DSRIP PPS Primary Care Plan

PPS Name: Alliance for Better Health Care, LLC

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Assessment of current PC capacity, performance and needs, and a plan for remediating need

In the six counties served by the Alliance For Better Health Care PPS (Alliance), there are approximately 519 primary care providers (PCPs) that have attributed Medicaid beneficiaries. Over 92% of these practitioners are open to new Medicaid beneficiaries. Of these 519 PCPs, 254 also participate in other PPSs in our region. In addition, the network has 573 specialists and 257 hospital based specialists. Our organizational partners include three hospital systems and two FQHCs. The seven hospitals include; Ellis Medicine and Sunnyview Rehabilitation Hospital; St. Mary's Healthcare Amsterdam and St Peters Health Partners comprised of St. Peter's Hospital, Albany Memorial Hospital, Samaritan Hospital and St. Mary's Hospital in Troy. The two FQHCs are Whitney M. Young Jr. Health Center and Hometown Health Center. While Alliance physicians are currently managing Medicaid and Medicaid MCO patients, they are also caring for Medicare Fee For Service, Medicare Advantage, and Commercial and self-insured patients through their individual contracts with commercial insurance companies.

Alliance as a DSRIP PPS entity has five sponsoring (Member) organizations as noted above and numerous participating Community Based Organizations (CBOs).   Specific remediation efforts are geared toward introducing more mid-level practitioners, proactive recruitment of primary care physicians and working with Alliance practices to achieve PCMH designation. In addition, one of the systems is planning to open a new Primary Care Urgent Care facility to treat minor illnesses better suited to that setting. This change improves access to walk-in care for low acuity cases and frees up primary care scheduling. This practice is also expanding operating hours and is exploring telemedicine to enhance the availability of scheduled appointments and improving overall access to care.

Each of the Alliance Member organizations have addressed the issue of primary care capacity and have developed focused plans and recruitment strategies to address these needs. Hometown Health Centers (HHC), a Schenectady based FQHC, has hired four (4) additional Nurse Practitioners and a new Medical Director. HHC has also redesigned their physical plant allowing for additional examination rooms, they have contracted with Northern Rivers to accommodate Behavioral Health needs and opened two school based health centers in the community.

HHC future plans include a redesign of provider schedules to better accommodate patient needs for scheduled, urgent and triage appointments, continuity of care, and expansion of hours of operation of the Amsterdam site to support PCMH Level 3 certification and enhanced access.

Ellis Medicine has been transforming its primary care services by opening new practices, expanding existing sites and implementing new models of care. Four new primary care offices have been added since 2012, with plans to open a new primary care/urgent care site in Schenectady at the end of 2016 or early 2017. Across the current eight locations there are 28 FTE physicians and 11.5 FTE APP providers.

The most recent Medical Staff Development Plan identified a need for approximately 50 new providers over the next five years. Efforts to attract these providers involve a variety of strategies including; engaging professional recruitment firms, advertising, conferences and recruitment fairs. There has also been a special focus on retaining the 10 Family Practice residents based at Ellis. Given the provider shortages both regionally and nationally, there is recognition and appreciation given to the importance of recruiting from the Ellis FP Residency Program. This will continue to be a cornerstone of Ellis' approach.

The growth of primary care reflects the needs of the community, but also reflects a strategy to transform the delivery of primary care in fundamental ways so that population's health improves, along with patient experience and at lower costs. To accomplish this a range of quality improvement and practice improvement efforts are used to build capacity over time. Specific measures being implemented include: Open Access at two locations, adding a Nurse Practitioner to foster team-based model of care, embedding care managers in all primary care sites and pursuing PCMH status for all practices.

St. Peter's Health Partners Medical Associates (SPHPMA) is actively recruiting for up to 12 new physicians or APPs to fill both vacant and additional positions throughout the SPHPMA service area. The group uses traditional media and social media to fulfill the identified needs. The group is also focusing efforts to gain additional productivity from existing staff through new and renewal of contracts for additional hours, and seeking a higher throughput rate for each service hour that may yield up to a 15% improvement.

