	DY1, Q4
5. Define care management continuum. For each role along the care continuum, describe criteria for patient referral, workflows, care planning process, responsibilities associated with transitions of care, policies and procedures, outcome measure reporting techniques, etc.	DY1, Q4
6. Convene three sub-regional meetings of individuals with knowledge of hospital-to-home transitions, hospital-to-nursing home transitions, and nursing home-to-skilled nursing facility (SNF) transitions to assess current practices, identify data needs, review root cause analyses, and develop standards for maximizing effectiveness of transitions of care across the PPS. Maintain records including meeting schedules, agendas, minutes, and lists of attendees (required in domain 1 metrics).	DY2, Q1
7. Finalize protocols for warm hand-offs of patients from intensive 30-day post-discharge care planning to HH care management services.	DY2, Q1
8. Engage trainers to provide introductory and ongoing care management training on policies and procedures to care managers. Provide written training materials, list of training dates, and number of staff trained (required in domain 1 metrics).	DY2, Q1
9. Develop standards for utilizing existing EHR systems to capture key data and process measures related to DSRIP goals for reporting on care management.	DY2, Q2
10. Implement process for tracking care outside of hospital to ensure that all critical follow-up services and appointment reminders are followed. Process will include contract, report, periodic reporting of discharge plans uploaded into EHR, and other means of demonstrating implementation of the system (required in domain 1 metrics).	DY2, Q3
11. In concert with IT, develop short- and mid-term IT platforms to use for tracking, monitoring, and reporting on care coordination transition processes and outcomes to ensure interoperability for all participating providers. Leverage existing PPS data exchange capabilities; reduce data redundancies.	DY2, Q3
12. Work with payers and others to clarify and develop care coordination and transition management billing processes; provide such information to providers.	DY2, Q4
13. Using evidence-based models, develop a plan to establish a chronic disease self-management program for use by providers throughout the PPS. Include catalog of existing chronic disease self-management providers. Collaborate with existing chronic disease self-management providers (CDSMP) to identify program offerings.	DY2, Q4
14. Identify cultural and language issues that must be addressed in care management, linkages with medical home care management services, and system for informing PPS partners of availability of chronic disease self-management services.	DY2, Q4
15. Clinical/Quality Committee, PSC, and Physician Performance Sub-Committee will monitor reports and dashboards to identify trends and make recommendations for improved data access, exchange, integration, and use.	DY2, Q4
<u>Requirement 4.</u> Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	DY3, Q4
1. Conduct gap analysis to determine which providers have already completed PCMH/MU or other connectivity readiness assessment. *- Is the practice/providers/patients currently connected to the HIE?* *- If not, is an agreement in place?* *- If so, what is the scope of the connectivity (% of providers; % of patients)?* *- Does EHR meet connectivity requirements of RHIO/SHIN-NY?* *- Name of EHR, version, and electronic functionalities in use*	DY2, Q1

