

DSRIP Implementation Plan

Introduction to this prototype:

This is the second installment of the DSRIP Implementation Plan Prototype. This document contains sections of a hypothetical 'prototype' implementation plan, written on behalf of Forestland PPS. This second installment contains the following organizational sections: Cultural Competency & Health Literacy, IT Systems & Processes, Performance Reporting, Practitioner Engagement, Population Health Management, Clinical Integration, Budget, and Funds Flow.

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Instructions

Note: the instructions on this tab relate to the template, rather than the prototype. Please see the "Before you begin.." tab for more notes on the prototype.

You must complete all of the organizational sections of the implementation plan and all of the project plan applications for the particular projects you are undertaking.

Part 1: The Organizational Implementation Plan Sections

There are a total of eleven organizational sections: Governance, Workforce, Financial Sustainability, Cultural Competency, IT Systems and Processes, Population Health Management, Clinical Integration, Performance Reporting, Practitioner Engagement, Budget and Funds Flow. You must complete all of these sections.

In most of these sections there are a number of specific milestones. In order for this template to be considered complete, you must enter the demonstration year and quarter by which you will achieve each milestone and set out the key sub steps that you will undertake in order to reach this milestone. The template also sets out, for each milestone, what supporting evidence you will be required to provide to the Independent Assessor in order to demonstrate: (a) that you have achieved that milestone; and (b) on an ongoing basis through the quarterly reporting process regarding that particular milestone.

There are several milestones/questions which are required for the first quarterly report, but for which the dates are not yet defined. Within your first quarterly report, you must enter, at minimum, an estimate to show that work is under way. A more detailed approach will be announced as soon as possible.

Part 2: The Project Implementation Plan Sections

The 'General Project Implementation' tab contains a number of headings to which you must respond. These headings apply across all of your chosen projects. You therefore only need to fill this tab out once.

You should then complete a separate project implementation plan for each of your chosen DSRIP projects.

Within each Domain 2 and 3 project tab, you will find a Project Implementation Speed table. This table requires you to provide a quarter-by-quarter breakdown of the target you set for Project Speed of Implementation in your project plan application for each project. Having set your quarterly targets for project implementation speed in this template, you will then be required to report your progress through the quarterly reports. Note: the Project Implementation Speed table for Project 2.a.i is structured differently to the tables for all other projects.

You will also find a Patient Engagement Speed table within each Domain 2 and 3 project tab (except Project 2.a.i). This table requires you to provide a quarter-by-quarter breakdown of the target you set for Patient Engagement Speed in your project plan application for each project. ***These quarterly forecasts for Patient Engagement Speed should match the counting methodology used in the Patient Engagement Speed Table for your project plan application for the corresponding project.*** The only difference in this Implementation Plan is that the values entered will be on a *quarterly* basis instead of a *semi-annual* basis. The counting methodology remains the same. For more detail on the counting methodology, please consult the DSRIP website. In summary, the counting methodology will be either:

-- A count of patients that meet the criteria for 'actively engaged' over a 1-year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is ***not*** additive across DSRIP years (projects 2.b.iv, 2.b.v, 2.b.vi and 3.a.ii); or

-- A count of patients that meet the criteria for 'actively engaged' over a 1-year measurement period. Duplicate counts of patients are ***not*** allowed. The count is ***not*** additive across DSRIP years (projects 2.a.ii, 2.a.iii, 2.a.iv, 2.a.v, 2.b.i, 2.b.ii, 2.b.iii, 2.b.vii, 2.b.viii, 2.b.ix, 2.c.i, 2.c.ii, 2.d.i, 3.a.i, 3.a.iii, 3.a.iv, 3.a.v, 3.b.i, 3.b.ii, 3.c.i, 3.c.ii, 3.d.i, 3.d.ii, 3.d.iii, 3.e.i, 3.f.i, 3.g.i, 3.g.ii and 3.h.i)

NOTES ON THE PROJECT IMPLEMENTATION PLANS:

- The quarterly speed of implementation targets that you set in this template must align with the overall targets that you committed to in your project plan application for each project.

- For Domain 2 & 3 projects, there will be specific Achievement Values associated with PPSs meeting: (a) their quarterly project implementation speed targets; and (b) their quarterly patient engagement speed targets. More detail on the assessment of Achievement Values and how they drive Domain 1 Process Payments will be forthcoming shortly in an 'AV Policies & Procedures Guide'.

- A more detailed version of the Project Implementation Speed table than the one included in this template will be published in Spring/Summer 2015 for PPSs to complete. The due date for this table, as well as the due dates for any other elements of the implementation plan not required by April 1, will be published shortly.

- PPSs will ultimately be required to identify all of the providers committed to each project. This will not be required for the April 1st submission of this template, but will ultimately be required for the quarterly reporting process using the MAPP tool. Throughout the 5 years of the DSRIP program, PPSs will be able to swap providers into and out of the lists of providers committed to particular projects. However, they will still be held accountable to the overall numbers they commit to in their project speed and scale of implementation tables.

Before you begin...

A note on the prototype:

This prototype does not contain detailed speed of implementation commitments for Forestland PPS (i.e. the patient speed of engagement table and the project speed of implementation table). The ramp up of speed of implementation is so specific to each PPS that including a hypothetical example would not have provided any useful guidance.

While this prototype is a hypothetical example, the target completion dates within it are all within a reasonable timeframe for completion of those milestones. Ultimately, it will be the role of the Independent Assessor to make a judgment about what constitutes an acceptable timeframe for completion of a given milestone for each PPS.

As described below, PPSs are able to add milestones into their implementation plans in addition to those milestones prescribed by the template. In this hypothetical example, Forestland PPS has added some additional milestones into some sections (notably Financial Sustainability). Please note: these additional milestones are part of the prototype and will not be included in the template; the milestones prescribed in the template are the only ones that PPSs must set target completion dates for in their April 1st implementation plans. You should consult the template for clarity on which milestones are mandatory.

Background: The Implementation Plan as the basis for the Quarterly Reports

Each quarter throughout the DSRIP program, PPSs must submit a quarterly report to the Independent Assessor. This quarterly reporting process will ultimately be automated via the MAPP tool. The submission of a complete quarterly report will drive one of the Achievement Values that drive Domain 1 process payments. The link between the different sections of the implementation plan & quarterly reports and Domain 1 process payments will be articulated in more detail in the '*AV Policies & Procedures*' guide, which will be released shortly.

This implementation plan will create a baseline against which the quarterly reports measure progress, although there are some sections for which that baseline will be created at a later date - for example, PPSs will not be expected to provide refined workforce transformation numbers (new hires, retraining, redeployment etc.) in this document. ***The exact timeline for when these refined workforce transformation numbers will be required - along with details of all the elements of this implementation plan that will be required at a later date - will be published shortly.***

You will see that the organizational sections of this implementation plan include specific milestones. In order for the implementation plan to be considered complete, PPSs must set dates for when they will achieve these milestones and must set out the steps they will take towards that milestone. For each of the milestones, this document also describes the specific supporting documentation or evidence that PPSs must submit to demonstrate they have achieved the milestone, as well as the evidence they will be required to submit on an ongoing basis in the quarterly reports.

The implementation plan milestones

The table below is an example of the milestone tables that you will see throughout this template.

The Milestone: PPSs must enter a target completion date against all specified milestones. You will then use the quarterly reporting process to update the Independent Assessor on your progress against this target date. Should you need to revise this target date, you will be able to do so, without compromising any achievement values associated with that milestone, as long as you provide sufficient explanation to the Independent Assessor explaining why your projected timeline has changed and what your plans are for addressing this.

The milestones prescribed in this template are not necessarily listed in sequential order; in the example table below, for example, you could set a target date for 'Establish a clinical governance structure...' that is later than your target completion date for 'Finalize bylaws and policies'. You can also add additional milestones should you wish. Whether you add additional milestones or not, you must, at a minimum, set target completion dates for all of the milestones prescribed in this document.

Target Completion Date: You must fill in this column using the drop down list, indicating in which year and quarter you will complete the milestone or step.

Supporting Documentation: This column describes the evidence that PPSs will need to submit, to the Independent Assessor's satisfaction, in order to demonstrate that the milestone in question has been achieved. Where relevant, we have set out the key elements that these pieces of supporting documentation will need to cover. More detail will be forthcoming in the 'AV Policies and Procedures' guide.

Step 1, Step 2, Step 3 etc.: These rows are where you should set out the key steps you will take in working towards the milestone above, as well as your target completion dates for these steps. You will not be asked to provide supporting documentation to demonstrate that you have undertaken these steps. These steps are intended to give DOH and the Independent Assessor more insight into the planning and implementation process that each PPS is undertaking. You should add more rows into the table in order to set out all of your key steps.

Governance structure updates	Target Completion Date	Supporting Documentation
Milestone: Establish a clinical governance structure, including clinical quality committees for each DSRIP project		Clinical Quality Committee charter and committee structure chart Subsequent quarterly reports will require minutes of clinical quality committee meetings to be submitted.
Step 1...		
Step 2...		
Milestone: Finalize bylaws and policies or Committee Guidelines where applicable		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.
Step 1...		
Step 2...		

A note on printing this document:

We have optimized the settings of this document for printing as far as possible but these settings may change depending on your own default settings. If you would like to print this document, you can take the following steps to make your document print-friendly (if it is not already configured as such):

1. Select all sheets in the document (select the first tab, scroll to the last tab, hold down 'Shift' and select the last tab)
2. Go to File > Print Preview
3. Within the Print Settings: (1) select 'Print Entire Workbook'; (2) set Page Orientation to Landscape; and (3) set your Scaling to 'Fit All Columns on One Page' if printing to paper, or 'Fit Sheet on One Page' if printing to PDF.

