AHI PPS

Primary Care Plan

Updated November, 2016

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Introduction

AHI is an independent, non-profit organization that partners with regional health care providers and community-based organizations to improve care, lower costs and realize a healthier future for the Adirondack region.

Mission
To promote, sponsor and coordinate initiative and programs that improve health care quality, access and service delivery in the Adirondack region.

Vision
Every individual in our region realizes their full potential and lives a healthy life.
DSRIP (Delivery System Reform Incentive Payment) is funded by Centers for Medicare & Medicaid Services (CMS). Up to $ 6.42 billion dollars has been allocated to New York State with payouts based upon achieving predefined results in system transformation, clinical management and population health.

DSRIP is the main mechanism by which the New York State Department of Health will implement Medicaid redesign. DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. DSRIP aligns with the state's Triple Aim: improve access to care, improve quality of care, and reduce costs.

Payment reform moves from fee-for-service to value based reimbursement to providers. Payments will be based on improvements in patient outcomes, utilizing incentives to get providers to work together to offer preventive, rather than reactive care; integrate behavioral- and physical-health services in the community setting; and address social determinants of health, such as nutrition, housing and employment.

The AHI PPS was formed as a partnership to plan for and manage the health care restructuring in the northern New York/Adirondack region. Spanning nearly 11,000 square miles and serving nine counties (all of Clinton, Essex, Franklin, Hamilton, Warren and Washington counties, and portions of Fulton, Saratoga and St. Lawrence) the region's 700,000 residents are expected to benefit from the increased support of population health. Of these, there are 144,000 attributed Medicaid lives.

The AHI PPS has partnered with more than 100 organizations including hospitals, primary care providers, mental health and substance abuse treatment providers, skilled nursing facilities and others to achieve our collective DSRIP goals.

Ensuring every primary care provider in our network has achieved Patient Centered Medical Home (PCMH) recognition or is practicing in a high performing Advanced Primary Care (APC) practice provide an opportunity to strengthen and expand primary care, which is central to achieving better health for patients and communities, and lowering costs for everyone.

Goals and Objectives

More than two million New York State residents lack sufficient access to primary care. The Delivery System Reform Incentive Program (DSRIP) is our best opportunity to strengthen and expand primary care, which is central to achieving better health for patients and communities, and lower costs for everyone.

New York State and all 25 DSRIP Performing Provider Systems (PPSs) have committed to this vision, including ensuring every primary care provider in their network is a high-performing Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) practice.

Our expectation is that at the conclusion of DSRIP:

- The vast majority of New York State residents currently without primary care will have regular and unfettered access;
- The vast majority of primary care providers will be practicing as advanced models (PCMHs/APCs);
- Primary care spending as a proportion of total health spending will at least double from current levels;
- Evidence of primary care value to health care quality, outcomes and costs will be clearly demonstrated and reflected in value-based payment models.

(Source: Primary Care Development Corporation "DSRIP Must Deliver on the Primary Care Promise" dated February 17, 2015)

Section 1 Overview

The AHI PPS recognizes the necessity and value of practitioner engagement in the health system transformation process. In particular, strengthening and expanding primary care is central to achieving better health for patients and communities, and lowering costs for everyone.

The AHI PPS strives to engage practitioners using a multi-faceted approach, in a manner that will:

- Listen to and address physician concerns, acknowledging the importance of their role in the PPS
- Implement effective incentives, to enable practices to implement change
- Develop strong physician leaders by engaging Physician Champions and Project Champions
- Improve transparency by providing data analytics and reporting of meaningful/actionable information
- Provide training, and gain enthusiasm for, quality improvement efforts

Practitioners are encouraged share their ideas about the AHI PPS. The governance structure of the PPS provides the opportunity for practitioners to contribute to the development and success of the integrated delivery system.

The governance structure includes the following committees:

- *Steering Committee* – provides strategic planning and oversight of PPS in relation to DSRIP
- *Clinical Governance & Quality Committee* – recommends clinical processes and guidelines as part of PPS project implementation

- *Network Committee* – recommends strategy to strengthen PPS participant network
- *Workforce Committee* – develops PPS-wide workforce strategy
- *Community & Beneficiary Engagement Committee* – facilitates patient and PPS stakeholder engagement
- *IT & Data Sharing Committee* – develops PPS-wide information technology strategy
- *Financial Committee* – develops and oversees PPS financial structure

There is one community-based family practice physician serving on the Steering Committee (out of 23 committee members).

There are two internal medicine practitioners (one physician and one nurse practitioner), one family practice physician and one pediatrician serving on the Clinical Governance & Quality Committee (out of 22 committee members). Of these two are community-based and two are hospital-based.

There is one community-based family practice physician serving on the Network Committee (out of 10 committee members).

A key element of AHI PPS' governance and implementation of the Integrated Delivery System (IDS) is the Population Health Network (PHN). The PHN is a structure that essentially creates a regional Strategic Business Unit responsible for the performance of that region's PPS partners. There are for components of each PHN, a Medical Director – which may be a hospital-based or independent physician - Administrator and Community Based Organization (CBO) and an AHI representative. The first three components, known as the Triad, are populated by PPS partners and ensure collaboration between hospitals, physicians and CBOs. The AHI representative is an Executive Director that will work with the Triad to engage AHI program resources required to support PHN initiatives. Because of the vast geography of the AHI PPS (11,000 square miles), there are five PHNs: Glens Falls, Plattsburgh, Tri Lakes, Fulton County and St. Lawrence County. The Triads for these five PHNs constitute the bulk of the AHI PPS Steering Committee membership. In this way, the Steering Committee serves not only as an advisory body in our Governance Structure but provides a regular forum for the PHNs to share best practices, challenges and successes.

