NEW YORK STATE | Department of Health | Medicaid Redesign Team

DSRIP Medical Record Review

GNYHA DSRIP Clinical Leadership Forum

MY2 Overview of Key Activities

June 2016

Agenda

- Introductions and meeting overview
- Record review process
  - Abstraction
  - Record retrieval
  - Challenging measures
- Walkthrough of project plan and operations
- Next steps
- Q & A

Presenters

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Goals for today's conversation

1. Discuss the mechanics of each measure, how measures are assembled, and how they drive operational requirements throughout the process

2. Address expectations across various stakeholders throughout the records collection process

3. Discuss the overall collection timeline, key contacts, and immediate next steps

Detailed discussion of record review process

Abstraction process

- Medical record abstraction
- What can be learned from review process

Medical record abstraction

Medical record documentation provides:

✓ Information to augment claims data (more specific evidence than revealed by claims, e.g. lab value data)

Medical records are used to:

✓ Supplement evidence of service provided (numerators)

✓ Verify population being measured (denominators/exclusions)

What can be learned from record review process?

✓ Best practices within a PPS, e.g. embedded PHQ2 screening within EMR

✓ Shortcomings/opportunities for Quality Improvement (QI) initiatives

Record retrieval process

- Where to look
- Understanding chase logic

Where to look

Need to determine the physical location where the patient was seen (i.e. outpatient, inpatient or clinic visit)

Claim may point to billing location and the medical record may be at the service location

- ✓Providers may see patients at multiple sites

Understanding chase logic

Need to know

- ✓ The measure specifications, including the type of provider likely to provide the service
- ✓ Your provider network

Chase logic may be based on

- ✓ Patient's PCP assignment
- ✓ Frequency and recentness of visits
- ✓ Content of the visit via claims

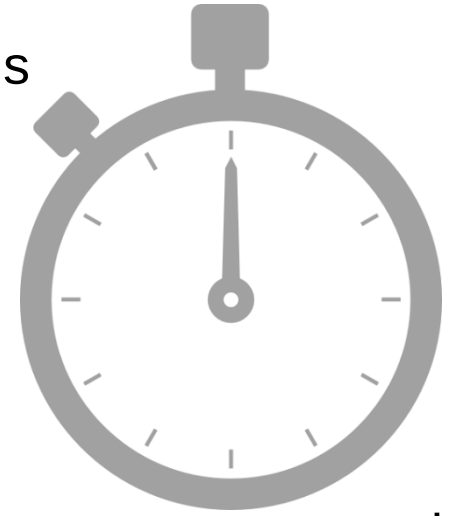
Prioritizing

- ✓ May want to focus more heavily on measures:
  - More dependent on medical record information (e.g. CPB)
  - Where several providers/types can provide the service (e.g. CDC)
  - That you know will require more effort (e.g. one large provider site, out of network)

Barriers observed in MY1 collection

Timing

- Delayed implementation: limited the time to retrieve/abstract records
- Deviation from the standard HEDIS timeline
    - Some confusion with chart requests
    - Abstraction tools needed revision
    - Reviewers needed additional training



Establishing liaisons with PPS staff

- The primary point of contact was not always the most appropriate person to oversee the retrieval process
    - Reviewers were not given overview of how to access EMRs
- Billing sites, not service sites, were often the first location identified
- Limited access to integrated health systems and electronic data (RHIOs/SHIN-NY)

Potential resolutions

Earlier Start:

- ✓ The validation process will begin earlier in the MY in order to identify and resolve retrieval and abstraction issues quickly
- ✓ Record retrieval issues should be identified and addressed as early as possible

Chase Logic

- ✓ Shared with the PPS to help guide the identification of provider(s) most likely to have provided the service

Education/Transparency

- ✓ More training provided to PPS and reviewers (e.g. MRR process, non-HEDIS measures, and off-cycle time period)

Potential resolutions (con't)

Enhance Lines of Communication

- ✓ Establish a points of contact to address stakeholder questions – vendors and PPS hold kick off and regular check-in meetings
  - Identify access barriers (remote locations/scheduling) early
- ✓ Communication strategy for PPS and providers
  - Vendors creating a formal communication strategy in collaboration with each PPS for provider outreach
- ✓ Dashboards for each measure by PPS
  - Present the PPS progress during the collection period by measure to help identify potential underreporting
- ✓ Topic-specific status calls
  - May focus on a specified topic
  - Identify problems early on
  - Common challenges

Challenging measures from MY1

- Invalidated Measures
- Why Challenging

Invalidated Measures

Controlling High Blood Pressure (CBP)

- Much lower than expected rate of high BP control
  (NYS MMC average=63.0%, MY1 average=33.0%)

Comprehensive Diabetes Care (CDC): HbA1c poor control

- Much higher than expected rate of poor control (NYS MMC average= 32.0%, MY1 average= 79.6%)

Frequency of Ongoing Prenatal Care (FPC)

- Much lower than expected rate of PNC visits
  (NYS MMC average=70.0%, MY1 average=17.3%)

Why so challenging?