Cultural Competency and Health Literacy

Key Steps and Measurable Milestones

Domain 1 Process Measures

<i>Progress Reports on the Implementation of the Cultural Competency/ Health Literacy Strategies</i>	<i>Target Completion Date</i>	<i>Supporting Documentation</i>
<p>Milestone: Finalize cultural competency / health literacy strategy.</p>	<p>DY1, Q3</p>	<p>Cultural competency / health literacy strategy signed off by PPS Board. The strategy should:</p> <ul style="list-style-type: none"> -- 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. <p>Subsequent quarterly reports will require updates on the implementation of your cultural competency / health literacy strategy.</p>
<p>1. Building on the Community Needs Assessment, conduct further analysis to confirm key priorities for Forestland PPS in terms of health disparities between different cultural, socioeconomic and linguistic groups. This will include an analysis of the driving factors behind these poorer outcomes, and the drivers of under-use of services by specific populations</p>	<p>DY1, Q2</p>	

<p><i>2. Building on the initial assessment carried out for our DSRIP application, carry out gap assessment of cultural competency at the provider level. This gap assessment will compare the priority patient groups & health disparities with the facilities and services available at a provider / site level, as well as the linguistic capabilities of individuals at those providers. The analysis will also consider the role of CBOs and the capabilities available through our CBO links. This analysis will be used to identify key targets (i.e. providers and/or geographic areas where the cultural competency of providers is a particular issue). The assessment will cover: the patient environment; the simplicity / accessibility of services; and the extent to which existing community groups are involved in services</i></p>	<p>DY1, Q2</p>	
<p><i>3. The Forestland PPS Cultural Competency & Health Literacy Working Group will define PPS-wide standards for culturally and linguistically appropriate services (building on national standards). The Working Group will consider relevant evidence-based clinical and/or programmatic approaches for their target communities for consideration, such as disease risk factors for specific ethnic/racial groups, cultural issues that impact adherence rates, psycho-social stressors, nutritional regimens that match ethnic traditions and/or financial affordability, and implicit biases in assessing patients. These standards will be signed off by the Clinical Quality Committee</i></p>	<p>DY1, Q2</p>	

<p>4. <i>The Cultural Competency & Health Literacy Working Group will develop, in collaboration with CBOs, a multi-channel approach to improving the health literacy and ability for self-management targeted to specific patient groups, including those with a particularly high need for full understanding of their most effective and efficient care and treatment options (e.g. new mothers, recent immigrants, patients with multiple chronic conditions, patients demonstrating a high rate of avoidable readmissions, and patients with long-term behavioral health conditions). This approach will include: a suite of language-appropriate patient engagement materials (e.g. educational pamphlets, advertisements); an engagement plan for those with low literacy, to include patient navigators and the teach-back approach to ensure complete understanding; one-off community engagement events; and self-assessment tools</i></p>	<p>DY1, Q3</p>	
<p>5. <i>Cultural Competency and Health Literacy Working Group to conduct consultation on draft Cultural Competency / Health Literacy Strategy with patient groups, CBOs, PPS provider network, Medicaid MCOs and Greater Forestland University</i></p>	<p>DY1, Q3</p>	
<p>6. <i>Develop literature / material designed to improve health literacy of target populations of attributed members, with specific reference to the availability of services and the most appropriate ways to access / navigate the health system; develop plan to disseminate this material in PPS learning collaboratives with providers within the network identified as having best practices in in cultural competency</i></p>	<p>DY1, Q3</p>	
<p>7. <i>Develop communications and engagement approach designed to build provider buy-in to improving their cultural competency and the accessibility of their services / facilities; work will be led by Cultural Competency & Health Literacy Working Group, in collaboration with Practitioner Champions and Forestland PPS Head of Communications</i></p>	<p>DY1, Q3</p>	

<p>8. <i>Develop metrics to evaluate and monitor ongoing impact of cultural competency / health literacy initiatives. Progress against these metrics will be evaluated on a semi-annual basis and results made public</i></p>	<p>DY1, Q3</p>	
<p>Milestone: <i>Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).</i></p>	<p>DY1, Q4</p>	<p>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</p> <p>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.</p>
<p>1. <i>Based on gap assessment and the adopted standards/approaches/strategy (step 2 and 3 of milestone above), develop priority target list of practitioners / providers / sites for cultural competency and health literacy training</i></p>	<p>DY1, Q2</p>	
<p>2. <i>Identify cultural competency ‘champions’ in providers throughout the Forestland PPS network and corresponding points of contact in CBO partners</i></p>	<p>DY1, Q2</p>	
<p>3. <i>In collaboration with CBOs, Medicaid MCOs and Greater Forestland University, the Cultural Competency & Health Literacy Working Group will develop an evidence base for training interventions that are effective in improving cultural competency, with a particular focus on the specific cultural / socio-demographic groups identified above</i></p>	<p>DY1, Q3</p>	

<p>4. Based on the evidence base (defined in the previous step), the Cultural Competency & Health Literacy Working Group will develop training program for front-line practitioners focused on the core competencies and skills required to deliver culturally competent, health-literate care (with specific reference to the patient populations identified as priorities above); training to be delivered on-site in order to incorporate a broad range of staff from each organization</p>	<p>DY1, Q4</p>	
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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.

The primary risk to the implementation of Forestland PPS’s cultural competency/ health literacy strategy is a lack of internal buy-in for the fundamental need for these initiatives to engage with currently isolated communities. Making the case for change – with a specific reference to the impact that cultural competency and health literacy can have on DSRIP outcome measures – will be a crucial part of engaging providers (particularly our PCP community) in the cultural competency / health literacy initiatives described in our strategy.

Our primary approach to mitigating this risk will be the cultural competency and health literacy training described above. The identification of cultural competency ‘champions’ will play another important role in mitigating this risk. One of the key measures of success for these individuals will be the extent to which practitioners in their organizations undertake cultural competency and health literacy training. They will also be assessed against the extent to which providers adopt the principles and core standards of the Forestland PPS Cultural Competency and Health Literacy Strategy.

Another risk to the delivery of our Cultural Competency Strategy is the availability of sufficient administrative and support staff in the provider organizations identified as priorities for cultural competency / health literacy initiatives. Based on the analysis conducted to support our initial application, we know that the providers delivering most care to linguistically & socially isolated communities are typically those under the most significant administrative / operational burden. In order to mitigate the risk of cultural competency / health literacy initiatives being lost to more immediate pressures, we will offer specific incentives to those organizations to support their implementation of our cultural competency strategy. In particular, we will offer support to those organizations in improving the efficiency of their back office and administrative work flows (through personnel and financial support), with the specific aim of freeing up time to be dedicated to cultural competency / health literacy initiatives.

Major Dependencies on Other Workstreams

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

The successful implementation of the Forestland PPS's cultural competency and health literacy strategy is interdependent with several workstreams. Recruiting staff that represent the communities we serve is a crucial element of our cultural competency strategy (particularly for those communities that are typically isolated from health services). The development of our Cultural Competency strategy will therefore depend heavily on the Forestland PPS Workforce Strategy Team; the Cultural Competency and Health Literacy Working Group will involve a representative of the Forestland PPS Workforce Strategy Team.

The provider / practitioner training that will be developed as part of the Cultural Competency strategy will be a central part of the broader training strategy that is to be developed and implemented by the Forestland Workforce Strategy Team.

The incentives described in this section (financial and personnel support for the streamlining of operations at a provider level) will rely heavily on the Forestland PPS PMO to manage these provider support initiatives.

Our implementation of our Cultural Competency / Health Literacy Strategy will depend heavily on our engagement with CBOs. To date we have contracted with one CBO that is a patient representative organization ('Forestland Voices') and 2 CBOs with experience of engaging local communities in improving the safety of their own neighborhoods ('Take Back Birchwood' and 'Safer Sprucefield'). These 3 CBOs are currently external stakeholders to our project leadership teams. Over time, we intend to involve them in the delivery of these projects and as non-executive members in the governance structure of the PPS. The project leadership teams for each project will be tasked with identifying CBOs that will add value to their projects and contracting with them accordingly.

In addition to the specific CBOs that we will contract with and involve in our project management structure, we engaged with a large number (approx. 40) CBOs in the development of our CNA and our Project Plan Applications. These organizations will continue to play a key role in all of our consultation and engagement activities.

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.

<i>Role</i>	<i>Name of person / organization (if known at this stage)</i>	<i>Key deliverables / responsibilities</i>
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<i>The Forestland PPS Cultural Competency & Health Literacy Working Group – Lead</i>	<i>Meryl Tural</i>	<i>Manage the direction and output of the working group; ultimately responsible for the Forestland PPS Cultural Competency / Health Literacy Strategy</i>
<i>Cultural Competency Committee – Head of Education</i>	<i>Sarah Compton</i>	<i>Lead the development of the PPS’s cultural competency training & education program</i>
<i>Cultural Competency Committee – Head of Health Literacy</i>	<i>Jacques Ensee</i>	<i>Lead the development of the PPS’s health literacy campaign</i>
<i>Forestland PPS Executive Body Member with specific responsibility for cultural competency and health literacy</i>	<i>John Cull</i>	<i>Liaison between the executive body and the Cultural Competency Committee</i>

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.

<i>Key stakeholders</i>	<i>Role in relation to this organizational workstream</i>	<i>Key deliverables / responsibilities</i>
<i>Internal stakeholders</i>		
<i>Downstream providers</i>	<i>Recipient of educational programs</i>	<i>Commit to and undertake cultural competency transformation</i>
<i>External stakeholders</i>		

Contracted CBOs	Provide assistance in the development and execution of the workstream	Subject matter expert & patient liaison
Patients & Families	Recipient of improved services; contributor to design of cultural competency / health literacy initiatives through consultation	Feedback on consultations

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.

Effective and up-to-date monitoring of the impact our cultural competency / health literacy strategy will require interoperable IT systems to be in place across our network, with a particular focus on the gathering of demographic information about patients. At the Forestland PPS PMO level we will then use this information to track the service usage of our priority patient groups (including avoidable admissions, emergency department visits etc.).

In addition, the use of interoperable patient information systems across our network will be a critical tool in developing culturally appropriate services for individual patients. Our patient information systems will gather information about patients' cultural, religious and personal preferences. Sharing this information between providers will allow those providers and practitioners to deliver culturally and linguistically appropriate services, and to understand the wider trends in the members utilizing their services.