In addition to taking an active role by participating on committees and assisting with governance of the PPS, practitioners will serve on work groups (in the role of Physician Champions) contributing to project's success.

AHI PPS Transformation Coaches are available to assist practitioners in practice transformation efforts through the following:

- Training and coaching of practitioners and staff in clinical transformation and quality improvement
- Assess practices to identify areas for improvement and work with the practice to apply the improvement model
- Facilitate the spread of best practices
- Training practitioners in patient self-management, behavior change and problem solving
- Evaluation of the effectiveness of practice support interventions
- Support practice efforts to obtain recognitions including NCQA PCMH 2014 Level 3 or NCQA PCSP recognition and Meaningful Use Stage 2 requirements for attestation

Resources are available on the DSRIP Project 2.a.ii – "Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (and developed under

the NYS Health Innovation Plan (SHIP)" web page http://www.ahihealth.org/ahipps/dsrip-projects/dsrip-project-2-a-ii/ including:

- Resources for those seeking National Committee for Quality Assurance (NCQA) recognition
- Updates for Physician Champions from the Project Champion
- Links to educational resources
- Presentations on practice management topics

The AHI PPS will be utilizing a learning management (LMS) that will offer some prepared content in identified areas as well as offer tool deliver content/courses developed by the PPS for support to partners. The on-line format will allow training to be available at a time convenient for the provider as well as reaching many more providers in a timely and cost effective manner. This will over another outlet for training when in-person training is not possible. Training will also take place in-person as training needs are identified.

Practice transformation support is provided to practices primarily through on-site coaching and practice facilitation, with ongoing remote support. In addition, group trainings will be offered bi-monthly and learning collaboratives quarterly to encourage sharing of best practices among practices.

The AHI PPS's over-arching DSRIP Plan for Primary Care addresses the following fundamentals:

- An assessment of current primary care capacity, performance and needs, and a plan for addressing those needs;
- How primary care expansion, practice and workforce transformation will be supported with training and technical assistance;
- How primary care will play a central role in an integrated delivery system;
- How the PPS will enable primary care to participate effectively in value based payments;
- How PPS funds flow supports the PPS primary care strategies; and
- How the PPS is progressing toward integrating primary care and behavioral health

Section 2 Capacity

The PPS Primary Care Provider (PCP) Network Analysis – Regional Comparison dated June, 2016 indicated the AHI PPS has 268 primary care providers (based on the Provider Network lists provided by the NYS Department of Health on 11/18/2015). However, the AHI PPS has a total of 332 primary care providers at present.

An appeal was submitted to the State in April, 2016 to correct provider classifications of 45 providers that were incorrectly listed as primary care providers on the 11/18/2015 Provider Network lists. The PPS is working on practice transformation with more than 100 additional primary care providers, to be added to the AHI PPS network during the network maintenance window, scheduled for mid-August through mid-September of this year.

Of the 332 primary care providers in the AHI PPS network 70% are family practice, 19% are internal medicine and 11% are pediatrics. Because family practice providers also see children, this distribution is adequate.

The network is almost evenly split between community-based primary care providers (52% of the 332 practitioners) and hospital-based providers (48% of the 332 practitioners).

Of the 332 primary care providers in the AHI PPS network, 15% are practicing at sites having PCMH 2011, Level 2 recognition; 53% are practicing at sites having PCMH 2011, Level 3 recognition; and 7% are practicing at sites having PCMH 2014, Level 3 recognition.

To meet NCQA requirements as a patient centered medical home, all PCMH recognized practices (accounting for 75% of the primary care providers) offer some type of extended after-hours care, per PCMH 1A "providing routine and urgent-care appointments outside regular business hours" (compared to the 21.6% indicated in the PPS PCP Network Analysis – Regional Comparison).

Three organizations (34 primary care providers or 10% of the total number of primary care providers) are participating in one or more PPSs other than AHI PPS (compared to the 15% indicated in the PPS PCP Network Analysis – Regional Comparison).

According to information provided during the baseline assessments with the primary care groups, 100% are accepting new Medicaid members (compared to the 91.1% indicated in the PPS PCP Network Analysis – Regional Comparison).

The AHI PPS serves nine counties (all of Clinton, Essex, Franklin, Hamilton, Warren and Washington counties, and portions of Fulton, Saratoga and St. Lawrence). With the exception of Saratoga county, the region served has been identified by the US Department of Health & Human Services "Health Resources and Services Administration" (HRSA) as health professional shortage areas and/or comprised of medically underserved areas and populations. http://www.hrsa.gov/shortage/

In particular, Clinton County was identified on the PPS PCP Network Analysis as having the highest attribution but only the 3rd highest PCP count. The AHI PPS has a number of initiatives underway to increase primary care access in Clinton county (please refer to Section 3 – Expansion and Workforce Transformation for details).