2. Develop strategy for low-cost data connectivity between Internet Service Providers (ISPs) (e.g., WNY R-AHEC) and local practice plans to determine minimum hardware and software requirements.	DY2, Q1
3. Gather results from readiness assessments already conducted.	DY2, Q1
4. Issue request for applications (RFA) or other action step for readiness assessment and transformation support services.	DY2, Q1
5. Select vendor or implement other structure for readiness assessment and transformation support services.	DY2, Q2
6. Identify funding model and/or PPS provider incentive model for EHR with the Finance Committee.	DY2, Q4
7. Connect PPS providers to EHR SaaS and MCC HIE solutions: *- Implement recommended EHR solution and integrate* *- Implement recommended data exchange/HIE solution and start data exchange* *- Implement PPS providers by waves grouped by the partner's ability to connect and integrate into the solution; start with the most able to connect; add others as they establish their capabilities*	DY3, Q1
8. Systematically contact PPS providers to provide the recommended EHR and data exchange solution: *- Reduced EHR subscription cost for PPS providers with no EHR solution* *- Recommended network topology connectivity solution for each PPS provider* *- If PPS providers have same EHR, align data exchange* *- If PPS provider has different EHR, integrate data exchange with MCC EHR* *- Data exchange/HIE connectivity requirements and limitations*	DY3, Q1
9. Facilitate QE participation agreements with MCC providers.	DY3, Q2
10. For providers in the process of acquiring EHR capabilities, develop and implement training on use of EHR features, including development of written materials. Track training dates and number of staff trained.	DY3, Q2
11. Implement and deploy alerts. Provide EHR vendor documentation, screenshots, and/or evidence of use of alerts.	DY3, Q3
12. Implement and deploy secure Direct messaging. Provide EHR vendor documentation, screenshots, and/or evidence of use of secure Direct messaging.	DY3, Q3
13. Implement and deploy patient record look-up. Provide EHR vendor documentation, screenshots, and/or evidence of use of patient record look-up.	DY3, Q3
14. Implement and deploy public health reporting capabilities. Provide EHR vendor documentation, screenshots, and/or samples of transactions to public health registries.	DY3, Q3
15. Continuously add PPS members when their EHR and data exchange capabilities reach the minimal level required to connect to the MCC EHR and data exchange/HIE.	DY3, Q4
16. PPS providers who are not actively exchanging systems will be addressed by the Physician Performance Sub-Committee. Corrective actions will be implemented for those PPS members found noncompliant.	DY3, Q4
Requirement 5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.	DY3, Q4
1. Conduct Safety Net MU stage 2 CMS/PCMH level 3 readiness assessment: *a. Identify site-specific IT/care management leadership* *b. Determine current EHR PCMH/MU certification status* *c. Identify site-specific barriers and risks to implementing a MU/PCMH Level 3 certified EHR system*	DY2, Q2
2. Facilitate engagement with MU/PCMH-certified EHR vendors as needed.	DY2, Q4
3. Practices provide MU and PCMH Level 3 certification documentation to the PPS.	DY3, Q4

Requirement 6. Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	DY2, Q4
1. Define IT requirements for initializing/maintaining/communicating risk stratification across settings, including means for electronic interfacing to the participating provider community and key data sharing.	DY1, Q4
2. Implement and deploy population health management risk stratification models and data analytics system leveraging data from the MCC integrated EHR and data exchange/HIE environments.	DY2, Q2
3. Define priority target population, pilot test, and implement risk-stratified patient registries (high risk, moderate risk, low risk, and well).	DY2, Q3
4. Track and monitor registry results to verify continuous improvement.	DY2, Q4
5. Report on patient engagement and engaged safety net practices according to project milestone reporting requirements.	DY2, Q4
Requirement 7. Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of Demonstration Year (DY) 3.	DY3, Q4
1. Perform PCMH and MU readiness assessment and transformation support services for primary care practices: a. Issue RFA or other action step for readiness assessment and transformation support services; b. Select vendor(s).	DY2, Q2
2. Identify site-specific physician champions and site-specific IT/care management leadership. Determine PCMH/MU current status and identify site-specific barriers and risks to transformation.	DY2, Q2
3. Gather results from readiness assessments already conducted.	DY2, Q2
4. Based on CNA results and current data, identify primary care shortages in high-need areas.	DY2, Q3
5. Complete gap analysis for all MU/PCMH level 3 elements based on readiness assessment results.	DY2, Q4
6. Each site will change policy/procedures, roles/responsibilities, workflow for population health management/care management/care coordination during transitions, performance measurement, CAHPS measurement as needed to meet PCMH/MU standards.	DY3, Q1
7. Implement strategies to recruit PCPs to serve high-need areas. Provide status reporting of recruitment of PCPs, particularly in high-need areas, and monitor improvements in access via CAHPS measurement (required in domain 1 metrics).	DY3, Q2
8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.	DY3, Q4
9. Maintain list of current/updated NCQA certified practices and EHR MU certifications.	DY3, Q4
10. Initiate PPS monitoring, oversight, and corrective action: *a. PSC and Physician Performance Sub-Committee monitor reports and dashboards to identify trends in adherence to MU and PCMH level 3 standards* *b. Results will drive recommendations to improve meeting MU and PCMH measures* *c. Non-responsive PCPs will be addressed by the Physician Performance Sub-Committee with corrective action*	DY3, Q4
Requirement 8. Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	DY2, Q4
1. Assess ability for MCC to contract as IDS with MCOs.	DY1, Q2
2. Elicit input from MCOs on elements of a multi-year plan to transition to VBP system; present MCC's proposed multi-year plan to MCOs.	DY1, Q4
3. Seek and obtain MCOs' revisions to plan. Secure MCOs' approval of plan. Catalog main issues/data needs that require resolution as part of the plan approval process.	DY2, Q1