Progress Reporting

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

At a high level, the annual refresh of the Community Health Needs Assessment will allow the PPS PMO to make an annual assessment of any change in the health disparities between different sub-populations identified in the CNA (and assess the extent to which that impact is as a result of our Cultural Competency Strategy). Improvements in the health literacy of our attributed population will support our achievement of targets for reductions in avoidable emergency visits/ admissions (through more effective use of the health system). Specifically, the metrics we will use to monitor the success of our work to improve the health literacy of target populations (which will be reported to the Clinical Quality Committee on a monthly basis) will be:

- Avoidable ED and inpatient utilization associated with priority cultural & socio-demographic groups (to assess the impact of our Cultural Competency / Health Literacy strategy on the way these groups are accessing and using healthcare services)*
- Uptake of practitioner cultural competency training*
- Patient involvement in specific community engagement initiatives (focusing specifically on cultural/linguistic communities)*

IT Systems and Processes

Key Issues

<i>Current state analysis</i>	<i>Target Completion Date</i>	<i>Supporting Documentation</i>
<p><u>Milestone:</u> 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).</p>	DY1, Q4	<p>Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.</p> <p>Subsequent quarterly reports will require updates on the key issues identified and plans for developing the PPS's IT infrastructure.</p>
1. Establish IT Governance Structure	DY1, Q2	
2. Conduct IT Readiness Survey and analyze results (survey to include readiness for data sharing at the provider level and a mapping of the various systems in use throughout the network and their potential interoperability)	DY1, Q2	
3. Share results of IT readiness assessment with network partners and discuss implications in provider IT leads' forum	DY1, Q3	
4. Update and approve IT Strategic Plan	DY1, Q4	
5. Map future state needs articulated in IT Strategic Plan against readiness assessment in order to identify key gaps in IT infrastructure, data sharing and provider capabilities	DY1, Q4	

IT Governance	Target Completion Date	Supporting Documentation
<p>Milestone: Develop an IT Change Management Strategy</p>	<p>DY1, Q4</p>	<p>IT change management strategy, signed off by PPS Board. The strategy should include:</p> <ul style="list-style-type: none"> -- 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; <p>and</p> <ul style="list-style-type: none"> -- Defined workflows for authorizing and implementing IT changes <p>Subsequent quarterly reports will require an update on the implementation of this IT change management strategy.</p>
<p>1. Define IT Change Approval Process (by Designated Authorities)</p>	<p>DY1, Q2</p>	
<p>2. Catalogue, define, and publish Standard/Non-Standard change scenarios</p>	<p>DY1, Q3</p>	
<p>3. Establish roles, responsibilities, and performance metrics for change process</p>	<p>DY1, Q4</p>	
<p>4. Identify, communicate, and escalate pathways for Change Advisory Board, representing multiple entities</p>	<p>DY1, Q4</p>	
<p>5. Approve and publish IT Change Strategy (including risk management), signed off by the Forestland PPS Executive Body</p>	<p>DY1, Q4</p>	

Data Sharing	Target Completion Date	Supporting Documentation
<p><u>Milestone:</u> Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network</p>	<p>DY1, Q3</p>	<p>Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include:</p> <ul style="list-style-type: none"> -- 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 DEAs 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). <p>Subsequent quarterly reports will require updates on your implementation of this roadmap and an update on any changes to the contracts / agreements in place.</p>
<p>1. Define data exchange needs based on the planning for the 11 DSRIP Projects and engagement with the network providers (as part of the current state assessment)</p>	<p>DY1, Q2</p>	
<p>2. Define system interoperability requirements, using HIE/RHIO Protocols (Performance, Privacy, Security, etc.)</p>	<p>DY1, Q2</p>	
<p>3. Map current state assessment against data exchange and system interoperability requirements</p>	<p>DY1, Q2</p>	
<p>4. Incorporate Data Sharing Consent Agreements and Consent Change Protocols into partner agreements, including subcontractor DEAs with all providers within the PPS; contracts with all relevant CBOs</p>	<p>DY1, Q2</p>	

5. Evaluation of business continuity, and data privacy controls by IT Governance Committee	DY1, Q3	
6. Develop transition plan for providers currently using paper-based data exchange	DY1, Q3	
7. Develop training plan for front-line and support staff, targeting capability gaps identified in current state assessment	DY1, Q3	
8. Finalize clinical data sharing and interoperability roadmap	DY1, Q3	
Milestone: Develop a specific plan for engaging attributed members in Qualifying Entities	DY2, Q1	<p>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.</p> <p>Subsequent quarterly reports will require updates on your progress in implementing this plan.</p>
1. Identify system needs, interfaces, and Action Plans for Existing/New Attributed Members	DY1, Q3	
2. Perform a Gap analysis of existing communication channels used to engage with patients (Call, Text, Mail Etc.), comparing this to demographic information about member population (using CNA)	DY1, Q3	
3. Establish new patient engagement channels, potentially including new infrastructure (Portal, Call Center, Interfaces)	DY1, Q4	
4. Incorporate patient engagement metrics (including numbers signing up to QEs) into performance monitoring for Forestland IT Transformation Group and establish reporting relationship (focused on this metric) with Forestland PPS PMO - DY2, Q1S	DY2, Q1	
5. Establish patient engagement progress reporting to Forestland PPS PMO	DY2, Q1	

<p>Milestone: <i>Develop a data security and confidentiality plan.</i></p>	<p>DY1, Q3</p>	<p>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.</p> <p>Subsequent quarterly reports will require an update on progress on implementing this plan.</p>
<p><i>1. Define data needs for PPS to access and establish protocols for Protected Data</i></p>	<p>DY1, Q2</p>	
<p><i>2. Establish Data Collection, Data Use, and Data Exchange Policies</i></p>	<p>DY1, Q3</p>	
<p><i>3. Data Security Audit or Monitoring Plan Established</i></p>	<p>DY1, Q4</p>	
<p><i>4. Identify Vulnerability Data Security Gap Assessment and implement Mitigation Strategies</i></p>	<p>DY1, Q4</p>	
<p><i>5. Create on-going Data Security Progress Reporting to IT Governance Committee</i></p>	<p>DY1, Q4</p>	

Major Risks to Implementation & 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.

As described in our application, the IT current state assessment identified a lot of variation between providers within the network in terms of the sophistication of their use of electronic patient information. There is also a percentage (8-15%) of our network that currently has limited technology infrastructure and no mainstream clinical documentation systems. Needless to say, it complicates the effort for improvement and contributes to a larger number of risks. Given the situation, our IT Transformation Group went through a series of meetings and identified appropriate risk mitigation strategies. Below we have described risks that we thought were most important and respective mitigation strategies for each:

Risk 1: There is a significant number of network partners utilizing paper-based records – these providers will be offered a short-term option of online care planning through EHR system utilizing a “lite” version of our EHR, or a capital loan for EHR purchase adjusted towards DSRIP based savings. In the medium-to-long term, our IT champions will be identified at the majority of providers, with the goal of transitioning to a stage where all partners have the electronic capability to engage in timely and accurate data-sharing activities. For the partners that currently have limited-to-no capabilities, the lite-version EHR can be a viable longer-term option to ensure at least some amount of data-sharing capacity across all providers.

Risk 2: There are multiple HIE/RHIOs utilized by partners in PPS – we will select an appropriate RHIO(s) and require all partners to connect with the selected RHIO(s) to service our attributed population. However, cross-RHIO data sharing is still not available and therefore there is a risk of not having full clinical knowledge of members. In advance of cross RHIO data sharing becoming available, we will attempt to mitigate this issue by establishing regular data pulls of encrypted member information, with manual transfer of information to PPS partners.

Risk 3: With over 1,000 partners in our PPS, there are extensive variations with EHR platforms, care management, and population health management systems. Our PPS is seeking financial and technological means to not only create a more standard infrastructure, but also one that will be set-up to meet the PCMH 2014 Level 3 standards by DY3. There is a critical need for custom programming for performance reporting – we will hire 2 reporting analysts to perform custom programming of DSRIP required reports that are not supplied by the MAPP tool.

Risk 4: Data Security Measures may not be in place. Although we are confident that our partners who have or will be signing data agreements will continue to ensure data security measures are in place, in order to mitigate data security risks, we will work with our partners to perform security audits and mitigate any issues that may arise from those audits.

Major Dependencies on Other Workstreams

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

As is described throughout this implementation plan, the development of new and / or improved IT infrastructure is a crucial factor underpinning many other workstreams including, in particular, clinical integration, population health management and performance reporting. However, without the right business and financial support, the Forestland IT Transformation Group (FITG) will not be able to drive the technological infrastructure development program to ensure the success of these workstreams. The interaction between the FITG and the PPS's clinical governance structure (especially the Practitioner Champions) will be vital to ensure that the IT infrastructure that we develop meets the needs of individual practitioners, providers and – particularly when it comes to population health management – the whole PPS network. During our development of the IT future state, we will work closely with the Forestland PPS Finance Team to review available capital and DSRIP funding resources. Adding new technologies, interfaces, reporting and monitoring solutions, and other engagement channels within our PPS will also require additional IT staffing, which will depend heavily on the Forestland PPS Workforce Strategy team. We will look to gain additional resources for IT call centers, support, analysis, and reporting. We will also look to other alternate means of staffing. Along with the need for new IT staff and systems, training the workforce to use new and expanded systems effectively will be crucial... To that end, a member of the FITG has been embedded in the Workforce Strategy Team, with a particular focus on the PPS-wide training strategy.

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
Chief Information Officer	Jill Smith, PPS Lead	IT Governance, Change Management, IT Architecture
Data, Infrastructure, and Security Lead	Joseph Mann, Healthcare Community Practice	Data security and confidentiality plan, Data Exchange Plan,

Project Management Lead	Gil Phillips, Hospital of Mercy	Project Portfolio, Risk Register, Vendor Contracts, Progress Reports
Application Lead	Todd Benner, Healthcare Associates of Forestland	Application Strategy and Data Architecture

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
<i>Internal stakeholders</i>		
Practitioner Champions	Interface between IT Transformation Group and front-line end users	Input into system design / testing and training strategy
Phil James, EHR PMO	Responsible for designing and managing EHR interfaces, and interoperability	Patient Engagement Plan
Chief Compliance Officer	Approver	Data Security Plan
<i>External stakeholders</i>		
Lisa Stoff, RHIO	RHIO Platform Lead	Roadmap for delivering new capabilities

Progress Reporting

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

Our IT Governance Committee has established expectations with all partners to supply key artifacts and monthly reports on key performance metrics. We will monitor the development and acquisition of key data sharing capabilities across the network and perform ongoing use and performance reports. These will be necessary to ensure continuing progress against our IT change management strategy. Follow-up specific IT questionnaires and surveys will be used periodically to identify any additional gaps, under/non-utilization, or the need for re-training.

