NEW YORK STATE OF OPPORTUNITY. Department of Health

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DOH REVIEW AND EXECUTIVE SUMMARY OF PPS PRIMARY CARE PLAN
DECEMBER, 2016

PPS NAME: CENTRAL NEW YORK CARE COLLABORATIVE (CNYCC) PPS

CNYCC connects 1,400 providers across six counties: Cayuga, Lewis, Madison, Oneida, Onondaga and Oswego. CNYCC identifies that 243.6 (out of 401) primary care and mid-level practices are hospital-based. Strong analytic baseline data for Workforce Transition Roadmap with clear strategies, the targeted positions and the projected achievement timelines in underway.

Overall Assessment: Overall approach to primary care is provided, however, activities cited in the primary care plan appear to be mostly in planning stages. Actual implementation is not addressed in much of the plan. Emphasis on extensive workforce training provided through monthly webinars and learning platform. Specific information regarding funds flowed to primary care were not provided in the plan. Recent hire of a Corporate Medical Officer is expected to accelerate activities.

FUNDAMENTAL #1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs

- Used a community needs assessment, comp and bene survey, IT readiness surveys, PCP Network Analysis/Regional Comparison and NYSDOH Performance and Quality Outcome Measures to assess and develop a primary care baseline and then planning activities.
- PC positions and those involved in an IDS have high vacancy rates (e.g., PCP 10.34%, PCNP 11.34%, Care Transitions 14.77%, Psych NY 18.79%), demonstrating a shortage of labor Efforts underway to provide incentives to partners to recruit new providers.
- Majority of PCPs are currently hospital-based primary care providers, and working on relationships with community based PCPs. Also working to increase capacity by increasing hours and PCMH recognition across the PPS (less than 30% are PCMH certified currently).
- Workforce transition roadmap is being finalized, a development specialist has been hired, and workforce committee includes subject matter experts and other partners and planning to determine how to offer recruitment incentives to fill gaps.
- To promote a longer term workforce strategy for meeting needs, PPS is developing health professional mentoring programs for students and emerging professionals.
- Partnership efforts have also resulted in contracts with community-based primary care practices for engagement in DSRIP projects.

FUNDAMENTAL #2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

- PCMH Certified Content Expert has been hired, incentive payments offered to complete PCMH readiness templates, and scheduling of free training onsite, online and via webinar.
- Comprehensive training strategy and schedule with focus on practice transformation
- CNYCC Learning Collaborative launched to share best practices.
- Engaged potential Learning Management System vendors for training to consolidate courses that cover many topics, and allows tracking and reporting.
- Working with regional medical societies to conduct education and awareness presentations.

- Telemedicine, use of mobile devices, and standardized patient satisfaction tools and other efficiency strategies are being considered to increase PCP utilization.
- PPS facilitating RHIO outreach and education to PPS partners.

FUNDAMENTAL #3: What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?

- Two step strategy: expand and strengthen primary care and then encourage collaboration with other partners, including raising awareness of Health home and benefits of care coordination.
- Population Health Management IT will help integrate EMR and RHIO data and provide real time messaging. Population health management platform to be launched in mid-2017.
- Plan is unclear how many practices will benefit from trained care coordinators located within primary care sites to help with patients who do not qualify for HH.
- ED Triage project using patient navigators to link back to Primary care; Care Transitions revolve around community coalitions; and external partnerships with MH/SUD specialists are being formed where a behavioral health provider is not on site.
- Governance bylaws designate representation from both hospital and community based entities that provide primary care services. 3 members are physicians. Within committee structures, 1/3 of the membership are physicians, and 1/3 of them are primary care providers.
- Modeling participation from the MAX series to other providers

FUNDAMENTAL #4: What is the PPS's strategy to enable primary care to participate effectively in value-based payments?

- Population Health Management platform (PHP) is expected to aid the transition to VBP with PM, QI, data analytics, Care Management and Care Coordination. It will organize information at the provider, practice and population level across provider types including hospital, behavioral health providers and CBOs. To be available for partner use in 2nd quarter 2017.
- VBP consultant retained and PPS working with partners to assess VBP readiness and develop a roadmap on which sites need help and where.

FUNDAMENTAL #5: How does your PPS's funds flow support your Primary Care strategies?

- Funds flow supports primary care with incentives for RHIO connection, engaging patients, reporting performance and capturing consents, EMR assessments and PCMH planning.
- Specific PC incentives added for BH integration milestones and cardiovascular disease mgmt.
- Centralized Investment fund available to PCPs to offset operational expansion (covers the PHM system, the PCMH consultant, and future CM/CC services).

FUNDAMENTAL #6: How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?

- Community Memorial Hospital (Bassett PPS partner) and Planned Parenthood of Mohawk Hudson participated in MAX series.
- Promoting OMH Licensed Behavioral Health Practitioner Benefit reimbursement of "off-site" behavioral health services.
- Internal challenges with primary care capacity to conduct a phased-in implementation of screening patients for MH/SUD and depression.
- Integration continues through Project 3aii, BH Crisis Stabilization project expanding access through mobile crisis and respite, and seeks to address long waiting list access issues.
- *Collaboration for Health* RFP for Project 4aii Prevention of SUD/MEB disorders to address challenges of opioid addition, suicide and Serious Mental Illness and facilitate collaboration between PC and BH.