Screening for Clinical Depression

- Non-HEDIS with no history of collection
- Complex measure with multiple components to meet numerator compliance
- Subjective exclusion criteria
- Administrative codes rarely found in claims

Controlling High Blood Pressure

- Reliance on medical record to confirm HTN and control
- Complex process to identify provider

Comprehensive Diabetes Care – Poor HbA1c Control >9.0

- Low rate indicates better performance
  - Record not found equates to “poor control”
  - Documentation of a test performed without a result equates to “poor control”

Frequency of Ongoing Prenatal Care

- Global billing issues render claims information incomplete
- Many visits needed to meet the >= 81% threshold
- Need GA from hospital record or birth certificate
  - If GA is not available, assume 280 days (40 weeks), which may require more visits to achieve compliance

Screening for Clinical Depression (SDC)

- Follow up plan rationale, specification, QI consideration, and improvement strategies
- Details, scoring, and suggested actions

Screening for clinical depression and follow up plan rationale

- **Depression decreases quality of life for patients, negatively impacts families, and is a significant driver of direct health care costs and lost productivity** (USPSTF 2016).
  - Depression is a leading cause of disability, and is associated with impaired ability to manage other health issues and adhere to treatment plans.
  - Persons with chronic conditions and substance misuse are at increased risk for depression
- **Depression is prevalent among primary care patients, yet there is evidence that it is under-identified** (AHRQ 2009, AHRQ 2016).
  - Screening improves accurate identification of depression among patients in primary care
  - There are reliable and valid depression screening instruments for adults
  - The accuracy of screening methods without formal screening measures is unknown and presumed variable
- **Screening instruments are not sufficient for diagnosis of depression, but rather indicate a need for further detailed evaluation by a clinician for diagnosis, severity assessment, and other diagnoses** (AHRQ 2009).
- **Routine screening for depression for adults should be implemented with adequate systems in place for accurate diagnosis and appropriate treatment and follow-up** (USPSTF 2016).

Screening for clinical depression and follow up plan specification

- **Percentage of patients age 18+ screened for clinical depression using a standardized depression screening tool, and if positive finding, received appropriate follow-up care**

- **EPOP**
  - 18 years or older as of the first day of the measurement year.
    - two age stratifications and a total result: 18 – 64, 65+, Total
  - Continuous enrollment for the measurement year.
  - A qualifying outpatient visit during the intake period

- **Required Administrative Exclusions** (using codes to exclude):
  - Depressive disorder, Bipolar disorder, severe intellectual disability, or dementia

Screening for clinical depression and follow up plan specification

Denominator: Sample drawn from the EPOP

MR Exclusions:

- Any history of bipolar disorder or history of a Depressive disorder, which includes major depressive disorder (MDD), persistent depressive disorder (dysthymia), or unspecified depressive disorder
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. Examples include members with delirium or severe cognitive impairment.

Numerator: Three components required for consideration of compliance

1. Screening: Members who were screened for clinical depression with a standardized tool in the MY
2. Result: Screened positive for depression
3. Follow-up of positive screens: Had appropriate follow up care within 30 days

- G codes can be used to administratively identify the numerator but are not often used
  - High reliance on medical record review

The Devil is in the details

What is a standardized tool?

- An assessment tool that has been normalized and validated for the adult population
- Scores associated with probability of depressive disorders
- PHQ most commonly used screens in the U.S. (AHRQ 2009)
- General queries are not compliant

What is a positive screen?

- Established cut point scores are provided in specifications for PHQ2 and PHQ9
- Provider interpretation is priority result

What is appropriate follow-up?

- A broad range of acceptable actions within 30 days are listed in specifications, including recommended follow-up, treatment, and further assessment

Who is excluded?

- For clarity, any member with a history of depression or bipolar disorder prior to screening or, if no screening, during the MY
- Patients who lack capacity for participating in screening, such as those with severe cognitive impairment

Scoring of common tools

Over the last 2 weeks, how often have you been bothered by any of the following:	Not at all	Several days	More than half the days	Nearly every day
	(0)	(1)	(2)	(3)
a. Little interest or pleasure in doing things?	☐	☐	☐	☒
b. Feeling down, depressed, or hopeless?	☐	☒	☐	☐
c. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☒	☐
d. Feeling tired or having little energy?	☐	☐	☐	☒
e. Poor appetite or overeating?	☐	☒	☐	☐
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?	☐	☐	☒	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☒
h. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☒	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☒	☐	☐

Established cut point for PHQ 2 for further action is 3 or greater
If the responses are yes/no, yes to either query is a positive PHQ2 screen

PHQ 9 scoring and suggested actions

Table 4. PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Screening for clinical depression and follow up plan QI considerations

Challenges to measure reporting

- EHR documentation formatted without name of screen
- Lack of result/scoring/interpretation documentation
- Documentation of action for lower positive scores (e.g. PHQ9 ≥ 5 but < 10)

Guidelines

- US Preventive Services Task Force's recommendation for depression screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm
- The USPSTF Community Guide's recommendations for collaborative care for the management of depressive disorders:

  http://www.thecommunityguide.org/mentalhealth/collab-care.html

Screening for clinical depression and follow up plan: improvement strategies

Effective strategies

- USPSTF
  - Support staff and clinician training
  - Nurse visit prior to physician visit for assessment
- AHRQ Innovations Exchange
  - Integrated physical and mental health care (including health homes)
  - Adapted EHR for screening and care coordination
- Community Preventive Services Task Force
  - Collaborative care-case managers to link primary care and specialists

Controlling high blood pressure (CBP)

- Rationale
- Relevant success in this Measure
- QI Considerations

Controlling high blood pressure rationale

- Approximately 67 million Americans have high blood pressure (CDC, 2012).
- Treatment to improve hypertension includes dietary and lifestyle changes, as well as appropriate use of medications.
- The goal of hypertension management is to attain and maintain control of high blood pressure to reduce the risk of complications.
- Blood pressure control targets have been identified using best available evidence of benefit for reducing adverse health outcomes for each subpopulation in the measure.
  - Lower BP control targets have been shown to have no additional benefit, or evidence is inconclusive.
- The measure is consistent with current clinical guidelines, such as United States Preventive Services Task Force (USPSTF 2015) and the Joint National Committee (James et al., 2014).
- National 2015 benchmark = 57%, NYS QARR 63%