Our Forestland IT Transformation Group will be responsible for engaging attributed members in QEs and will report on this to the Forestland PPS PMO. The FITG will also report to the Clinical Quality Committee on the level of engagement of providers in new / expanded IT systems and processes, including data sharing and the use of shared IT platforms.

In addition, the FITG will use the following ongoing performance reports to measure continuous performance of all partners:

- 1. Annual Gap Assessment Report – Partner adoption of IT infrastructure, enablement of clinical workflows, and application of population analytics*
- 2. Annual refresh of IT Strategic Plan*
- 3. Annual Data Security Audit Findings and Mitigation Plan*
- 4. Monthly workforce training compliance report*
- 5. Monthly Project Portfolio 'Earned Value' report for all IT related projects within DSRIP project portfolio*
- 6. Monthly HIE usage report depicting turnaround time for various data elements*
- 7. Weekly shared services performance report*
- 8. Weekly Performance report on vendor agreed SLAs*

Forestland IT Transformation Group will also conduct a quarterly survey of IT stakeholders (in particular the users of new infrastructure / systems) to derive qualitative assessments of user satisfaction.

Performance Reporting

Key Issues

Reporting Structure	Target Completion Date	Supporting Documentation
<p>Milestone: Establish reporting structure for PPS-wide performance reporting and communication</p>	<p>DY1, Q3</p>	<p>Performance reporting and communications strategy, signed off by PPS Board. This should include:</p> <ul style="list-style-type: none"> -- 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 <p>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)</p>
<p><i>1. The Clinical Quality Committee and the Financial Governance Committees to designate one or two key individuals per project (a minimum of 11 to a maximum of 22) to be ultimately accountable for both patient care and financial outcomes. These individuals will be held accountable for the realization and continuous improvement of the multi-disciplinary care pathways underlying their respective projects.</i></p>	<p>DY1, Q1</p>	

<p><i>2. Establish process for communicating state-provided data (accessed through the MAPP Tool) to providers through existing templates and Excel files as a short-term solution. Begin building the PPS-wide Performance Measurement system</i></p>	<p>DY1, Q1</p>	
<p><i>3. Perform a current state assessment of existing reporting processes across the PPS and define target state outcomes.</i></p>	<p>DY1, Q2</p>	
<p><i>4. Develop PPS-wide Performance Measurement system for medical record-based outcome measures, as well as for those process measures that our project development groups are identifying as driving the outcomes we aim to realize.</i></p>	<p>DY1, Q2</p>	
<p><i>5. Finalize arrangements with MCOs to exchange key information (including additional quality metrics).</i></p>	<p>DY1, Q2</p>	
<p><i>6. PPS-wide standardized care practices to be signed off by the Clinical Quality Committee and Financial Governance Committee.</i></p>	<p>DY1, Q2</p>	
<p><i>7. Establish regular two-way reporting structure to govern the monitoring of performance based on both claims-based, non-hospital CAHPS DSRIP metrics and DSRIP population health metrics (using Forestland's MAPP PPS-specific Performance Measurement Portal).</i></p>	<p>DY1, Q3</p>	

<p>8. Finalize layered PPS-wide reporting structure: from the individual providers, through their associated projects' metrics and the Project Leadership Teams, up to the Forestland PPS PMO. Performance and improvement information made available by the state (MAPP but also the further evolving Salient SIM tool) will be maximally integrated into this reporting structure. This reporting structure will define how providers are to be held accountable for their performance against PPS-wide, statewide and national benchmarks.</p>	<p>DY1, Q3</p>	
<p>9. Develop performance reporting dashboards, with different levels of detail for reports to the PMO, the Clinical Quality Committee and the Forestland PPS Executive Body. The monthly Executive Body dashboard reports will show on one (digital) page the overall performance of the PPS. The various dashboards will be linked and will have drill-down capabilities.</p>	<p>DY1, Q3</p>	

Performance Reporting Culture	Target Completion Date	Supporting Documentation
<p>Milestone: Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting</p>	<p>DY1, Q3</p>	<p>Finalized performance reporting training program.</p> <p>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.</p>
<p>1. After performing current state analyses and designing workflows, the Forestland PPS Workforce Strategy Team will create a dedicated training team to integrate new reporting processes and clinical metric monitoring workflows into retraining curriculum.</p>	<p>DY1, Q1</p>	

<p>2. This dedicated training team will integrate Lean training practices from Rosewood Medical Center's management training program into performance reporting/ rapid cycle evaluation training regime</p>	<p>DY1, Q2</p>	
<p>3. Deliver training module to practitioner champions; use their feedback to refine training program for practitioners throughout the network, including specific program for new hires</p>	<p>DY1, Q2</p>	
<p>4. Validate schedule to roll out training to all provider sites across the PPS network, using training at central hubs for smaller providers; specific thresholds will also be defined for minimum numbers to undertake training</p>	<p>DY1, Q2</p>	
<p>5. In collaboration with the PPS PMO, the training team will identify decision-making practitioners and staff at each site / provider to train in advance of PPS-wide training; these individuals will become performance management champions in their individual providers / sites and will work alongside the practitioner champions for those sites</p>	<p>DY1, Q2</p>	
<p>6. Roll out training to provider sites</p>	<p>DY1, Q3</p>	

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.

The four main pillars of our approach to effective performance reporting are: (1) a culture devoted to optimizing outcomes for patients; (2) clear responsibilities and accountability of staff for these outcomes; (3) optimizing and standardizing processes; and (4) continuous measurement of outcomes and the process-metrics that drive them. To achieve each of these building blocks, our PPS must overcome threats to each.

Our PPS collectively experiences the largest number of Medicaid patient encounters on an annual basis within our service areas. There are many enthusiastic providers and strong performers amidst our partners, but the current fragmentation in the provider and payment environment undermines our ability to create a common, outcomes-focused culture that spans organizational boundaries.

We will set the tone from the top of the PPS. The core members of the PPS, represented on its Governance Committees will be responsible for communicating the vision of a network in which providers only accept the highest standards of excellence for patient outcomes. Our training program will also be centered on this vision.

Another risk to the development of our performance monitoring system is the lack of clear lines of accountability for patient care outcomes. Our clinical and professional governance structures (including the Clinical Quality Committee and the Practitioner Champions) will form a structure with specific individuals / teams given responsibility for embedding performance reporting processes, and clear accountability for specific outcomes, whether on a project-by-project basis or across the whole PPS.

Our approach to creating these lines of accountability will be designed to ensure that front-line practitioners have the autonomy to determine which measures require the most focus, without overloading PPS leadership (such as the Executive Body) with more data and information than they can meaningfully process. Top-down designated accountability will need to be matched by strong practitioner engagement, to ensure that the performance reports which flow upwards are relevant to both the PPS leadership and to the improvement of patient care.

The geographic spread of the Forestland PPS network and the diversity of our provider network also poses a risk to the pan-PPS care protocols and operating procedures that we need to put in place. This is compounded by the longstanding professional independence of these providers and the different reporting cultures and workflows they have in place. Designing and implementing a standard reporting workflow that will functionally work for the entire PPS will be a significant challenge.

The practitioner engagement work, led by our Practitioner Champions, will be an important factor in mitigating this risk. They will be responsible for incentivizing practitioners throughout the network to participate in the PPS performance reporting systems. These professional incentives (improving quality of care) will be coupled with financial incentives, such as financial / personnel support for small practices to help them streamline their operations to support the increased reporting burden.

As described above, our approach to performance monitoring combines effective reporting IT systems and a workforce focused on continuously monitoring, measuring, analyzing, and reporting patient outcomes. In light of this, one risk we face is the risk of inadequate measurement and reporting frameworks to effectively aggregate meaningful data and create actionable reports. We will first aim to leverage our PPS-specific MAPP Performance Measurement Portal for the monitoring of our performance on the claims-based, non-Hospital CAHPS DSRIP metrics, as well as the DSRIP population health metrics. This portal (which will go live during DY1) will also show our performance vis-à-vis baseline information, benchmarks, and the gap-to-goals targets per metric. We will also develop our own PPS-wide Performance Measurement system for more timely information and for those Forestland-specific process measures that our project development groups are identifying. With these sources, we will have both long-term and sufficiently timely information available. We will use sophisticated Statistical Process Control methods to capture emerging unfavorable trends at the earliest moment possible.

Major Dependencies on Other Workstreams

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

Our success with Performance Reporting has significant dependence on our Governance workstream. Without effective leadership and a clearly defined organizational structure, with clear responsibilities and lines of accountability, our ability to create a common culture and to embed performance reporting structures and processes will be severely hampered.

The Workforce Strategy workstream is also an important factor in our efforts to developing a consistent performance reporting culture and to embed the performance reporting framework we will establish. Training on the use of these systems – as well as the vision of Forestland PPS as an organization where practitioners don't accept less than excellent quality – will need to be a central part of our broader training strategy for all the staff who are impacted by our workforce transformation.

The success of performance reporting relies on quick and accurate transfers of vital performance information. If providers cannot gather the right information, or an oversight committee fails to gather and distribute the aggregated data in a timely manner, the data will not be reported in such a way that it can be acted upon to improve clinical outcomes and ultimately improve performance throughout the network. A crucial dependency for our successful implementation of a performance reporting culture and processes is the work of the Forestland PPS IT Transformation Group to customize existing systems and implement the new IT systems that will be required to support our reporting on patient outcome metrics.

Practitioner Engagement and Clinical Integration will both be absolutely crucial to the success of our efforts to create a common performance culture throughout the PPS network, and to embed the new performance reporting practices within business-as-usual clinical practice.

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.