The service area can be described as predominantly rural with significant proportions of residents who are vulnerable to poor access to health care and poor health status. Most notably, residents of this region are older, have lower incomes, have a disability, and have lower levels of educational attainment, in comparison to all residents of New York State.

In general, data from New York's Expanded Behavioral Risk Factor Surveillance System (BRFSS) show that residents in the region are less likely than the NYS population overall to have a regular health care provider and to have seen a physician for a routine checkup within the past year.

Workforce analyses had identified the need for nearly 130 additional primary care providers – taking in to account project implementation, vacancies identified at a point in time and anticipated retirements through 2020. Primary care has been identified as one of three priority areas in the AHI PPS, which also includes behavioral health and post-acute care. Workforce efforts towards increasing the number of primary care providers include provisions through the Workforce Recruitment and Retention Fund to assist partner organizations with recruitment resources on efforts in their own organization/practice. Efforts are also underway to bring training initiatives, such as best practices, for successful recruitment and retention to be offered PPS-wide for partners. Providing successful strategies for recruitment will lay the groundwork for success beyond the lifespan of DSRIP. In addition, the AHI PPS is advocating for increased family medicine residency programs within the region with the understanding that many residents choose to remain in the region once their residency is complete.

Section 3 Expansion & Workforce Transformation

The AHI PPS is planning four initiatives to expand primary care access in the region:

- Development and construction of a Federally Qualified Health Center (FQHC) in Plattsburgh, NY to increase primary care capacity, integrate behavioral health services and incorporate state of the art PCMH and care management concepts (Clinton county)
- Replace the North Country Family Health Center in Champlain, NY (Clinton county) with a new, expanded Federally Qualified Health Center that increases primary care capacity, integrates behavioral health services and incorporates state of the art PCMH and care management concepts/space (Clinton County)
- Assist Planned Parenthood health centers in transformation to provide comprehensive primary care (St. Lawrence, Franklin, Clinton, Essex, Fulton, Warren and Saratoga counties)
- Construct a primary care center in Fonda to increase primary care capacity based on PCMH concepts (Montgomery county)

Federally Qualified Health Center (FQHC) in Plattsburgh, NY

Two PPS partner organizations, Hudson Headwaters Health Network and University of Vermont Health Network-CVPH have come together to construct a Federally Qualified Health Center (FQHC) in Plattsburgh, NY. The proposed service area is not currently served by an FQHC limiting robust primary care access to those, mostly adults, covered under the Medicaid program and the uninsured as most of the small, private practice primary care providers cannot afford to participate in such programs.

The proposed 15,000 square foot facility would enable the development of a primary care practice with six to eight providers, integrated behavioral health services and onsite care management programs.

The proposed facility will increase primary care access for 5,000 to 7,500 patients in the largest population center in Clinton County. The site expects to secure NCQA recognition as a Level 3 Patient Centered Medical Home (PCMH) and provide integrated space for full time care management staff. The site will include behavioral health rooms integrated within the primary care pods with services provided not only by Hudson Headwaters and CVPH, but also Clinton County Mental Health and Behavioral Health Services North.

The timeline for completion of construction is Year 4 of DSRIP. This project will dramatically increase primary care access for Clinton County, which was identified on the PPS PCP Network Analysis as having the highest attribution but only the 3rd highest PCP count.

Construction of Consolidated Federally Qualified Health Center (FQHC) in Champlain, NY

Hudson Headwaters Health Network plans to replace the North Country Family Health Center in Champlain, NY (Clinton County) with a new, expanded Federally Qualified Health Center that increases primary care capacity, integrates behavioral health services and incorporates state of the art PCMH and care management concepts/space.

The proposed 21,000 square foot facility will increase primary care access for an additional 3,500 to 4,000 patients more than doubling the current number of patient encounters. The site is the only source of health care in the border region 22 miles north of the city of Plattsburgh.

The site will pursue NCQA recognition as a Level 3 Patient Centered Medical Home (PCMH). The

new site will provide integrated space for full time care management staff and will also include behavioral health rooms integrated with the primary care pods with services provided by HHHN, Clinton County Mental Health and Behavioral Health Services North. As an FQHC the site will address capacity needs of the uninsured and low utilizing Medicaid population.

Construction has broken ground and the center is tentatively planned to open by DSRIP DY2 Q4 or DY3 Q1 depending on the weather.

Transformation of Planned Parenthood Health Centers

For many individuals, Planned Parenthood is their primary source of care and the provider they most trust with their health care needs. Consumers rely on Planned Parenthood for a comprehensive range of health care services. This includes preventive health care services (such as well-woman exams, breast and cervical cancer screenings, vaccinations and birth control).

More than half of Planned Parenthood health centers are in rural or medically underserved areas. These are communities where there are not enough providers to adequately serve the community's needs and where lower-income consumers often struggle to find a health care provider they can afford. In these areas, Planned Parenthood is on the front lines, helping ensure that patients have timely access to care.

Alongside other safety net providers like FQHC's, Planned Parenthood is an important partner in providing high-quality care to underserved communities. The AHI PPS is assisting Planned Parenthood of the North Country and Planned Parenthood Mohawk Hudson with transformation for both of these organization's health centers to achieve NCQA recognition as Level 3 Patient Centered Medical Homes through the provision of direct technical assistance.