St. Mary's Healthcare –Amsterdam (SMH-A) has identified current and projected needs to serve the community for all types of providers including PCPs. There are current needs of 9 PCPs across Family Medicine, Internal Medicine and Pediatrics and their model for succession planning due to retirement and relocations has identified an additional 12 PCP providers needed. Strategies to address current and future gaps involve continuous recruitment efforts which have been successful to add four new mid-level providers. In addition, SMH-A is implementing an open access program with a designated time period daily for same-day appointments. Additionally, a third Urgent Care Center recently opened in St. Johnsville.

The need to address primary care capacity and recruitment extends beyond the Members of the Alliance representing large systems and affects independent primary care practices as well. As an example of this, Five Corners Family Practice in Rotterdam has added a full-time nurse practitioner within the past year and has planned their space to be able to add an additional physician or mid-level provider. Five Corners works with the Family Practice Residency in Schenectady and has invited graduates of the program to join the practice. One recruitment difficulty is being able to compete with the salaries offered by larger systems and hospitalist based employment.

These are representative of the combined efforts of Alliance participants to address the ongoing need to add capacity, maintain services while planning for future growth in demand and to be successful at recruitment.

Primary care expansion and practice and workforce transformation will be supported with training and technical assistance

The Alliance sees the unique challenges and opportunities of our upstate primary care network as a launching pad to transform primary care education, innovation, sustainability and service. We seek to provide a comprehensive support system to the practices and assist them to better understand the sometimes overwhelming expectations for change and system transformation.

Alliance is working actively with the PPS primary care providers to cultivate effective physician leadership who may serve as a bridge between the various physician constituencies and the hospitals. The goal to achieve NCQA 2014 Level 3 Medical Home standards by the end of DSRIP Year 3 drives the strategic plan. PCMH adoption is lagging; a few hospitals / physician groups have achieved various levels of NCQA recognition, while others are pursuing official status.

The organizational structure of the PPS provides opportunities for broad participation among medical staff members, with a mix of specialties and a variety of relationships with the hospital, including employed, contracted (e.g. medical directors, hospital-based physicians), and independent practitioners. Alliance is a collaborative network of more than 1,400 providers led by three health systems (Ellis Medicine, St. Peter's Health Partners and St. Mary's Healthcare, Amsterdam); two federally qualified health centers (Hometown Health Centers and Whitney M. Young, Jr. Health Center); and a large and highly diverse group of community based organizations.

Maximizing the use of teams including physicians, nurse practitioners, physician assistants, nurses, health educators, and other ancillary personnel to effectively coordinate and manage care for a patient population is completed through the development of Project Workgroups and break-out groups. Workgroups specific to each project were created, bringing different cultures together, to further analyze and foster collaboration on project development at the PPS level with key roles (provider mapping) for primary care physicians, community-based organizations, providers of medical services and long-term care services, and other service providers. These team members, including the physicians' in-office staff, work to expand the reach of the physician, manage disease registries, coach and teach patients, perform case management duties, and coordinate care among multiple providers. The workgroup dynamics allow local implementation by partner organizations and providers that respect unique local needs, and networks operational attributes and processes. Identification of service planning and information management system capability and the level of desire and involvement to engage and redesign internal processes to improve patient satisfaction and outcomes are discussed.

Leverage existing infrastructure and expertise within the Alliance PPS network is critical to DSRIP success. For example, the two primary care providers who have achieved NCQA 2014 Level 3 Medical Home standards and demonstrate successful initiatives and programs are regarded as best practices for the other sites. Disease management efforts within specialty environments lend workflows and protocols to the PPS providers. Continued identification of internal resources that can be tapped to help support clinical integration efforts will also minimize administrative costs.

Some of the challenges faced by a primary care practice considering recognition as a patient-centered medical home include staffing the human resources needed to write policy and procedure manuals, redesigning workflow, incorporating information technology, and documenting processes already in place. In preparation for Alliance to lead practices in transformation, dedicated staff were hired to specifically engage the practices and provide services, from one-on-one and team consulting, to hands-on activities. The team also works with Alliance's internal DSRIP project leads and identifies interdependencies within

each project, drives the specific PCMH related tasks, and provides guidance on the cross reference of a project to PCMH elements.

The efforts provided directly to the provider network are predicated by the need of each practice. During the initial assessment, key areas are explored for a starting point. Furthermore, the status of these components will also contribute to related costs as true costs of implementation are difficult to predict because of the same factors.