<i>Role</i>	<i>Name of person / organization (if known at this stage)</i>	<i>Key deliverables / responsibilities</i>
<i>Project Leadership Teams</i>	<i>TBD</i>	<i>Responsible for project management of the 11 DSRIP projects, including their role in the performance reporting structures and processes in place across the PPS</i>
<i>Project-specific Finance / Clinical Performance Monitoring Leads</i>	<i>TBD</i>	<i>Members of Project Leadership Teams Ultimately accountable for quality of patient care and financial outcomes per project Accountable for the realization and continuous improvement of the multi-disciplinary care pathways underlying their respective projects</i>

<p>Practitioner Champions</p>	<p>TBD</p>	<p><i>Responsible for spreading and embedding common culture of continuous performance monitoring and improvement throughout Practitioner Professional Peer Groups</i> <i>Responsible to Clinical Quality Committee for practitioners' involvement in performance monitoring processes</i></p>
<p>Forestland PPS IT Transformation Group</p>	<p>TBD</p>	<p><i>Responsible for ensuring the implementation, support, and updating of all IT and reporting systems to support performance monitoring framework.</i> <i>Also responsible for ensuring that the systems used provide valuable, accurate, and actionable measurement for providers and staff.</i></p>

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.

<i>Key stakeholders</i>	<i>Role in relation to this organizational workstream</i>	<i>Key deliverables / responsibilities</i>
<i>Internal stakeholders</i>		
<i>IT Staff within individual provider organizations</i>	<i>Reporting and IT System maintenance</i>	<i>Monitor, tech support, upgrade of IT and reporting systems.</i>
<i>Providers</i>	<i>Organizations immediately responsible for delivering on the performance monitoring processes established across the PPS.</i>	<i>Promote culture of excellence Employ standardized care practices to improve patient care outcomes.</i>

<p>Forestland PPS Executive Body</p>	<p>Ultimately responsible for Forestland PPS meeting or exceeding our targets</p>	<p>Prioritizing and improving patient care and financial outcomes for the entire Forestland PPS. Act as a high-profile, organization-wide champion for a common culture, standardized reporting processes, care guidelines, and operating procedures. Hold monthly executive meetings with patient outcomes as the main agenda item and will review patient outcome reports prepared by the sub-Committees.</p>
<p>Forestland PPS Finance Committee</p>	<p>Responsible for collecting, analyzing, and handling financial outcomes from performance management system</p>	<p>Will elect key decision makers to champion the performance management cause within the DSRIP projects, and to interface with the Clinical Quality Committee.</p>

<p>Forestland PPS Clinical Quality Committee</p>	<p>Ultimately responsible for all clinical quality improvement across the whole network</p>	<p>Monthly Executive Report for the Executive Body which includes patient care metrics updates. Will elect several key decision makers to champion the performance management cause within the DSRIP projects, and will interface with the Finance Committee.</p>
<p><i>External stakeholders</i></p>		
<p>Managed care organizations</p>	<p>Will provide key information to the Forestland PPS. Will also be necessary for arranging shared shavings agreements with the PPS in the later stages of DSRIP.</p>	<p>Provide data to PPS Shared savings</p>
<p>Patient representative organizations</p>	<p>Provide patient feedback to support performance monitoring and performance improvement</p>	<p>Input into performance monitoring and continuous performance improvement processes</p>

IT Expectations

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

Our PPS will be using a number of IT solutions to accurately measure, monitor, and report on DSRIP and non-DSRIP metrics. To this end, our IT Transformation Group (FITG) will be responsible for interfacing with the clinical and finance leads of the DSRIP projects to ensure that dashboards, reports, and metrics-gathering software are accurate and have no usability issues. We detail some of the specifics within our key steps of Milestone 1 and in the 'Key Risks' section.

Initially, existing performance reporting structures within the larger provider organizations in the PPS will be leveraged to provide the staff and IT infrastructure needed to build up the evolving PPS-wide Performance Measurement system as planned. In the interim, a system of Excel files transferred from the state's MAPP tool and Salient's SIM tool, to the leading workstream committee, through the project leads, and down to the individual providers will serve as a bridge before the robust final system is fully ready for deployment. We are currently considering several options for the procurement of PPS-wide performance reporting systems, including a collaborative buying solution with our neighboring PPS, Concreteville. The final system will have to have the capabilities to aggregate information on projects & care processes from the providers to the workstream lead, and from the state to the providers, in a way that is accessible, while also sufficiently secure to protect patient information.

Progress Reporting

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

This workstream's success will be measured by how our providers' understanding of their performance is improved by our implementation of performance measurement. We will continually measure the level of engagement and involvement of providers in the performance reporting systems and processes that are established. In DY 1, Q2, we will define metrics to measure providers' involvement in the PPS performance reporting structure (e.g. active users of performance reporting IT systems, involvement in feedback discussions with Clinical Quality Committee about performance dashboards). We will also set targets for performance against these metrics. The Practitioner Champions and the Project-specific Performance Monitoring Leads will be held accountable for driving up these levels of involvement.

Our front-lines will measure the outcomes that matter most to patients, and use our reporting and IT systems to monitor, evaluate, and identify the contributing processes and intermediate outcomes. They will be surveyed and interviewed to determine the level at which they find that the performance reporting system provides them with the right information, and the level at which they find that the information is clear and – most importantly – actionable.

On a monthly basis, our Profession Peer Groups, led by our Practitioner Champions, using the standardized measurement and reporting framework, provide their members with the relevant patient metrics, along with their deviation or improvement from the previous month. Our Clinical Quality Committee and our Finance Governance Committee will then aggregate these reports and compile them into the Executive Report, which will be the top item during the monthly Executive Body meetings. The quarterly reports will show the variation in patient care outcomes between quarters, which will be easily accomplished using our monthly model. Tracking change in the metrics included on these dashboards over time will be the primary tool we use to evaluate the impact of our performance reporting systems and our efforts to embed a culture of continuous improvement.

Practitioner Engagement

Key Issues

<i>Practitioner engagement / involvement in the DSRIP program</i>	<i>Target Completion Date</i>	<i>Supporting Documentation</i>
<i>Milestone: Develop practitioner communication and engagement plan</i>	DY1, Q3	<p>Practitioner communication and engagement plan. This should include:</p> <ul style="list-style-type: none">-- 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 <p>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.</p>

<p><i>1. Appoint Forestland PPS ‘Practitioner Champions’ to represent: (a) key professional groups (physicians, nurses, behavioral health specialists, community health workers etc.); and (b) geographic areas or clusters of providers (our largest provider organizations / sites will have a Practitioner Champion of their own). This group will be responsible for representing the interests and views of practitioners to the PPS Executive Body and representing the Executive Body’s views to the various communities of practitioners. The Champions of the practitioner groups will sit on the Clinical Quality Committee and will be the leads for their respective professional peer groups</i></p>	<p>DY1, Q1</p>	
<p><i>2. Clinical Quality Committee to develop draft communication and engagement plan, including:</i></p> <ul style="list-style-type: none"> <i>a. Structures and processes for two-way communication between front-line practitioners and the Governance of the PPS – using the Practitioner Champions as a key line for this communication</i> <i>b. Process for managing grievances rapidly and effectively</i> <i>c. High-level approach to the use of learning collaboratives</i> <i>d. Other forums for practitioners to discuss, collaborate, and shape how DSRIP will affect their practices</i> 	<p>DY1, Q1</p>	
<p><i>3. Consultation process on communication and engagement strategy (leveraging professional networks and Champions). This will involve seeking input with the practitioners themselves on their role in the DSRIP transformative process</i></p>	<p>DY1, Q1</p>	

<p>4. Build out practitioner support services designed to support the engagement plan. These are services designed to help practitioners and providers improve the efficiency of their operations, thereby freeing up time for the new collaborative care practices – these services might include facilitating back-office shared services, support with streamlining work flows, or the creation of a PPS-wide forum to facilitate purchasing co-ops to reduce the pricing of practice supplies</p>	<p>DY1, Q2</p>	
<p>5. Finalize practitioner communication and engagement plan</p>	<p>DY1, Q3</p>	
<p>Milestone: 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</p>	<p>DY1, Q4</p>	<p>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.</p>
<p>1. Develop training module for ‘Practitioner Champions’ focused on: a. Core goals of DSRIP program b. Forestland PPS projects c. Cross-PPS workstreams underpinning the delivery of the DSRIP projects, including value-based payment, case management and clinical integration</p>	<p>DY1, Q1</p>	

<p><i>2. Leverage Practitioner Champions to develop practitioner training / education plan, including the following. This plan will include material to be delivered online and in-person.</i></p> <ul style="list-style-type: none"> <i>a. Core goals of DSRIP program and the financial and operational impacts on providers (including PPS-wide plans for mitigating the impacts of revenue loss)</i> <i>b. Financial risk seminars for concerned practitioners (involving MCOs)</i> <i>c. The services and support available to providers / practices to help them improve the efficiency of their operations and thereby free up the time to allow for a shift to more collaborative models of care</i> <i>d. Seminars on population health management</i> <i>e. The delivery of the 11 Forestland PPS projects</i> <i>f. Cross-PPS workstreams underpinning the delivery of the DSRIP projects, including value-based payment, case management and clinical integration</i> <i>g. The role of different groups of practitioners in the delivery of the DSRIP projects</i> <i>h. New lines of clinical accountability and the expectations around clinical integration</i> <i>i. The various aspects of IT / data sharing infrastructure development and how this will impact on practitioners day-to-day</i> 	<p>DY1, Q4</p>	
<p><i>3. Develop an overarching schedule of face-to-face training sessions across Forestland, designed to directly communicate with and answer questions from the majority of practitioners in the PPS – target of reaching at least 65% of sites with this road trip and delivering training to the remaining practitioners electronically</i></p>	<p>DY1, Q4</p>	

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.

The first major risk to the implementation of the practitioner engagement strategy is the broad geographic spread of the providers in the Forestland PPS network. Given the current disjointed nature of our provider network (particularly amongst primary care providers), engaging with 65% of providers face-to-face will be a significant challenge. We intend to bring our smaller provider organizations together for larger group training /education sessions, using the interactive provider map (described in the clinical integration section) to identify clusters of smaller providers

The 'Practitioner Champions' will also play a central role in the roll-out of the road shows described above. Their role will be to ensure buy-in and involvement in the practitioner education and training.

Our Workforce Transformation Strategy involves significant redeployment and recruitment of new staff. This will result in a high proportion of new staff within some organizations throughout the course of the DSRIP program. This creates a risk that the education and training delivered to a group of practitioners becomes lost as a provider organization takes on new staff. To mitigate this risk, we will involve a 'train the trainer' approach as part of our training and education program. We will also develop electronic and printed training materials that will continue to engage practitioners in the DSRIP program, even if they join a provider after the practitioner education and training roadshow. This is designed to ensure the core behaviors and practices of our DSRIP program remain embedded within organizations.