There are nine Planned Parenthood health centers in the AHI PPS service area: Plattsburgh Center (Clinton County), Canton and Ogdensburg Centers (St. Lawrence county), Malone and Saranac Lake Centers (Franklin and Essex counties), Johnstown Center (Fulton county), Glens Falls Center (Warren county), Clifton Park and Saratoga Centers (Saratoga county).

It is anticipated the transformation for Planned Parenthood Mohawk Hudson will be complete by the end of DSRIP Year 2, and the transformation for Planned Parenthood of the North Country by the end of DSRIP Year 3.

Construction of Primary Care Center in Fonda, NY

As a result of primary care access and availability shortages in Fulton County, and a demonstrated need and underserved in the bordering Montgomery county, Nathan Littauer Hospital plans construction of a new health center with expanded primary care capacity and services, obstetrical and gynecology specialists and radiology services.

The proposed 5,400 square foot facility will be staffed with three providers and provide office hours six days a week. The site will pursue NCQA recognition as a Level 3 Patient Centered Medical Home.

It is anticipated construction will begin in DSRIP Year 2.

Workforce Transformation

AHI PPS offers an experienced, knowledgeable, multi-disciplinary Practice Transformation team that is available to successfully support transformation activities in primary care practices. The main goals

of this team are to work with practices to improve care, lower costs and realize a healthier future.

We are committed to ensuring that primary care physicians in our network are armed with the tools to deliver the value that they are uniquely suited to provide to their patients and the health care system.

Our Practice Transformation team provides expert services including: practice transformation, patient centered medical home (PCMH) recognition assistance, and quality improvement (QI) initiatives.

Our process is targeted toward the needs and challenges of each primary care practice. Our model enables us to effectively determine how ready a practice is to absorb a change; identify and address challenges; determine the level of support needed; and provide support to assist practices in meeting goals.

Our scope of work includes:

- NCQA Patient Centered Medical Home (PCMH) recognition support
    - On-site and remote coaching from practice transformation experts
    - A comprehensive pre-transformation practice assessment
    - A practice-specific plan to achieve recognition
- Access to a transformation-targeted educational curriculum and regional learning collaboratives
- Support improvement in population health
- Assistance with meaningfully using EHRs
- Assistance with adapting to value-based payment models
- Support the sustainability of transformation

As outlined in the AHI PPS *Practitioner Engagement Strategy*, the transformation-targeted educational curriculum includes such topics as: Overview of DSRIP and Integrated Delivery Systems, Practice Transformation to Prepare for Value Based Payment, NCQA Recognition – Patient Centered Medical Home, Sharing Health Information Among Clinical Partners (RHIO/SHIN-NY), Integrating Behavioral Health into Primary Care, Advanced Care Planning & Palliative Care, Population Health Management, Continuous Quality Improvement, Building A Medical Neighborhood, Identifying and Managing High Risk Patients, Health Literacy & Cultural Competency, Building Referral Networks for Crisis Stabilization & Ambulatory Detoxification Programs, Leveraging the Use of Telemedicine, Implementing Value Based Contracts Successfully, Clinical Protocols of the AHI PPS, Care Coordination Following Hospital Discharge, Evidence Based Decision Support, Strategies to Avoid Emergency Department Visits, Patient Activation/Behavioral Change/Motivational Interviewing, and Advanced Primary care Models Beyond PCMH.

Supporting primary care providers are dedicated care coordination staff that provide systematized care coordination for patients throughout the medical neighborhood. The AHI Health Home supports care coordination activities throughout the PPS as well.

PPS workforce funds support care coordination training, and other identified training needs. To date (DSRIP Year 1 and year-to-date DSRIP Year 2) a total of $ 431,338 has been provided for recruitment of primary care practitioners – including 12 physicians, 7 nurse practitioners and 6 physician assistants. An additional $ 7,000 has been provided for retention of primary care physicians. $ 71,195 of AHI PPS Workforce Funds have supported both PCMH and care coordination training.

Transformation coaches provide on-site training to primary care staff, not only on the technical aspects

of NCQA recognition, but also on developing patient-centered care teams and health literacy.

AHI has also been selected as a vendor for the Office of Quality and Patient Safety's State health Innovation Plan (SHIP)/State Innovation Model (SIM) Initiative, Practice Transformation Technical Assistance Services for two regions, North Country and Capital District. These awards will provide additional resources to assist transformation of area practices, including those not participating in the PPS to achieve APC status.

In addition to the PPS and SIM resources, AHI has administered the Adirondack Medical Home Initiative (AMHI) which has, since 2010, included enhanced payments to AMHI practices by all of the region's commercial payors, Medicaid and Medicare. Those payments have been used for provider recruitment and retention as well as establishing robust Care Management and Coordination programs HIT infrastructure. In contrast to the loss of PCPs prior to the start of the AMHI, over 30 new MDs, NPs and Pas positions have been added to AMHI practices during that time. The AMHI practices are currently in negotiations with the commercial payors to extend the program through 2019. A HEAL 10 grant that was implemented within the AMHI framework allowed us to ensure that AMHI practices were using Meaningful Use compliant eHRs and sending Continuity of Care Documents (CCD) to Hixny, the local RHIO. The grant also funded technical assistance to remediate workflows and her configuration to ensure comprehensive, quality data flowing to Hixny.