4. Establish partner-specific incentives based on established utilization and quality metrics.	DY2, Q2
5. Utilize approved value-based payment (VBP) transition plan to guide agenda-setting in monthly meetings with MCOs.	DY2, Q2
6. Provide documentation of executed Medicaid Managed Care contracts (required in domain 1 metrics).	DY2, Q4
7. Set up system to monitor progress with respect to evaluating the VBP transition plan's guideposts against actual results. Provide reports demonstrating percentage of total provider Medicaid reimbursement using value-based payments (required in domain 1 metrics).	DY2, Q4
8. MCOs make recommendations to MCC on VBP arrangements. Implement programs, in-servicing information, and proposals for MCC partners based on MCO recommendations via the Physician Steering Committee.	DY2, Q4
Requirement 9. Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	DY2, Q4
1. Charge VBP Sub-Committee (see Milestone #10) with responsibility of recommending structure and process to meet regularly with MCOs to review and evaluate costs, quality, utilization, and other relevant topics.	DY1, Q2
2. For each of the top four MCOs serving WNY (Independent Health, Fidelis, Blue Cross Blue Shield, and Univera) define the following: participants, meeting schedule, agenda items, and other relevant processes for building PPS partnerships. Establish a process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership. Maintain records of meeting agendas, attendees, minutes, and materials (required in domain 1 metrics).	DY1, Q4
3. Ascertain from NYS DOH what recourses are available to PPS if an MCO does not agree to meet regularly or to engage in an organized VBP agenda with PPS.	DY1, Q4
4. Devise and secure buy-in from MCOs that they will adhere to a timetable for transitioning to a VBP system.	DY2, Q1
5. Establish agreed-upon data sources, utilization and performance metrics, reports, and dashboard.	DY2, Q1
6. Report Medicaid managed care metrics and opportunities to MCC Board of Manager committees.	DY2, Q2
7. Publish dashboards to MCC intranet for transparency with partners.	DY2, Q4
8. Identify opportunities for improvement based on the agreed-upon metrics and reports and develop process improvement strategies.	DY2, Q4
9. Measure and report progress of process improvement plans to MCC governance on a quarterly basis.	DY2, Q4
Requirement 10. Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	DY2, Q4
1. Establish VBP Sub-Committee under MCC's Finance Committee with representatives from finance, legal, medical staff, executive leadership, and others, to formulate a multi-year VBP transition plan.	DY1, Q2
2. Engage external expert/consultant to assist in and provide recommendations for development of five-year plan for transitioning to value-based reform system.	DY1, Q3
3. As part of plan, summarize process measures and clinical outcome benchmarks that will guide PPS's work over five years.	DY1, Q3
4. Based on data from population health, data analytics, PAM, coordination of care, HEDIS, predictive monitoring, risk stratification, and other systems, establish PPS provider compensation tables and incentives. Develop compensation model and implementation plan (required in domain 1 metrics).	DY2, Q1
5. Develop a methodology to calculate criteria for distribution of incentive pool monies to reward performance of PPS partners.	DY2, Q1
6. Obtain both Finance Committee and Board of Managers approval of VBP transition plan.	DY2, Q2