In general, resistance to changes in clinical pathways and new ways of working is a major risk to this work stream. Managing this risk is the core role of the 'Practitioner Champions'. Key elements of their approach to addressing this issue include:

- Evidence-based change – in all of our communication about the overarching DSRIP program, as well as about the specific projects and initiatives we are undertaking, we will articulate the evidence base*
- Case studies of similar successful initiatives. We believe this will be particularly powerful when the case studies are from New York State, so we intend to use the MIX platform to identify examples of best practice*

Major Dependencies on Other Workstreams

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

Our plans for practitioner engagement depend on effective, rapid and easy-to-access communications tools. We intend to use the MIX platform to facilitate communication and best practice sharing between practitioners working in different provider organizations.

The role of the Practitioner Champions is central to our plans for practitioner engagement. It is important that they are able to play the role we intend them to play in the governance structure – advocating to the Executive Body on behalf of the practitioners they represent and communicating information back down to those practitioners effectively. To this end, our practitioner engagement is dependent on an effective governance structure and processes.

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.

<i>Role</i>	<i>Name of person / organization (if known at this stage)</i>	<i>Key deliverables / responsibilities</i>
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<i>Forestland PPS Director of Communications</i>	<i>John MacDonald</i>	<i>Oversee the development and implementation of the physician engagement strategy Oversee the training program and report its progress to the PPS executive body</i>
<i>Physician Champion</i>	<i>TBD</i>	<i>Represent physicians on the Clinical Quality Committee; responsible for driving their engagement in the DSRIP program</i>
<i>Nursing Champion</i>	<i>TBD</i>	<i>Represent nurses on the Clinical Quality Committee; responsible for driving their engagement in the DSRIP program</i>

<i>Community care Champion</i>	<i>TBD</i>	<i>Represent care coordinators and other community care workers on the Clinical Quality Committee; responsible for driving their engagement in the DSRIP program</i>
<i>Regional / Organization-specific Practitioner Champions</i>	<i>TBD</i>	<i>Act as liaison between the Clinical Quality Committee and the PPS's downstream providers</i>
<i>Patient representative</i>	<i>TBD</i>	<i>Ensure practitioner engagement activities and culture shifts across the PPS are patient-centric whenever applicable.</i>

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.

<i>Key stakeholders</i>	<i>Role in relation to this organizational workstream</i>	<i>Key deliverables / responsibilities</i>
<i>Internal stakeholders</i>		
<i>Practitioners throughout the network</i>	<i>Target of engagement activities</i>	<i>Attend training sessions; report to relevant Practitioner Champions</i>
<i>Forestland PPS Workforce Transformation Group</i>	<i>Oversight of all training strategies, including practitioner education / training described above</i>	<i>Input into practitioner education / training plan</i>
<i>Clinical Quality Committee</i>	<i>Governance committee on which practitioner Champions sit</i>	<i>Monitor levels of practitioner engagement; forum for decision making about any changes to the practitioner engagement plan</i>

IT Expectations

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

Easy, accessible communication platforms to support communication between practitioners will be important for engaging practitioners in DSRIP and for the sharing of best practice. This is true both within Forestland PPS and between PPSs. We intend to develop a specific Forestland PPS portal on the MIX platform, potentially with sub-groups for various professional groups and for practitioners interested in specific projects.

The ability for providers to share clinical information easily will also be important, not just for the improvements in clinical integration but also for the ongoing buy-in of individual practitioners. It is important, therefore, that the IT infrastructure developed under the remit of the Forestland IT Transformation Group is: (a) in place quickly and (b) developed with the input of Practitioner Champions.

Improved IT infrastructure will also be important for the delivery of our practitioner engagement education and training materials. Our interactive provider map will give us insight into the provider organizations / sites where this will be a challenge.

Progress Reporting

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

The roll-out and attendance at the practitioner engagement programs will act as an indicator of the reach of our practitioner engagement plan. We have set the target of delivering education & training face-to-face at 65% of provider organizations in our network and we will use this metric to monitor the progress of this workstream. In addition, we will monitor the attendance at practitioner training events. The design of these programs (DY1, Q4) will involve specific targets being set for the number of attendees per training., as well as questionnaires pre- and post-testing designed to assess impact (designed in collaboration with our workforce transformation team). Our Practitioner Champions will be responsible for generating interest and involvement in these training programs and will be held accountable against the participation targets set in the programs' design phase.

The use of our practitioner discussion forums on the MIX platform will be another indicator of the level of engagement of practitioners in the DSRIP program. It will also allow us to identify specific groups of practitioners that are less engaged.

The Profession and Regional Champions will report regularly to the Clinical Quality Committee on the levels of engagement (and coordination and integration) they see amongst the group they represent.

Population Health Management

Key Issues

<i>Population health roadmap</i>	<i>Target Completion Date</i>	<i>Supporting Documentation</i>
<p><u>Milestone:</u> <i>Develop population health management roadmap</i></p>	<p>DY2, Q1</p>	<p>Population health roadmap, signed off by PPS Board, including:</p> <ul style="list-style-type: none"> -- 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. <p>Subsequent quarterly reports will require an update on the implementation of this roadmap.</p>
<p><i>1. Conduct inventory of available data sets with individual demographic, health, and community status information, to supplement our use of the data available through the MAPP tool</i></p>	<p>DY1, Q2</p>	

<p><i>2. Expand on the data collected as part of our CNA and create a relational database for program planning and individual care management (establish program for annual update of community needs assessment); Identify priority practice groups to have access to registries; evaluate IT capacity and identify gaps in IT infrastructure at a provider level that need to be addressed to support effective access to these registries</i></p>	<p>DY1, Q2</p>	
<p><i>3. Create a dashboard to periodically update the program planning and individual care management database and registries, available for easy access by all participating providers in the PPS. Build out a public facing dashboard derived from the internal database to monitor outcomes and successes of the program.</i></p>	<p>DY1, Q2</p>	
<p><i>4. Complete workforce assessment for priority practice groups' care management capabilities, including staff skills and resources required to manage the diabetic and cardiovascular disease populations in each geographic area</i></p>	<p>DY1, Q2</p>	
<p><i>5. Establish Forestland PPS PCMH Certification Working Group – to be responsible for assessing current state with regard to PCMH 2014 Level 3 certification, identifying key gaps and developing overarching plan to achieve Level 3 certification in all relevant providers</i></p>	<p>DY1, Q2</p>	

<p><i>6. Refine priority clinical issues from the Community Needs Assessment (at a whole-PPS level and also specific priorities for specific geographic areas) to ensure alignment between undertaken projects and clinical priorities, with particular focus on diabetes and cardiovascular health. Solicit participating provider feedback before finalization</i></p>	<p>DY1, Q3</p>	
<p><i>7. Develop care guidelines for providers on priority clinical issues; establish metrics for each clinical area to monitor progress in managing population health</i></p>	<p>DY1, Q3</p>	
<p><i>8. Forestland PPS PCMH Certification Working Group to finalize PPS-wide roadmap for achieving Level 3 certification in all relevant providers</i></p>	<p>DY1, Q3</p>	
<p><i>9. Deploy staff support at provider level (as part of practitioner engagement training plan) to train providers to use and apply information learned from the registries; how to implement established care guidelines; develop disease pathways etc.</i></p>	<p>DY1, Q4</p>	
<p><i>10. Clinical Quality Committee to finalize population health management roadmap</i></p>	<p>DY2, Q1</p>	

Bed Reduction Plan	Target Completion Date	Supporting Documentation
<p>Milestone: Finalize PPS-wide bed reduction plan</p>	<p>DY2, Q4</p>	<p>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.</p> <p>Subsequent quarterly reports will require updates on bed reductions across the network and updates on the delivery of your bed reduction plan.</p>
<p>1. Establish Service Utilization Monitoring Team (SUMT). This team will report into the PMO and will be responsible for monitoring and reporting on reductions in avoidable hospital use, as well as modeling the impact of all DSRIP projects on inpatient activity</p>	<p>DY1, Q3</p>	
<p>2. SUMT to model the forecast impacts of all DSRIP projects on avoidable hospital use and utilization – both in terms of the impact on hospital services and in terms of the demand for community-based services (model will be established by DY1, Q4 and updated regularly with activity / utilization data to provide ‘live’ and ‘forecast’ pictures)</p>	<p>DY1, Q4</p>	
<p>3. Based on modeling and in consultation with provider network, SUMT to establish high-level forecasts of the following (this forecast capacity model will be updated on a regular basis throughout the 5 years)</p> <ul style="list-style-type: none"> a. Reduced avoidable hospital use over time b. Changes in required inpatient capacity; and c. Resulting changes in required community / outpatient capacity 	<p>DY2, Q1</p>	
<p>4. Providers impacted by forecast capacity change to determine their own ‘first draft’ capacity change plan</p>	<p>DY2, Q2</p>	

5. SUMT to lead consultation on first draft capacity change plans	DY2, Q3	
6. Finalize and publish final capacity change / bed reduction plan and schedule of annual updates on capacity changes across the network	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.

The first risk to the implementation of a population health management approach throughout Forestland PPS is the present disconnect between population health management issues identified at system level and the approach to care delivery at the practice / provider level. For example, while Cardiovascular disease is a clear priority issue for our attributed population, the availability of services does not match in terms of capacity or in terms of geographic location. In addition, care on the frontline for cardiovascular conditions is typically delivered in practice silos. To mitigate this risk, many workstreams in the PPS's implementation plan (particularly clinical integration and practitioner engagement) are focused on integrating care management through the development of cross-disciplinary treatment teams for the most complex (multi-morbid) patient groups. Care managers will take on a more active role in the continuous management of patient pathways, with consistent engagement made with the care management team.

A second risk to implementation is a prolonged focus on analysis of a given population's health needs, at the expense of acting on that data quickly to develop new services or interventions. To mitigate this risk, this workstream's implementation will first leverage existing data sources to identify population-wide health needs for which rapid, coordinated action can generate "quick wins" to build momentum. Specifically, we will use value stream mapping to identify the clinical priorities with the most room for the removal of 'wasteful' activities and where the implementation of new, more efficient, support systems is likely to have the greatest impact. .