Controlling high blood pressure

- **Percent of members 18-85 with a Dx of HTN and whose BP was adequately controlled**
  - Age 18-59 – BP <140/90 m Hg
  - Age 60-85 with Dx of diabetes whose BP <140/90
  - Age 60-85 without Dx of diabetes whose BP <150/90
- **EPOP** : members administratively identified as hypertensive
  - One visit with a Dx of HTN during the first six months of the measurement year (MY)
  - Flag used to assign members with diabetes identified via claims and pharmacy
  - Continuous enrollment criteria applied (measurement year)
- **Denominator**: sample drawn for the EPOP
  - Must confirm documented Dx of HTN in the medical record **anytime** in patient history (on or before first six months of measurement period)
- One record should be used to confirm the Dx and the BP reading

Controlling high blood pressure

- **Numerator** patients in the denominator whose BP is adequately controlled during the measurement year
  - Adequately controlled defined as per current clinical guidelines
  - Control is defined differently by diagnosis and comorbid diabetes, based on evidence for different optimal targets
  - Measure considers most recent reading in outpatient setting other than ED

- **Exclusions (Optional)**
  - Pregnancy, ESRD, kidney transplant, non-acute inpatient admission

Successful record retrieval is especially relevant for this measure

Two components of successful record retrieval include

1. **Complete record retrieval**
    - Administratively identified members with HTN remain in the denominator but are numerator non-compliant if:
        - No medical record is found
        - The medical record does not include a BP reading
        - The medical record does not include evidence that the most recent BP reading is adequately controlled

2. **Appropriate record retrieval**
    - Identifying the appropriate provider to ensure complete and appropriate record
        - Identify PCP → if more than one, most recent → if no PCP or PCP visit, most recent practitioner who provided care
        - The medical record of a practitioner other than the PCP can be used if he/she manages the member's HTN

Controlling high blood pressure QI considerations

Measure reporting process improvements

1. **Identify appropriate providers**
   - Primary care providers (internists, family practice, nurse practitioners)
   - Other providers who may manage hypertension (cardiologists, nephrologists, endocrinologists people with diabetes)
2. **Identify relevant medical record documentation**
   - Problem lists, nurse notes, physician notes, EMRs, hospital discharge notes (for diagnosis), consultation reports
3. **Ensure communication with front-line staff**
   - Potentially involved providers
   - Office administrators
   - Medical record staff

Controlling high blood pressure QI considerations

Evidence-based strategies to address barriers to blood pressure control

- **Patient medication adherence**
  - Discuss risks of non-adherence
  - Explore side effects at every visit and encourage discussion of barriers to adherence
  - Promote medication reminders
  - Establish a refill protocol
- **Optimized delivery system design**
  - Develop patient registries for monitoring
  - Implement systems to provide clinician alerts elevated readings
  - Implement standardized treatment protocols
- **Patient supports**
  - Provide written self management plans
  - Provide ongoing contact until blood pressure controlled
  - Implement clinical support systems based on home blood pressure readings and customized feedback
  - Supporting lifestyle changes, nutritional counseling, physical activity counseling
  - Collaborative Care Teams: pharmacists, community health workers

Comprehensive diabetes care poor control (CDC)

- Rationale
- Poor Control
- QI Considerations

Comprehensive diabetes care HbA1c poor control >9% rationale

- **Diabetes is one of the most costly and prevalent chronic diseases in the US**
  - ~26.5 million Americans have diabetes
  - Annual US cost of diabetes complications is nearly $245 billion (ADA 2013)

- **Hemoglobin A1c is the primary predictor of diabetes complications**
  - Optimizing A1c control decreases the risk of microvascular and neuropathic complications

- **Optimal glycemic targets vary by patient and disease factors** (ADA 2016)
  - An A1c goal of <7% is appropriate for many adults (ADA 2016)
  - Less stringent (<8%) A1c goals are potentially appropriate for some patients
  - However, an A1c level of >9% constitutes a clearly modifiable, high level of risk that is not likely appropriate for any persons with diabetes (CDC 2012)

- **National 2015 Benchmark = 46%; NYS QARR = 32%**
  - (low rate indicates better performance)

Comprehensive diabetes care HbA1c poor control >9%

- Poor control is part of a suite of diabetes measures based on the same EPOP
- **Percent of patients 18-75 with diabetes whose most recent HbA1c is poorly controlled (>9.0%)**
- **EPOP**
  - Ages 18-75 with continuous enrollment criteria for the measurement year
  - Diabetes identified via claims/encounters and pharmacy data
- **Denominator**: Sample drawn from the EPOP (n = 548 to achieve 411)

Comprehensive diabetes care HbA1c poor control >9%

Numerator:

- Administrative: Codes (e.g., CPT Category II)
  - Codes are often not captured or absent - a level is required
- Hybrid:
  - Documentation must include the **date** of the HbA1c test and the **result** (a distinct number is required)
  - Patient is numerator compliant if the result is >9.0, the result is missing, or if the test was not done

Exclusions (optional): no diagnosis of diabetes (MY and year prior) and had a Dx of gestational diabetes or steroid-induced diabetes

Comprehensive diabetes care HbA1c poor control >9% QI considerations

Common barriers:

- Patients do not know their numbers or do not check their levels often.
- Patients are noncompliant with medication and lack understanding about the disease process.
- Even when patients check their levels, they do not understand the implications on their health of numbers out of range.