AHI participated in the statewide group that was awarded under the Transforming Clinical Practice Initiative (TCPI), as well. We determined that transformation assistance through TCPI was not a viable option because of restrictions that would have made it impractical to align with the AMHI and PPS. We do however maintain contact with the TCPI group and have had discussions about participating in TCPI learning collaboratives.

AHI has conducted two Health Information Technology (HIT) surveys of all of our partners, encompassing all sectors of the Integrated Delivery System. Those surveys were instrumental in developing our HIT Roadmap, Population Health Management (PHM) roadmap and Clinical Data Sharing plans which will guide our implementation of the PPS HIT infrastructure to facilitate efficient data sharing, robust data analysis and decision support for our PPS partners. AHI also plans to leverage our Health Home Care Management platform to support PPS partner management of the DSRIP population. The platform provides robust care plan and care team management functionality. We also plan to investigate Hixny's capabilities to support and manage comprehensive, secure messaging and alert processes.

A collaboration with the Fort Drum Regional Health Planning Organization (FDRHPO) has allowed AHI to fund a Telehealth Coordinator position for the past year. The Telehealth Coordinator has worked with PPS partners to identify potential telehealth applications including teleconsultation and remote monitoring. As part of this effort, AHI coordinated an application for a USDA Telehealth grant for over 10 PPS partner organizations. AHI has also conducted two regional Telehealth Summits with the 2016 event attracting over a hundred participants.

Section 4 Role in the Integrated Delivery System

In this era of health care reform, where value-based payment, bundled services and population risk management are becoming the norm, the AHI PPS recognizes that primary care is the foremost strategic component of any sustainable integrated delivery system (IDS).

Advanced primary care models (NCQA's Patient Centered Medical Home and/or the SIM Advanced Primary Care) are critical to ensuring access to medical services, as well as emphasizing prevention, anticipatory guidance, disease management and care coordination leading to enhanced quality and overall cost savings.

The primary care provider is key to resolving problems that result from fragmentation of health care. The "medical neighborhood", is a clinical-community partnership that includes the medical and social supports necessary to enhance health, with the PCMH serving as the patient's primary "hub" and coordinator of health care delivery (defined by the Patient Centered Primary Care Collaborative).

Community based organizations and public agencies (including local health departments, local social services agencies, Office for the Aging, etc.) are crucial providing expertise in addressing social determinants of health and in advancing population health.

Well-functioning medical neighborhoods require communication and coordination:

- Primary care provides specialists with background information, clinical data and goals for consultation
- Specialists let primary care know what care the patient needs after surgery/course of treatment
- Hospitals let primary care know when patients are admitted or visit the ED
- Community based organizations connect the patients to social support and human services in the community while focusing on prevention and wellness in ways that emphasize behavior change

Primary care clinicians and team members have a broad understanding of the patient's health care needs to assist in coordinating all care, help the patient navigate the system and ensure the treatments plans (and prescription medications) of different specialists work together as a whole.

The AHI PPS Integrated Delivery System Model assumes that PCMHs function as the core of the medical neighborhood. Health is a community issue. Financial incentives may improve care coordination. And, effective use of health IT may improve flow of information across the neighborhood.

AHI PPS IDS Model: Resources/Inputs

- Patients and their families
- Providers and health care systems
- Community and social service organizations
- Financial incentives by purchasers/payers
- Dedicated staff for care coordination

AHI PPS IDS Model: Activities

- Clarify respective roles and responsibilities of clinicians in the system
- Facilitate and enhance information flow within the neighborhood
- Develop protocols for communication and coordination of patient care across providers
- Engage in referral behaviors that promote good neighbor behavior
- Train providers in coordination, communication and team-based care
- Systematize care coordination activities within the PCMH
- Educate patients on PCMH and the medical neighborhood, and their rights and responsibilities within it
- Promote the medical neighborhood concept through educational activities

AHI PPS IDS Model: Outputs

- Increase information flow among clinicians
- Improved communication between clinicians and with community services
- More appropriate referrals
- Increased accountability in terms of who is responsible for what
- Increased patient and family engagement; shared decision making
- Increased use of public data to focus on population health

AHI PPS IDS Model: Anticipated Outcomes

- Short term
    - Improve care coordination
    - Improved patient safety
    - Improved patient experience
- Long term
    - Improved clinical outcomes
    - Reduced costs through reduced duplication and waste
    - Improved population health management

Section 5 Participation in Value-Based Payment Models

The AHI PPS has formed a Value-Based Payment (VBP) Workgroup (a subgroup of the Finance Committee) that is creating a plan towards achieving 90% value-based payments across the network by DSRIP Year 5.

To help gain a better understanding of our partners' preparedness for Value based Payment, AHI distributed a VBP survey to PPS Partners in DY2Q2. To date, 64 of 111 partners have returned the survey (57.6% response rate) and the survey results were compiled in October 2016. The survey results will be used to help identify role(s) AHI should fill in assisting PPS partners with transition to VBP. Survey questions including asking Partners to identify and rank barriers to success in VBP system and areas in which Partners would seek assistance from AHI to succeed in a VBP system.