The most serious risk facing this workstream's successful implementation is the risk that a population health management approach, described in provider training and education, will 'dissolve' into reactive care over time. As the program expands, there tends to be a desire for patient-facing care managers to fill all clinical care gaps for their individual patients immediately, which is not resource efficient and can quickly lead to provider fatigue. Mitigating this risk and staying true to the principles of population health management involves the PPS's communication strategy and workforce training approach, both of which must reinforce the difference between population management-based care delivery and patient complaint-based care delivery.

Major Dependencies on Other Workstreams

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

The development of effective population health management across Forestland PPS is highly dependent on the successful implementation of three other workstreams.

First, the PPS needs a strong and well-executed practitioner engagement strategy. The practitioner engagement training & education described in the Practitioner Engagement section will include both the high-level principles of an approach to population health management, as well as the specific skills and behaviors that providers must adopt. If physicians, clinical specialists, nursing practitioners, or case managers are not fully committed to reforming their practices of care, the shift to team-based management of population health will not be successful. It is critical, therefore, that the practitioner engagement work stream achieves strong buy-in from practitioners throughout the PPS to the goals of the DSRIP program, as well as the specific changes in practice that will be required.

Second, a successful population health management approach is dependent on effective clinical integration and the rapid communication and data sharing that underpin it.

Last, the workstream requires a robust and functional set of data gathering and monitoring tools in order to be successful (for example, access to Healthcare Effectiveness Data and Information Sets (HEDIS) across the PPS). Our data & analytics workstream will be provide the population-level health metrics required to monitor the impact and success of population health management across Forestland PPS.

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.

<i>Role</i>	<i>Name of person / organization (if known at this stage)</i>	<i>Key deliverables / responsibilities</i>
Population Health Management Workstream Lead	TBD	Oversee the implementation of the population health management strategy Report its progress to the PPS executive body

<p><i>Service Utilization Monitoring Team</i></p>	<p><i>TBD</i></p>	<p><i>Monitor the impacts of DSRIP projects in terms of inpatient & community capacity; oversee the modelling and implementation of capacity change (including bed reductions) linked to improvements in population health management and the resulting reduction in the need for hospital-based services</i></p>
<p><i>Forestland PPS PCMH Certification Working Group</i></p>	<p><i>TBD</i></p>	<p><i>Lead the development and implementation of a PPS-wide work plan for all relevant providers to achieve PCMH 2014 Level 3 Certification. Work in coordination with the PPS's central IT team to ensure population health management IT needs are procured and developed</i></p>

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
<i>Internal stakeholders</i>		
Forestland PPS PMO	Oversight of DSRIP projects	Jointly responsible for Bed Reduction Plan
Hospitals represented on Forestland PPS Bed Reduction Working Group	Stakeholder to bed reduction plan	Represented on the Bed Reduction Working Group; will sign off on any bed reduction goals set at an individual provider level
Nursing homes represented on Forestland PPS Bed Reduction Working Group	Stakeholder to bed reduction plan	Represented on the Bed Reduction Working Group; will sign off on any bed reduction goals set at an individual provider level

Professional Peer Groups	Key role in the adoption of population health management practices amongst their members	Active engagement in the development of training & education materials
CBOs, including organizations focused on crime reduction, housing, and transportation	Vital component of ensuring the success of the population health management strategy	Work with care management teams in adapting care to better serve target populations
External stakeholders		
MCOs	Key partner in payment reform	Collaborate in PPS payment reforms (VBP) in line with VBP roadmap; provide insight into population health management approach to be implemented across Forestland PPS

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.

One of the key principles of our approach to population health management is that all care will become 'data-driven'. Our data & analytics team will be responsible for ensuring that practitioners have the data and the tools available to allow them to develop interventions and services that will address the wider determinants of population health for their local population. This effort will be facilitated by the use Forestland's MAPP PPS-specific Performance Measurement Portal, which will help our team monitor performance of both claims-based, non-hospital CAHPS DSRIP metrics AND DSRIP population health metrics. The analysis of population-level outcome data will also be the basis for our assessment of the impact of population health management on the priority groups and clinical areas identified in our population health management roadmap (see above).

Our IT team will also select an appropriate RHIO(s), and leadership will require all partners to connect with the selected RHIO(s) to service our attributed population. This effort will be conducted in tandem with the EHR platforms, care management, and population health management systems that we have already implemented, or are currently implementing.

Progress Reporting

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

As described above, we will monitor the impact of our population health management work stream through a combination of the DSRIP outcome measures and our own specific population health metrics. These Forestland-specific metrics will be identified in the population health roadmap and will be monitored by the Forestland PPS PMO and reported to the Clinical Quality Committee. For example, we believe we can augment the DSRIP outcome metrics for Domain 4.A. with additional metrics that will allow us to monitor the substance abuse issue in Forestland. Our goal will be to isolate metrics that are not wholly represented by the available DSRIP outcome measures, and to focus upon elements that our front-lines deem important, which is in line with our approach to Performance Management.

We will build continuous quality improvement into the population health road map, establishing timeframes for the reevaluation of data sets, functionality of registries, and of our priority issues for population health management.

Our group of Practitioner Champions will also play a role in identifying groups of providers that have been particularly successful in tackling the broader determinants of health and having a measurable impact on population health. These groups of providers will then become case studies to spread best practice throughout the PPS network.

Clinical Integration

Key Issues

<i>Clinical Integration</i>	<i>Target Completion Date</i>	<i>Supporting Documentation</i>
<p><i>Milestone: Perform a clinical integration 'needs assessment'</i></p>	<p>DY1, Q3</p>	<p>Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including:</p> <ul style="list-style-type: none"> -- 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
<p><i>1. Finalize the design of a clinical integration needs assessment framework to use for each of the DSRIP projects. This framework will outline the people, process, technology and data components that are relevant for clinical integration as it pertains to each of the DSRIP project target populations (including the technical requirements for data sharing and interoperability)</i></p>	<p>DY1, Q2</p>	

<p>2. Create a map of the provider landscape that will be involved in each DSRIP project, incorporating the community needs assessment and the current partner lists. This provider landscape per project will cover the entire continuum of the providers involved</p>	<p>DY1, Q3</p>	
<p>3. For each project, perform a gap analysis of the provider network involved in that project, using the clinical integration needs assessment framework. This will demonstrate how many of the required elements of clinical integration (in terms of the people, process, technology and data components) are currently present and where they are completely or partially lacking to address the needs of the relevant population.</p>	<p>DY1, Q3</p>	
<p>Milestone: Develop a Clinical Integration Strategy</p>	<p>DY1, Q4</p>	<p>Clinical Integration Strategy, signed off by Clinical Quality Committee, including:</p> <ul style="list-style-type: none"> -- 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 <p>Subsequent quarterly reports will require an update on the implementation of this strategy.</p>

<p>1. For each DSRIP project: define with the project group what the target clinical integrated state should look like from a people, process, technology and data perspective (including assessment and care protocols and specific attention to care transitions). Identify the main functional barriers to achieving this from the perspective of both provider organizations and individual clinicians</p>	<p>DY1, Q2</p>	
<p>2. Based on this target state and the gaps identified in the integrated care needs assessment, define and prioritize the steps required to close the gaps between current state and desired end state (in terms of the needs for people, process, technology and data).</p>	<p>DY1, Q3</p>	
<p>3. Identify synergies between the steps required for each project. For example: the need for supportive IT infrastructure to enable data sharing.</p>	<p>DY1, Q3</p>	
<p>4. Conduct engagement exercise with practitioners and other stakeholders, focused on identifying the key clinical (and other) data that will be required to support effective information exchange at transitions of care</p>	<p>DY1, Q3</p>	
<p>5. Define incentives to encourage the behaviors and practices that underpin the target state (e.g. multi-disciplinary care planning). These incentives might include financial / personnel support to providers looking to improve the efficiency of their operations in order to create more time for coordinated care practices; or the creation of shared back office service functions to improve the efficiency of provider organizations.</p>	<p>DY1, Q3</p>	
<p>6. Carry out consultation process on draft strategy with internal and external stakeholders to the transformation (including patients).</p>	<p>DY1, Q3</p>	
<p>7. Finalize PPS strategy and roadmap document on clinical integration across all projects.</p>	<p>DY1, Q4</p>	

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.

The primary risk for clinical integration in our PPS is the current lack of clear lines of accountability between disjointed provider organizations and the practitioners within them, as well as a lack of accountability between independent practitioners in the community. This risk is particularly significant given the need for practitioners to work & collaborate outside of their traditional (siloed) units of care and take on new lines of communication in order to better serve complex patients. With new lines of activity comes a need for more defined lines of accountability to ensure that the correct practitioners are responsible for the patient's care every step of the way.

- Our clinical integration strategy will define clear pathways (focusing initially on pathways identified as currently having poor levels of clinical integration / coordination) and the different practitioners accountable for transitions and communication at each step of those pathways

- Our pan-PPS professional peer groups (which are described elsewhere in this implementation plan) will be responsible to the Clinical Integration Working Group (a sub-committee of the Clinical Quality Committee) for developing clear lines of accountability and communication between relevant groups. They will also be the groups to which poor performance is reported.

A second risk to clinical integration in Forestland is the reliance on new IT and communications infrastructure, needed to support communication between practitioners and between organizations. The IT and data sharing survey that we carried out prior to our DSRIP application revealed limited use of electronic data sharing tools, particularly amongst our PCP community. Rolling out new tools for data sharing at the same time as trying to establish new ways of working and new lines of communication and accountability will be a complex challenge. To mitigate this risk, we will:

- Involve practitioners from our professional peer groups in the design and implementation of new clinical IT and data sharing systems;*
- Integrate a member of the Forestland IT Transformation Group into the team developing our clinical integration strategy; and*
- Include a specific focus on IT in the consultation on our clinical integration strategy (described above)*

A third risk is the authorizations required by managed care plans not being aligned with clinical pathways and transitions of care processes, or otherwise necessitating significant provider time without adding any real value to care processes, outcomes or cost benefit.