Strategies to improve care:

- Refer members to a diabetes population management program to help foster self-management
- Have patients complete a nutrition consultation, discuss importance of exercise and develop a plan for weight control.
  - Refer to nutritionist/dietician
- Schedule frequent follow up appointments for patients with diabetes.
- Hold frank discussions with patients regarding importance of managing diabetes and implications on health.
- Suggest the use of HbA1c home test kits, if available
- Remember HbA1c is one component of comprehensive care for diabetes (i.e. foot exams, eye exams, BP)

Comprehensive diabetes care HbA1c poor control >9% QI considerations (con't)

- Ensure complete record retrieval

- Members with diabetes but missing A1c tests or missing test results are numerator non-compliant
  - Seek appropriate provider records: Primary care and endocrinologist records
  - Ensure review of result of most recent A1c test

- ADA Professional Practice Committee Clinical Guidelines: http://care.diabetesjournals.org/content/39/Supplement_1D

Frequency of prenatal care (FPC)

- Rationale
- Specifications
- QI Considerations

Frequency of ongoing prenatal care rationale

- Pregnancies with limited prenatal care have twice the risk of preterm birth and infant mortality than pregnancies with sufficient care (Centers for Disease Control and Prevention [CDC], 2013).
- The need for ongoing, dynamic risk assessment and risk-appropriate intervention to improve birth outcomes has long been recognized (IOM 1985)
  - Strong evidence for the effectiveness of risk-appropriate interventions with early implementation and ongoing support (ACOG 2012, USPSTF 2009)
  - Optimal prenatal visit frequency is determined by a patient's needs and risks, which can develop throughout pregnancy (AAP/ACOG 2012)
- At minimum, prenatal visit frequency should be sufficient for assessment and timely intervention for risks to maternal/fetal well being (AAP/ACOG 2012)
  - Expected visit frequency is based on ACOG guidance for frequency for uncomplicated pregnancies, i.e. visits every 4 weeks for first 28 weeks, every 2 weeks to 36 weeks gestation then weekly
- National 2015 benchmark = 55%; NYS QARR = 70%

Frequency of ongoing prenatal care specifications

- **Measure tracks Medicaid-enrolled women who had live births during the past year to determine the percentage of recommended prenatal visits they had.**
- Adjusted for the month of pregnancy at enrollment and gestational age
- Percent of deliveries in the MY that had the following number of expected prenatal visits:
  - <21 percent of expected visits
  - 21 percent–40 percent of expected visits
  - 41 percent–60 percent of expected visits
  - 61 percent–80 percent of expected visits
  - **≥81 percent of expected visits** (DSRIP score)
- **EPOP** (administratively defined):
  - Medicaid only
  - Continuously enrolled 43 day prior to delivery though 56 after the delivery (EPOP is same for postpartum care)
  - Delivered a live birth in any setting
    - Women who delivered twice in the MY are counted twice

Frequency of ongoing prenatal care specifications (con't)

Denominator:

- Administrative:
  - Algorithm used to determine gestational age at enrollment
  - Claims/encounters to determine count of prenatal visits
- Hybrid: a sample of 411 (plus oversample)

Numerator:

- Women who had unduplicated count of the number of expected visits in each numerical category. For DSRIP, the performance measure is: **≥81 percent of expected visits**
  - **Prenatal visits are defined as visits with a practitioner**
  - **Ultrasound and lab results alone are not considered visits**

Medical record documentation:

- Determine gestational age from hospital record or birth certificate
  - Hospital records: admission write-ups, H&P, discharge summaries, labor or delivery records
- If gestational age is absent, assume 280 days (40 weeks)
- Methods to determine gestational age:
  - Physician ultrasound or Dubowitz assessment.
  - (LMP) calculation (date of LMP – date of delivery) ÷ 7 (round down to completed weeks)

Frequency of ongoing prenatal care specifications (con't)

Medical record documentation – Prenatal Care visits:

- Prenatal visit to OB/GYN or other prenatal provider or PCP
- Diagnosis of pregnancy and date of visit required
- One of the following is required during the visit:
  - A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used).
  - Evidence that a prenatal care procedure was performed, such as:
    - ✓ Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
    - ✓ TORCH antibody panel alone, ***or***
    - ✓ A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
    - ✓ Echography of a pregnant uterus.
  - Documentation of LMP or EDD in conjunction with *either* of the following.
    - ✓ Prenatal risk assessment and counseling/education.
    - ✓ Complete obstetrical history.

Frequency of ongoing prenatal care QI considerations

Challenges to measure reporting

- Lack of gestational age at birth can overestimate the expected number of prenatal visits
- Lack of documentation of practitioner visit when procedure performed

Barriers to care (MCHB 2013)

- Lack of understanding of importance of early/ongoing prenatal care for optimal outcomes
  - Late entry to care
  - Competing priorities
- Appointment access barriers
  - Barriers to scheduling – pregnancy test or medical record required, after hours access
- Logistics
  - Transportation, child care
- Language and cultural barriers

Strategies to improve

- Work with health plans to arrange for transportation services
- Case management to find avenues of support, interpreters, social services support and to facilitate scheduling of visits
- Registries to monitor attendance at visits and arrange for rescheduling of missed appointments
- Preconception counseling and education during post-partum visits