Top barriers were identified as Patient Disparate Geography, Financial/Cost Accounting Tracking, Health Information Exchange, and Data Analytics. Top areas for needed assistance were identified as Contract Negotiations, Patient Engagement Solutions, Support Building New Care Models, and Data Analytics.

While AHI PPS is still evaluating this information to determine how best to respond, there are steps being taken that will address some of these findings. In particular, AHI PPS is in the final stages of selecting a vendor to provide advanced data analytics and decision support. The system will provide a wide range of applications that will not only support activities to improve the population health management performance of PPS partners but will allow us to closely monitor cost and identify significant drivers from high utilizing patients to referral patterns, network leakage, and identification of high cost providers. These capabilities are critical to our partners' ability to effectively negotiate sustainable value based contracts.

For primary care, the 90% VBP goal translates to the establishment of, at a minimum, Level 1 VBP integrated primary care contracts centered on the concepts of Patient Centered Medical Home (PCMH) and/or Advanced Primary Care (APC) with the managed care organizations (MCOs) in our

service area.

Integrated primary care (IPC) models are contracts between MCOs and PCMH and/or APC arrangements, and reward the provider based on the savings and quality outcomes achieved. These models emphasize population health, the integration of physical and behavioral health and care coordination.

These IPC contracts may include additional payments for practice transformation, care management and can tie additional rewards to progression toward APC status. All attributed members will be included.

Savings in these IPC contracts will be primarily based on reductions of "downstream" costs: expenditures across the total spectrum of care that would be reduced when Integrated Primary Care is functioning optimally. Avoidable ED visits and hospital admissions due to lack of care coordination or ease of primary care access, for example.

Savings may substantially increase funding to primary care because potential savings are larger than the practices' total current revenues. To maximize shared savings in this model, the primary care practices will collaborate with hospitals and other providers throughout the AHI PPS on activities such as outreach, care management and post-discharge care.

- ***Level 1 VBP for IPC*** consists of fee for service (FFS) (plus per member per month – PMPM – subsidy) with upside-only shared savings based on total cost of care (savings available when quality scores are sufficient).***Level 2 VBP for IPC*** consists of fee for service (FFS) (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high).
- ***Level 3 VBP for IPC*** consists of PMPM capitated payment for primary care services (with quality-based component).

To encourage cooperation between primary care providers and hospitals, the three criteria (statewide standard in determining equitable shared savings in IPC) outlined below will be incorporated:

1) Data Management and Data Sharing – provide real time direct data feeds to providers for emergency room utilization, admission and discharges (including behavioral health and substance use).

   The AHI PPS plans to leverage data available through local health information exchange/RHIO/SHIN-NY. Confidentiality issues specific to substance use records need to be resolved to receive data on substance use.

2) Innovation and Care Redesign – fulfill at least one of these measures:
   a. Develop standardized care plans based on evidence-based guidelines and practices to reduce inappropriate variation in the organization for at least one of the following service areas: high cost imaging, emergency room care, oncology treatment, diagnostic testing, behavioral health treatment, substance use treatment, etc.

      Each project team will work the with Clinical Quality & Governance Committee to establish PPS-wide evidence-based guidelines and "best practices", with specific focus on behavioral health and substance abuse treatment as the PPS is undertaking five

projects within the mental health realm.

b. Enhance care transitions to post-acute settings such as mental health treatment facilities, substance use disorder treatment facilities, Skilled Nursing Facilities, home, etc. to reduce readmission rates and potential complications.

   In collaboration with project 2.b.viii "Hospital Home Care Collaboration Solutions" the AHI PPS will enhance relationships throughout each region and leverage the use of telehealth to improve care transitions using the INTERACT model.

c. Implementation of palliative care and collaboration with hospice.

   In addition to Project 3.g.i "Integrating Palliative Care", the AHI PPS is planning to work with primary care practices on widespread Advanced Care Planning discussions, utilizing the Respecting Choices conversation model.

3) Quality and Engagement – collaborate with primary care providers on DSRIP Domain 2 (System Transformation) and Domain 3 (Clinical Improvement) metrics and quality indicators affective population health.

   The AHI PPS Population Health Management road map outlines how primary care practices will be engaged in achieving the overarching goals of the PPS. Project managers work with practices on achieving project-specific quality metrics and deliverables, implementing rapid cycle PDSA projects to improve performance as necessary.

In keeping with the State's goal for Medicare alignment, AHI PPS and many of our provider partners are exploring the possibility of pursing advanced Alternative Payment Models (APMs) and/or participation in the Comprehensive Primary Care Plus (CPC+) program.

Training related to value based payment will be completed through several mediums. A learning management system (LMS) will offer on-line training which may be combination of training developed they the LMS vendor as well as content either identified by the PPS as a useful resource or developed by the PPS. In addition, some partners have identified specific training related to value based payment which they have identified as valuable and these partners can apply for Workforce Training Funds to offset the costs related to registration and travel, which may have prevented participation.

Section 6 Funds Flow to Support Primary Care Strategies

The AHI PPS is working to re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.

A per-project value for partner-level distribution has been determined. Within each project, there are funded project activities; primary care providers receive payment as each activity is completed.

Although the overarching goal of the DSRIP program is to achieve a 25% reduction in avoidable hospital use, the AHI PPS felt it was important to provide funding to primary care practices throughout the transformation process – rather than base payment solely on project completion.