7. Share transition plan with MCOs and secure their buy-in.	DY2, Q3
8. Engage MCOs and payers to agree to specific VBP rates. Specific rates and duration are contractually established.	DY2, Q3
9. Utilize feedback from PPS providers to ensure that improvement of desired patient outcomes, patient engagement, positive interventions, and avoidance of negative patient events are included in analysis of MCC programs and delivery models. Establish MCC provider compensation for patient outcomes.	DY2, Q4
10. Communicate agreed-upon payment rates and procedures to PPS members.	DY2, Q4
11. Continuously monitor outcomes, trends, and other sources to verify agreed-upon measures are on target. Provide contracts, reports, payment vouchers, and/or other evidence demonstrating implementation of the compensation and performance management system (required in domain 1 metrics).	DY2, Q4
12. Identify PPS providers who are not actively attempting to meet compensation and outcomes established by the Governance Committee. Corrective actions will be implemented for those PPS providers found noncompliant.	DY2, Q4
Requirement 11. Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	DY4, Q4
1. Initiate outreach and navigation activities; partner with CBOs to implement patient activation activities.	DY1, Q2
2. Document partnerships with CBOs (required in domain 1 metrics).	DY1, Q2
3. Define roles for, hire, and train navigators. Provide evidence of community health worker hiring, co-location agreements, and/or job descriptions (required in domain 1 metrics).	DY2, Q1
4. Create communication and education plans for patients for inclusion in the Engagement Strategy and Plan (see IT Systems & Processes, milestone #3).	DY2, Q1
5. Implement and deploy patient engagement systems including the patient portal, leveraging data from the MCC integrated EHR and data exchange/HIE environments.	DY2, Q4
6. Leverage the communication capabilities available in the patient portal to increase and improve patient-to-caregiver communications.	DY2, Q4
7. Utilize monitoring in population health management and data analytics for formative evaluation. Report on how many patients are engaged with community health workers (required in domain 1 metrics).	DY3, Q1
8. Verify patient engagement is having the desired positive impact on outcomes and interventions.	DY4, Q4
9. Adjust MCC processes and procedures to address gaps in patient engagement, outcomes, and other results via the PSC and Physician Performance Sub-Committee.	DY4, Q4

2.b.iii ED Care Triage for At-Risk Populations

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	*14300*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	1,000	2,000	3,000	1,100	2,200	3,400	4,500	1,900	3,800	6,400	9,000	4,450	8,900	11,600	14,300

2.b.vii Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table

Expected # of actively engaged patients (total, as per project plan application)	*575*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	125	200	300	150	250	325	400	175	300	425	575	200	400	500	575

2.b.viii Hospital-Home Care Collaboration Solutions

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	*1125*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	147	206	265	175	325	538	750	220	450	675	900	300	754	940	1,125

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

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	*81000*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	6,000	8,000	12,200	4,000	8,000	18,000	28,500	10,000	21,000	35,000	59,000	30,000	59,000	65,000	81,000

3.a.i Integration of Primary Care and Behavioral Health Services

IMPORTANT: Please select which model(s) you will pursue for this project by highlighting the cell(s) of the corresponding model(s) in YELLOW	Model 1 (PCMH)	Model 2 (BH)	Model 3 (IMPACT)

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	*22700*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	1,200	2,000	5,000	3,000	9,000	12,500	18,500	5,000	13,000	18,500	22,700	5,000	13,000	18,500	22,700

3.a.ii Behavioral Health Community Crisis Stabilization Services

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	*12750*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	3,825	5,000	7,650	2,300	5,610	6,700	9,563	4,500	8,670	10,000	11,475	7,500	9,945	11,500	12,750

3.b.i Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only)

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	*32800*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	2,500	3,000	5,137	2,000	4,500	7,500	11,986	4,500	10,000	20,000	32,800	7,500	18,000	25,000	32,800

3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)

Patient engagement speed

In the Patient Engagement Speed section, PPSs will describe the ramp-up of their implementation in a greater level of detail than was required in the Application. In the table below, you should set out the number of patients that will have become 'actively engaged' by each quarter (or the number engaged in each quarter, depending on the counting methodology applied to that project). These detailed numbers must, of course, be in line with the half-yearly numbers that the PPS committed to in the Application.

Your progress against these patient engagement speed commitments will be linked to a Domain 1 Process Payment.

Patient speed of implementation table															
Expected # of actively engaged patients (total, as per project plan application)	*1000*														
	DY1, Q2	**DY1, Q3**	**DY1, Q4**	**DY2, Q1**	**DY2, Q2**	**DY2, Q3**	**DY2, Q4**	**DY3, Q1**	**DY3, Q2**	**DY3, Q3**	**DY3, Q4**	**DY4, Q1**	**DY4, Q2**	**DY4, Q3**	**DY4, Q4**
Patients Engaged	250	300	500	300	750	850	1,000	500	1,000	1,000	1,000	500	1,000	1,000	1,000