Bronx-Lebanon experience

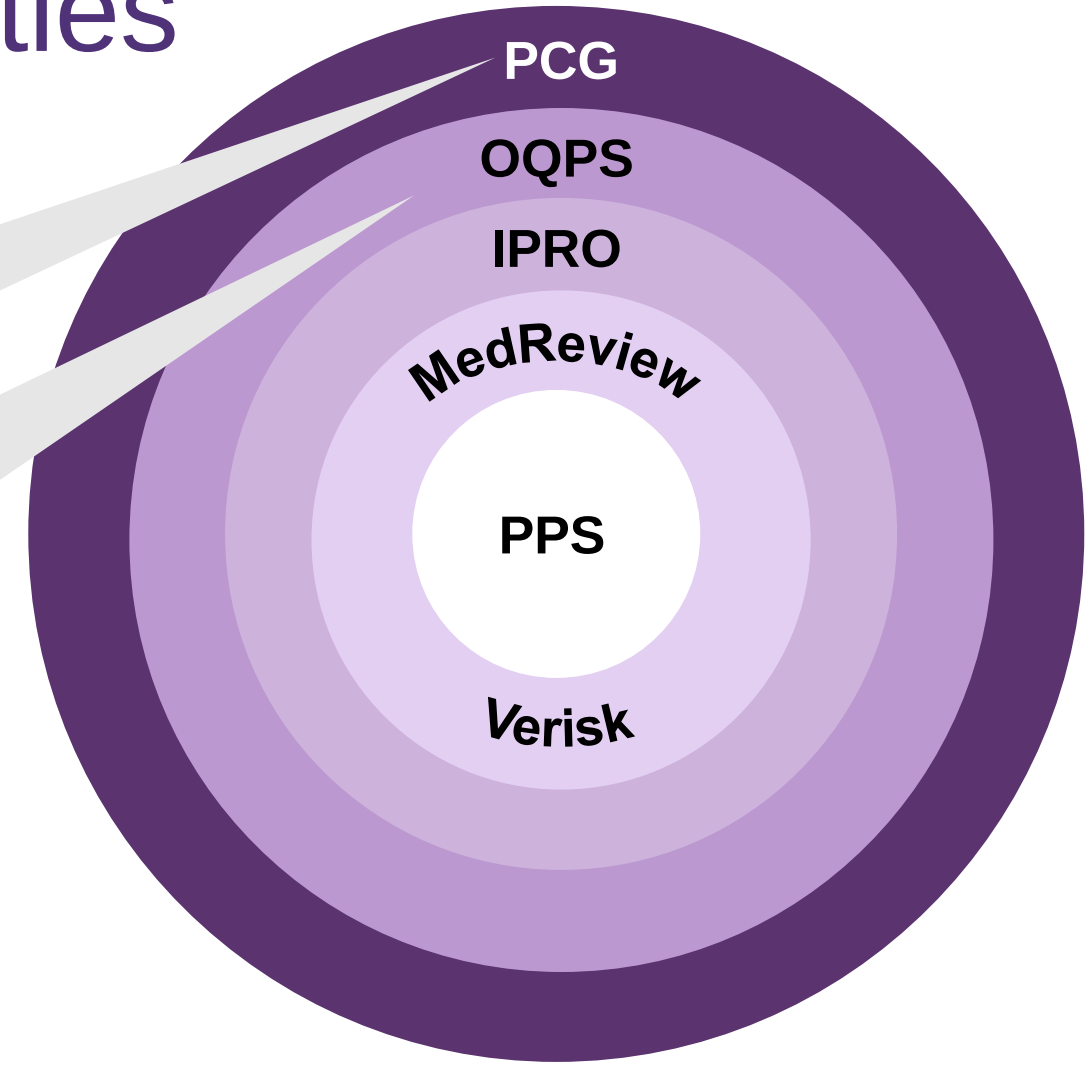
- Noted experience, approach and lessons learned

Overview of MY2 project plan and operations

Roles and responsibilities

Project Management Office:
- Maintaining project timeline
- Facilitate training and project updates
- Account support for PPS

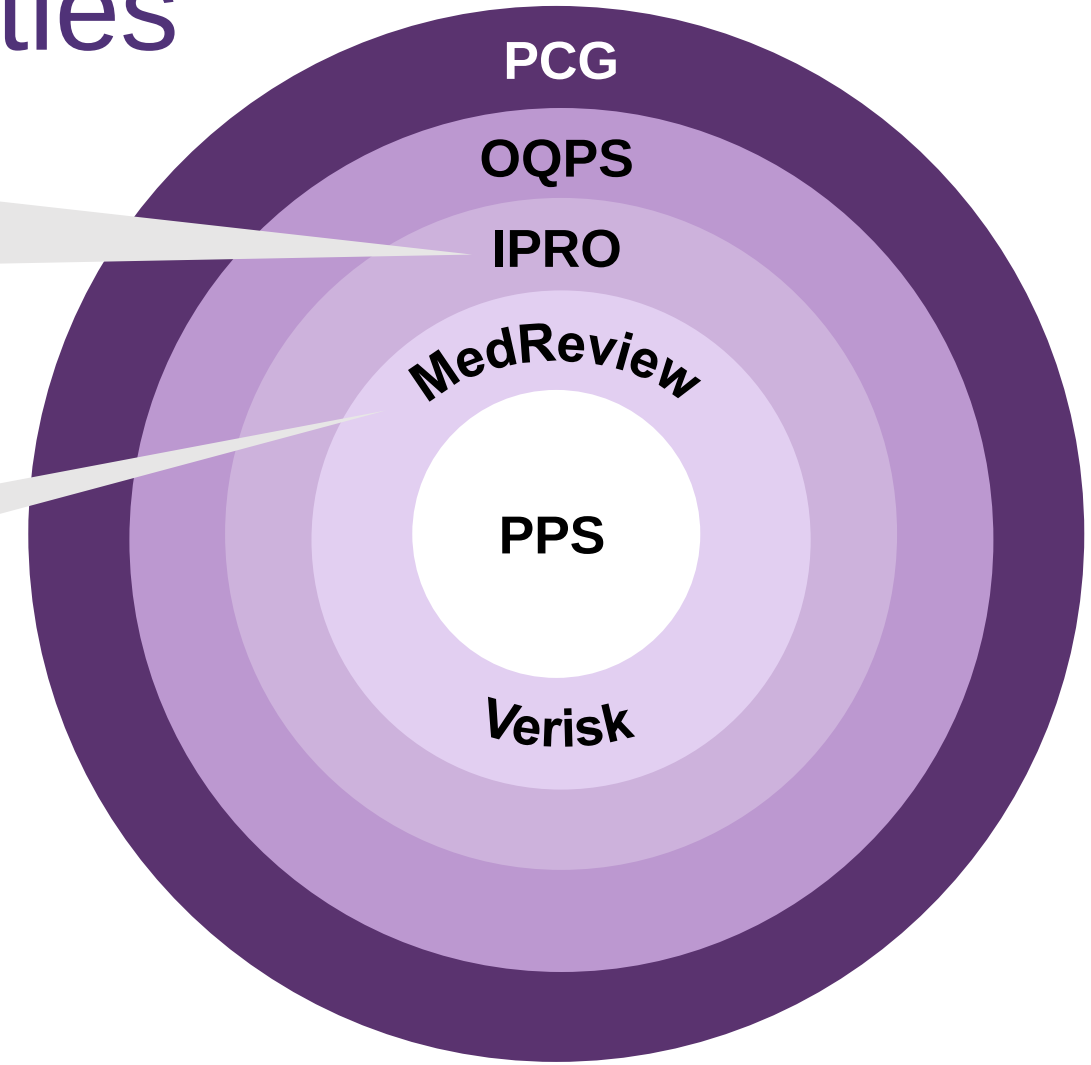
Office of Quality and Patient Safety:
- Maintain program measures and metrics
- Overall program data owner (sample generation, attribution)
- Project oversight on data integrity issues
- Finalize results