There are four DSRIP projects that primary care providers are most likely participating in:

- ***Project 2.a.i "***Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management***"***
- ***Project 2.a.ii*** "Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care models (as developed under the NYS Health Innovation Plan (SHIP)"
- ***Project 3.a.i*** "Integration of Primary Care and Behavioral Health Services"
- ***Project 3.g.i*** "Integration of Palliative Care into the PCMH Model"

Engagement funds were provided to the primary care practices at the start of the project, for activities such as securing certified EHR technology, connecting with local health information exchange/RHI/SHIN-NY to facilitate sharing of clinical information among clinical partners, and participating in a baseline assessment of the practice's capabilities and progress toward advanced primary care.

To date, there have been two rounds of engagement funds. Engagement funds Round I included:

- $1.2M to "Tier 1" Partners that included FQHC and five Hospital Based Partners with Primary Care Sites
- Engagement funds Round I also included $75Kto Planned Parenthood and $80K to private practice PC providers and another $40K to Hospital Based "Tier 3" Partners with Primary Care sites

Engagement funds Round II included:

- $1.8M to "Tier 1" Partners including an FQHC and five Hospital Based Partners with Primary Care Sites
- $842K to other Partners with Primary Care Sites

On an ongoing basis, direct payment to primary care providers will encompass project milestone requirements and partner involvement across projects specific to performance. Two rounds of project addenda, or schedules, are planned. The first round of addenda focuses on partner performance on process and reporting activities.

For example, for ***Project 2.a.ii*** "Primary Care" activities include:

- Successful demonstration of PCMH 2014 "MUST PASS" elements.
    - PCMH 1A Patient Centered Access
    - PCMH 2D Team Based Care
    - PCMH 3D Population Health Management
    - PCMH 4B Care Management and Support
    - PCMH 5B Care Coordination and Care Transitions
    - PCMH 6D Performance Management and Quality Improvement

  As practices complete documentation for the "MUST PASS" elements it is submitted to AHI for review by a PCMH Certified Content Expert, and feedback provided to the practice prior to application submission to NCQA.
- Achieving PCMH 2014 Level 3 recognition and/or Gate 2 of the NYS Advanced Primary Care model
- Demonstrate providers and staff are trained on evidence-based preventive and chronic disease management
- Implementing preventive care screening protocols, including behavioral health screenings for all patients, to identify unmet needs

- Monitor and work to improve “no show” rates to improve access to primary care

Payment for each of the above activities is direct to the primary care practice, and is made on a “per practice site” basis for all except the preventive care screenings, which is made “per patient” screened.

For ***Project 3.a.i*** “Integration of Behavioral Health” activities include:

- Adoption of clinical guidelines consistent with generally accepted principles documenting collaborative evidence-based standards of care
- Implementing preventive care screening protocols, including behavioral health screenings for all patients, to identify unmet needs

For ***Project 3.g.i*** “Integration of Palliative Care” activities include:

- Adoption of clinical protocols meeting the principles established by the Center to Advance Palliative Care and/or consistent with NQF’s “A Crosswalk of National Quality Forum Preferred Practices”
- Providing palliative care services in the primary care office, and completing the Palliative Care Outcome Scale (POS) assessment tool per NYS DOH requirements

Payment to providers has been budgeted with focus on pay for performance measures.

Additionally, all AHI PPS partner organizations are eligible to apply for Workforce funds (for recruitment and retraining needs – refer to pages 8-9 for details on payment amounts made to date, and are eligible to apply for Innovation funds for activity beyond that included in specific DSRIP projects.
Budget allocations for Primary Care Focused projects for this round are:

- 2aii $1,777,751
- 3ai $1,216,017
- 3gi $2,331,453

These funds flow to practices based upon completion of payment activities and are generally structured so that funds can flow to the practices throughout the life cycle of the project rather than holding the funds until the end. Payments under this set of addenda are planned to begin in November 2016 and continue at least semiannually through May 2018. These schedules are designed with activity payments that were developed with the following considerations:

- DSRIP dollars must be earned
- Aligning Partner requirements with PPS requirements
- Ensuring funding for all partners
- Complying with DSRIP 95/5 Safety Net funds flow requirement
- Utilizing existing reporting requirements to collect data to support funds flow whenever possible
- Flow funds early and continuously throughout each project
- Weight critical activities more heavily

Development of the second set of addenda will begin in DYQ3 with implementation expected to begin by the end of DY2Q4. This round will be based on P4P funds and development will include significant input from the PHNs as well the AHI PPS Finance Committee.