- Clinical pathways and workflows will also be examined to identify authorizations and procedures required by the various contracted managed care plans and their impact on the service delivery process.*
- Discussions will be held with the managed care plans to streamline process flow for care bundles, to minimize unnecessary authorizations and for incorporation into various Value-Based Payment models.*

Major Dependencies on Other Workstreams

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

As described above, our approach to clinical integration depends significantly on IT Systems and Processes. In addition to the need for systems to support the rapid, safe transfer of patient information, we will need to establish new forms of communication between practitioners working in different organizations, in part to support the cross-disciplinary case management teams proposed in the strategy. If the transformation towards a clinically integrated system is viewed by practitioners as increasing the administrative burden involved in managing care for their patients, that shift in practice will not 'stick'. An important factor in facilitating greater clinical integration will, therefore, be freeing up the time required for individual practitioners to engage in multi-disciplinary care planning. Our IT systems and processes will therefore need to be designed and built (a) with the goal of reducing administrative processes from their current levels and (b) with the input of clinical end users. Another way in which Forestland PPS will support our providers in adopting more integrated practices is by providing the financial / personnel support to help them improve the efficiency of their operations. Both the Forestland PPS PMO and the Workforce Strategy Team will play important roles in delivering this support.

The Clinical Integration and Practitioner Engagement workstreams are also highly interdependent. Clinically integrating Forestland's diverse set of providers and practitioners will require the input, insight, and engagement of all involved. All affected practitioners must be engaged in the DSRIP process in order for them to value – and support – the clinical integration of our PPS. To ensure coordinated efforts in these two areas, some of the core elements of our approach to practitioner engagement – including the development of pan-PPS professional peer groups – also play a central role in the delivery of our clinical integration strategy.

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.

<i>Role</i>	<i>Name of person / organization (if known at this stage)</i>	<i>Key deliverables / responsibilities</i>
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<i>Clinical Integration Working Group (CIWG) Lead</i>	<i>TBD – will be a member of Clinical Quality Committee</i>	<i>Manage the development of the clinical integration strategy, report on its progress to the Clinical Quality Committee and Forestland PPS Executive Board</i>
<i>Forestland PPS IT Transformation Group (FITG) Clinical Integration Lead</i>	<i>Steven Taskes</i>	<i>Member of FITG but also a permanent representative on the Clinical Integration Working Group. Responsible for ensuring that the IT infrastructure that is developed throughout the network meets the needs of a more clinically integrated front-line workforce (for example, to support transitions of care, or multi-disciplinary care planning)</i>
<i>CIWG PCP Representative</i>	<i>Clive Livingstone</i>	<i>Act as the liaison between primary care and the clinical integration process</i>
<i>CIWG Physician Representative</i>	<i>Isaac Nelson</i>	<i>Act as the liaison between physicians and the clinical integration process</i>
<i>CIWG Behavioral Health Representative</i>	<i>Isolde Chalmers</i>	<i>Act as the liaison between behavioral health and the clinical integration process</i>
<i>CIWG Social/community Representative</i>	<i>Allison Lang</i>	<i>Act as the liaison between the community and the clinical integration process</i>

CIWG Nursing Representative	Nicolas English	Act as the liaison between nursing and the clinical integration process
CIWG Social Worker/Care Coordinator Representative	TBD	Act as the liaison between care coordinators and the clinical integration process
CIWG MCO Liaison	Roberto DeMarco	Act as the liaison between MCOs and the clinical integration 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		
Practitioners	Their buy-in and support of new pathways, lines of accountability, responsibility and communication will be central to the success of this workstream	Engage in the process, including: <ul style="list-style-type: none"> - The consultation process; and - The training

<p>Clinical staff</p>	<p><i>Their buy-in and support of new pathways, lines of accountability, responsibility and communication will be central to the success of this workstream</i></p>	<p><i>Engage in the process, including:</i></p> <ul style="list-style-type: none"> - <i>The consultation process; and</i> - <i>The training</i>
<p><i>External stakeholders</i></p>		
<p>Patients</p>	<p><i>Care improved upon by the clinical integration of the PPS</i></p>	<p><i>Response to consultation on clinical integration strategy</i></p>
<p>Family members</p>	<p><i>Communication with practitioners, particularly on behalf of children, the elderly, or those without mental capacity</i></p>	<p><i>Response to consultation on clinical integration strategy</i></p>
<p>CBOs</p>	<p><i>Supporting the development and implementation of the clinical integration strategy</i></p>	<p><i>Response to consultation on clinical integration strategy</i></p>

IT Expectations

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

Effective clinical integration 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 (such as the existing population health management IT system currently in place at the Forestland Medical Center Health Home, which we plan to roll out across our provider network in DY 1). For other providers in our network, effective clinical integration is likely to rely more heavily on the coordinated use of patient registries. A core element of our clinical integration needs assessment will be identifying where new or expanded data-sharing systems are required and where a different approach is required. The integration of the Forestland PPS IT Transformation Group and the Clinical Integration Working Group will be important in ensuring that our plans for developing IT infrastructure across the PPS support better clinical integration. At this stage, our immediate priorities (quick wins) include: medication reconciliation, patient transfers and transport, and outpatient clinic scheduling.

Achieving the buy-in of our large community of downstream providers to the new ways of working that fall under the clinical integration workstream will greatly depend on the providers and the individual practitioners having easily accessible methods of communicating with one another. We plan to investigate options for developing pan-PPS communications forums, potentially leveraging the DOH-sponsored MIX platform.

Progress Reporting

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

We plan to use surveys of patients and practitioners to assess the effectiveness of clinical integration and coordination throughout our network, over the course of the DSRIP program. The patient and practitioner surveys will be separate, but they will both be used by the Clinical Integration Working Group to assess improvement /change in clinical integration against the current state picture created under the milestone above. The CIWG will also use the results of these surveys to hold the professional peer groups accountable for the coordination and communication seen amongst their practitioners. The patient survey will focus on how the quality of care has changed or been enhanced across various care settings over the course of the DSRIP program. In particular, this survey will look at the patient experience during transfers of care and immediately after them. The practitioner / provider surveys will seek to identify the specific links in patient pathways where information sharing and collaboration could be improved. For example, behavioral specialists will be surveyed on whether (and when) they receive information from hospital emergency departments on patients who have presented with behavioral health issues, in addition to physical health issues.

DSRIP Flow of Funds

Designing your funds flow	Target Completion Date	Supporting Documentation
<p>Milestone: Complete funds flow budget and distribution plan and communicate with network</p>	DY1, Q3	<p>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.</p> <p>Subsequent quarterly reports will require updates to the budget and funds flow tables contained in this template.</p>
1. Distribute the Project Impact Assessment and Matrix (prepared as part of current state financial stability assessment) to network provider partners with explanation of the purpose of the matrix and how it will be used to finalize funds flow in determining expected impact of DSRIP projects and expectations of costs they will incur	DY1, Q2	
2. Complete a preliminary PPS Level budget for Administration, Implementation, Revenue Loss, Cost of Services not Covered budget categories (Excludes Bonus, Contingency and High Performance categories)	DY1, Q2	
3. Review the provider level projections of DSRIP impacts and costs submitted by network providers. During provider specific budget processes, develop preliminary - final provider level budgets including completion of Provider Specific funds flow plan	DY1, Q2	
4. Develop 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 network participating providers for review and input	DY1, Q3	
6. Revise plan based on consultation and finalize; obtain approval from Finance Committee	DY1, Q3	
7. Prepare PPS, Provider and Project level funds flow budgets based upon final budget review sessions with network providers for review and approval by Finance Committee	DY1, Q3	
8. Communicate approved Provider Level Funds Flow plan to each network provider. Incorporate agreed upon funds flow plan and requirements to receive funds into the PPS Provider Partner Operating Agreements	DY1, Q3	
9. Distribute Funds Flow policy and procedure, and schedule DSRIP period close requirements, along with expected Funds distribution schedule, to PPS network provider partners	DY1, Q3	
10. Roll out education and training sessions for providers regarding the funds flow plan, the administrative requirements related to the plan, and related schedules for reporting and distribution of funds. Individual sessions will be run for larger providers; collaborative group sessions will be run for smaller providers and for providers with close operational ties	DY1, Q3	

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
- Actual distribution of funds may vary from these forecasts over the course of the DSRIP program. PPSs will therefore be able to revise these forecasts through the quarterly reporting process.

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.

The PPS and PPS Lead Administration costs from the Project Plan Application are shown in the "All Other" Item below.

Funds Flow Items	DY1	DY2	DY3	DY4	DY5	TOTAL
Waiver Revenue	\$34,462,256	\$36,724,930	\$59,351,664	\$52,563,644	\$34,462,256	\$217,564,750
Primary Care Physicians	\$2,067,735	\$2,937,994	\$7,122,200	\$6,307,637	\$4,210,254	\$22,645,821
Non-PCP Practitioners	\$1,033,868	\$1,101,748	\$2,967,583	\$2,628,182	\$1,033,868	\$8,765,249
Hospitals	\$13,095,657	\$13,955,473	\$20,773,082	\$18,397,275	\$12,061,790	\$78,283,278
Clinics	\$1,723,113	\$1,836,246	\$2,967,583	\$2,628,182	\$1,723,113	\$10,878,238
Health Home/Care Management	\$689,245	\$734,499	\$1,187,033	\$1,051,273	\$1,033,868	\$4,695,918
Behavioral Health	\$2,412,358	\$2,937,994	\$5,935,166	\$5,782,001	\$3,618,537	\$20,686,056
Substance Abuse	\$689,245	\$734,499	\$1,187,033	\$1,051,273	\$689,245	\$4,351,295
Skilled Nursing Facilities/Nursing Homes	\$2,412,358	\$2,937,994	\$4,748,133	\$4,730,728	\$3,101,603	\$17,930,816
Pharmacies	\$689,245	\$734,499	\$1,187,033	\$1,051,273	\$689,245	\$4,351,295
Hospice	\$689,245	\$734,499	\$1,780,550	\$1,051,273	\$689,245	\$4,944,812
Community Based Organizations	\$1,723,113	\$1,836,246	\$2,967,583	\$3,153,819	\$2,067,735	\$11,748,497
All Other	\$4,480,093	\$4,774,241	\$7,715,716	\$6,833,274	\$4,480,093	\$28,283,418
Total Funds Distributed	\$31,705,276	\$35,255,933	\$60,538,697	\$54,666,189	\$35,398,596	\$217,564,691
Undistributed Revenue	\$2,756,981	\$4,225,978	\$3,038,944	\$936,399	\$ -	\$ -