Roles and responsibilities

Validation Team:
- Validate abstraction tools
- Ensure measure specification compliance
- Validate final results

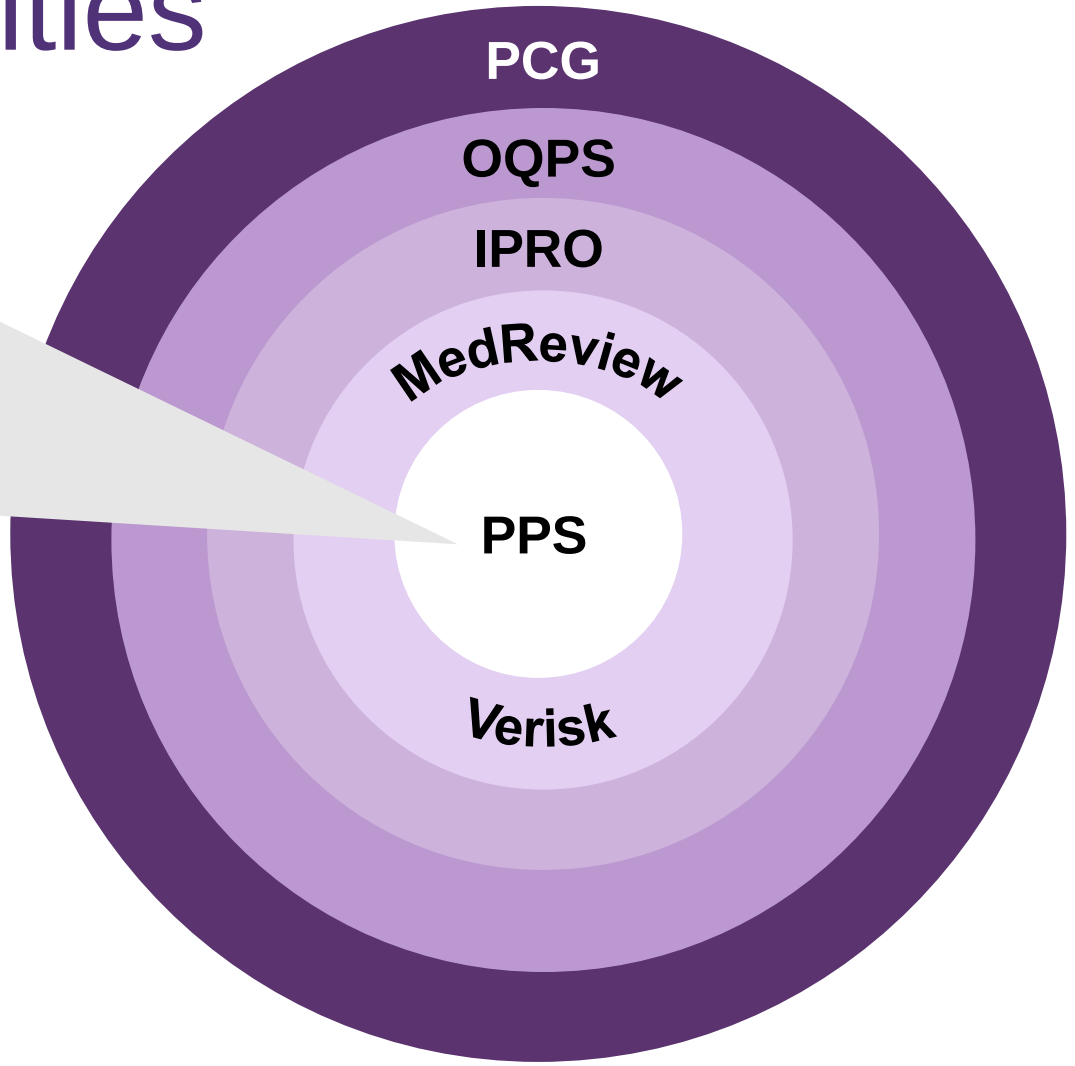
Record Collection and Abstraction Team:
- Tool development
- Chase logic development
- Record collection and abstraction services
- Interim reporting of results