The total budgeted partner payments for the both set of addenda, P4R and P4P, DY2 and DY3 are as

follows:

DSRIP Waiver Revenue by Achievement Values (DY2 + DY3)				
P4R & P4P Allocation by Project				
				Project
Project	Project Name	P4R	P4P	Total
2.a.i	Create an IDS	$ 1,690,077	$ 3,356,257	$ 5,046,334
2.a.ii	Increase PCMH certification	$ 1,777,751	$ 2,262,331	$ 4,040,082
2.a.iv	Create a medical village	$ 2,869,233	$ 3,167,644	$ 6,036,877
2.b.viii	Hospital-Home Care collaboration	$ 2,301,423	$ 2,540,781	$ 4,842,204
2.d.i	Implementation of PAM	$ 640,826	$ 2,280,679	$ 2,921,506
3.a.i	Primary Care/Behavioral Health integration	$ 1,216,017	$ 2,960,207	$ 4,176,224
3.a.ii	Crisis stabilization	$ 1,141,558	$ 2,778,948	$ 3,920,506
3.a.iv	Develop withdrawal management	$ 1,102,736	$ 2,684,440	$ 3,787,176
3.g.i	IHI "Conversation Ready" model	$ 2,331,453	$ -	$ 2,331,453
4.a.iii	Strengthen MH and SA Infrastructure	$ 1,683,913	$ -	$ 1,683,913
4.b.ii	Increase Chronic Disease Management	$ 1,940,976	$ -	$ 1,940,976
Totals		$ 18,695,964	$ 22,031,287	$ 40,727,251

Section 7 Integration of Primary Care & Behavioral Health

The AHI PPS promotes the concept of "whole person care" which is the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources (defined by the SafetyNetInstitute.org).

The current health care system utilizes primary care to treat the symptoms of behavioral health rather than managing the behavioral health conditions. Treatment of behavioral health conditions in primary care offices may vary from practice to practice. This variation can lead to undiagnosed depression or treatment of depression in ways inconsistent with evidence-based guidelines.

The DSRIP program enables opportunities to integrate primary care and behavioral health.

For ***Project 2.a.ii*** "Primary Care" all primary care providers will implement preventive care screening protocols including behavioral health screenings (PHQ-2, -9 if positive, and/or SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner. (Milestone #8)

The behavioral health providers in the network identified a need to educate primary care providers about behavioral health screening beyond depression screening. A *Behavioral Health Screening Toolkit* was created, for use by the primary care providers and staff, including information:

- Depression screening (PHQ-2, and -9)
- Substance use disorder screening (SBIRT, CAGE, CRAFFT, AUDIT)
- Anxiety screening (GAD-7)
- Guidelines for when to refer a patient to behavioral health
- Workflow redesign for integrated care to accommodate "warm handoff" of patients between medical and behavioral providers

Additionally, primary care practice will achieve NCQA's requirements for integrating primary care and

behavioral health to achieve Level 3 recognition as a Patient Centered Medical Home (PCMH). These criteria include:

- ***Medical Home Responsibilities (PCMH 2B)***
  - The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain information on the score and services available within the practice including how behavioral health needs are addressed (among other topics)
- ***Comprehensive Health Assessment (PCMH 3C)***
  - To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes: mental health/substance use history of patient and family – and – depression screening for adults and adolescents using a standardized tool (among other criteria)
- ***Evidence Based Decision Support (PCMH 3E)***
  - The practice implements clinical decision support (eg, point of care reminders) following evidence based guidelines for: a mental health of substance use disorder (among other criteria)
- ***Identify Patients for Care Management (PCMH 4A)***
  - The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: behavioral health conditions (among other criteria)
- ***Referral Tracking and Follow Up (PCMH 5B)***
  - The practice maintains agreements with behavioral health care providers
  - The practice integrates behavioral health care providers within the practice site

Or, primary care practices will achieve the State Innovation Model (SIM) criteria for Advanced Primary Care (APC) models relating to behavioral health integration (Milestone #1) These criteria include:

- ***APC Gate 1***
  - Commitment to using self-assessments for BH integration and commitment to achieving Gate 2 BH milestones within one year
- ***APC Gate 2***
  - Commitment to integrating evidence-based behavioral health screening process
  - Engage in BH integration training
  - Create collaborative care agreements with BH providers
  - Define process and workflows to demonstrate adherence to BH quality measures
- ***APC Gate 3***
  - Commitment to delivering coordinated care management for behavioral health
  - Demonstrate linkage with social service agencies

For ***Project 3.a.i*** "Integration of Behavioral Health with Primary Care" (Model 1) primary care providers will co-locate behavioral health services at primary care sites (Milestone #1), and will implement preventive care screening protocols including behavioral health screenings (PHQ-2, -9 if positive, and/or SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner. (Milestone #3)

For ***Project 3.a.i*** "Integration of Behavioral Health with Primary Care" (Model 2) behavioral health providers will co-locate primary care services at behavioral health sites (Milestone #1), and will implement preventive care screening protocols including behavioral health screenings (PHQ-2, -9 if

positive, and/or SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner. (Milestone #3)

In addition, The AHI Health Home is an active part of the PPS and has subcontracted with nearly all of the legacy Office of Mental Health Targeted Case Management providers in the region. A number of physician practices, including the FQHC, are subcontracted providers as well. Other physician practices are network providers for the Health Home. This tight linkage facilitates collaboration with behavioral health organizations on a large scale within the PPS. As a point of example, the FQHC refers their HARP [Health and Recovery Plan] patients to the Health Home (with patient permission) to facilitate a warm handoff to care management agencies with expertise serving those with behavioral health needs. Transfers also work in the other direction wherein behavioral health community organizations will refer clients to primary care practices for care management that is more focused on medical concerns. Integration and alignment of patient-centered care across providers in the PPS is taking place for Health Home clients and this model, and the relationships formed, are being leveraged for expanded populations.