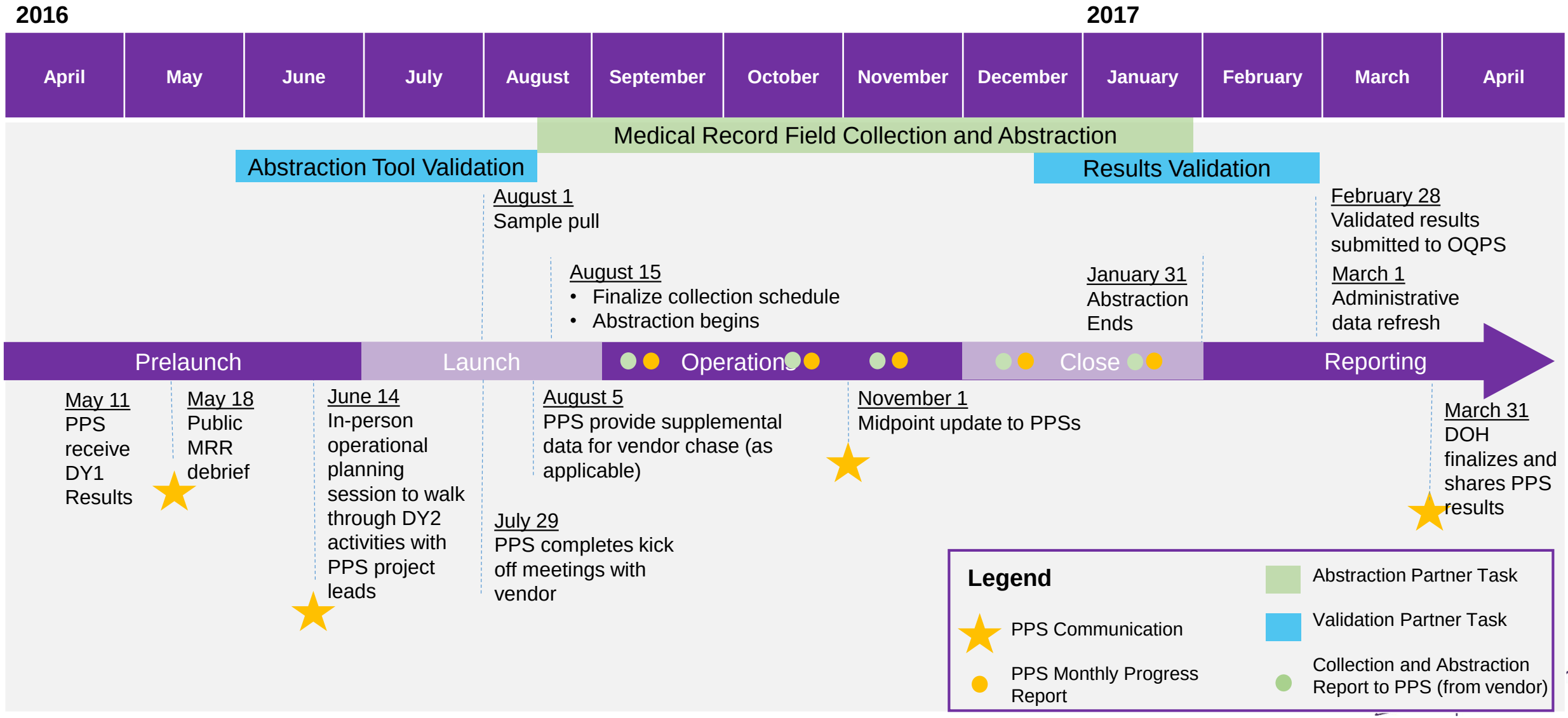
Roles and Responsibilities

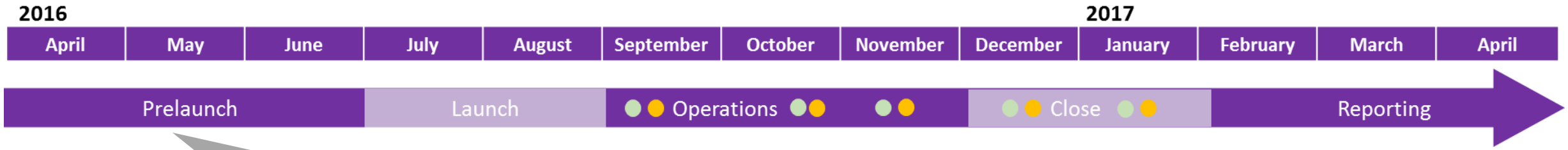
PPS Medical Record Lead Responsibility:

- Review chase logic from abstraction partners; supplement data as available
- Assist with collection scheduling, remote access, supporting outreach with record review staff, etc.
- Identify key contacts, lead provider communications for collection efforts
- Monitor project progress
  - Review weekly record collection and abstraction reports
  - Report progress during monthly AST check-in
  - Participate in all project trainings and reporting activities

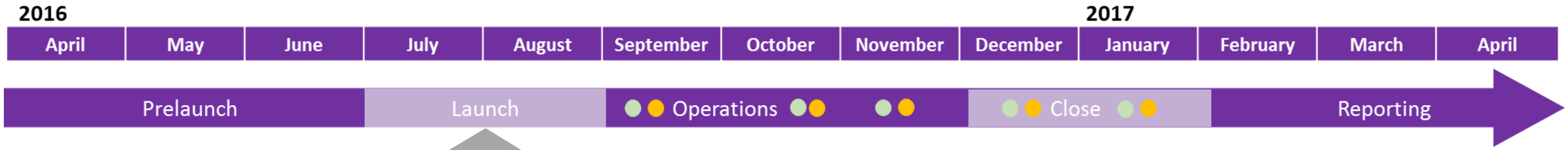


DSRIP Measurement Year 2

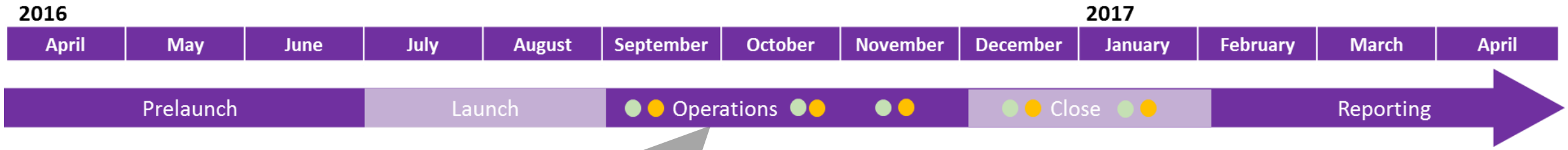




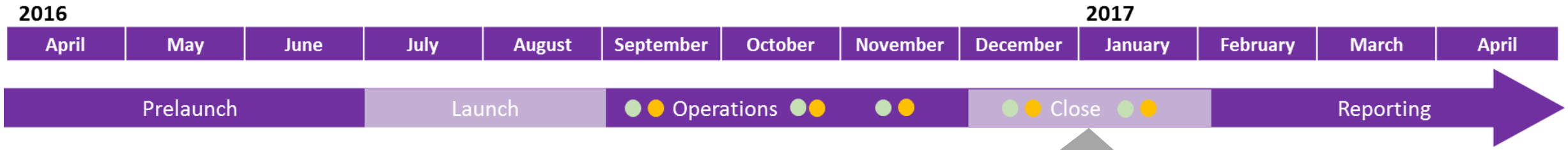
Tasks	PPS Role	Partner(s)
June 14: In-person operational planning session to walk through MY2 activities	PPS to attend with relevant participants	IPRO, PCG, OQPS, Abstraction teams



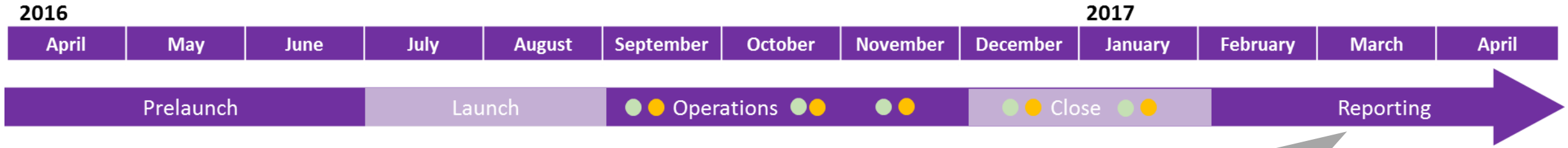
Tasks	PPS Role	Partner(s)
July 29: Complete kick off meetings	PPS to coordinate with abstractors	Abstraction teams
August 1: Sample pull	N/A	OQPS
August 5: Provide supplemental data for chase logic	PPS to provide supplemental provider and encounter data, as applicable	N/A
August 15: Finalize collection schedule	PPS to coordinate and assist with collection schedule	Abstraction partners
August 15: Abstraction begins	PPS to work with partners to facilitate record retrieval and provider communication	Abstraction partners



Tasks	PPS Role	Partner(s)
November 1: Midpoint update to PPS	N/A	PCG, OQPS, IPRO
Ongoing: Monthly progress update to PCG	PPS to provide updates during monthly account support check-in, meeting, or alternative report	PCG (AST)
Ongoing: Collection and abstraction report to PPS	N/A	Abstraction partners



Tasks	PPS Role	Partner(s)
December – March: Results validation	N/A	IPRO
January 27: Training: Preparing for MY3 and P4P switch in MY4	PPS to identify relevant attendees	PCG, OQPS, IPRO
January 31: Abstraction ends	N/A	Abstraction partners



Tasks	PPS Role	Partner(s)
February 28: Validated results submitted to OQPS	N/A	Abstraction partners
March 1: Administrative data refresh	N/A	OQPS
March 31: Results finalized	N/A	DOH

PPS Launch Checklist

- ❑ **Now:** Pre-kick-off activities
  - ❑ Schedule kick-off meeting with record collection team
  - ❑ Develop communication plan for providers
- ❑ **July 29:** Complete kick-off meetings
  - ❑ Introduction of team members (record collection team and PPS team) and review regular reporting
  - ❑ Share provider communication plan
  - ❑ Walkthrough timeline and identify key coordination points
    - ❑ Review available data sources
    - ❑ Review chase development process
    - ❑ Record location
    - ❑ Site visit scheduling
    - ❑ Discuss provider outreach and determine initial collection schedule and remote access, as applicable
- ❑ **August 5:** Deployment planning
  - ❑ Review initial chase results with record collection team
  - ❑ Identify supplemental data for chase logic, as applicable
  - ❑ Develop collection plan (identify provider groups, regions)
- ❑ **August 15:** Collection begins

Key Contacts

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Questions

For more information, please contact your Account Support Team or submit your question to DSRIP@health.ny.gov