Areas of review at starting point:
- Size of practice
- Existing capabilities
- Ramp up costs
- Availability of low cost or subsidized practice and patient support resources
  As strategy is put into place to assist the PPS practices in achieving recognition, the broad "change concepts" that are considered by the dedicated team include:
- engaged leadership
- a quality improvement strategy;
- empanelment or linking patients with specific providers to ensure the continuity of the patient–provider relationship;
- continuous and team-based healing relationships, including cross-training staff to allow team members to play various roles;
- organized, evidence-based care, including the use of decision support systems;
- patient-centered interactions to increase patients' involvement in their own care;
- enhanced access to ensure patients have access to care and their clinical information after office hours;
- and care coordination to reduce duplication of services and increased anxiety and financial costs for patients and their families.

Alliance offers two models of support predicated by practice status/need:
- independently with internal staff and/or contracting with outside resources for project management
- collaboratively and with the assistance of a Transformation Coach for:
  o Training and education on NCQA requirements and MU
  o Developing resource recommendations to support Medical Home model of care
  o Practice support for project related EHR vendor issues
  o Practice assistance to develop a work plan and timeline for NCQA documentation, submission, and policy and procedure development

Alliance also adopted an approach in consideration of supporting the providers using specific characteristics of medical homes, which provide general directions for transforming a practice.[1]

For example, leadership in a practice can be found at many levels and in consideration of a patient centered medical home that is physician driven, the leader at the helm is often a physician, but it is not limited to one. Regardless, visible leadership must be established in the practice who can assist the team/staff envision a different and improved model of care. Alliance assists a practice in identifying this leadership and

assembling a (PCMH) team usually representing physicians, practice managers, nurses, informational technology support, and quality, and we emphasize the importance this team executes clear communication and situational monitoring in the work environment.

Quality is another critical area of early review in the pursuit of PCMH recognition in order to build an infrastructure that supports performance measurement, provider alerts and reminders, computerized order entry, and population management. Alliance has completed a detailed Roadmap the Population Health IT Infrastructure and is building an IT asset that will enable success in these areas, measuring quality. Included in that Roadmap is an assessment of the current IT Infrastructure and its capacity to support true Population Health, as well as an assessment of needed functionality.

Creating effective teams within practices will allow cross training and the transition to team-based primary care. This type of care offers many potential advantages (fundamentally related to PCMH requirements) including but not limited to increasing access to care, staff working at the top of their licensure and providing additional services essential to high quality care, e.g. behavioral health, and care coordination. A larger provider team might also support quality improvement; with effective intra-team communication and problem solving, practices can engage in data-driven, continuous quality improvement.

Patient-centered care, a consistent concept driving medical home success is considered to be care that is relationship-based and makes the patient feel known, respected, involved, engaged, and knowledgeable. Deliberately putting the patient at the center of the home is one key to ensuring that this promising model of health care delivery meets patients' needs and achieves its potential for improving health. Research also links patient-centered care to positive outcomes through PCMH recognition, including improved physician-patient communication and relationships, higher patient satisfaction, better recall of information and treatment adherence, better recovery, and improved health outcomes. The Alliance team encourages the practices to examine their processes to ensure they are patient focused, identifying and resolving disparities, and increase their patients' involvement in decision making, care, and self-management.

Lastly, improving care transitions is not only an important component of ensuring the delivery of high quality care, it is also a way to reduce the cost of health care for patients, payers, and the system as a whole, exemplifying the PCMH model of care. Many patients benefit from services outside the medical home, from medical or behavioral specialists, community service agencies, hospitals, and emergency rooms, for example. But these handoffs and transitions, if not managed well, can lead to serious problems in care, duplication of services, and increased anxiety and financial costs for patients and their families. Effective care coordination involves helping patients find and access high-quality service providers, ensuring that appropriate information flows between the PCMH and the outside providers, and tracking and supporting patients through the process.

The role of Alliance in an improvement effort with the practices is varied and depends on the needs of each site and the scope and scale of the improvement being tried. It is important to not only be able to identify those needs but also be able to maintain the vision of success when things get really challenging. In the end, it isn't the Alliance who is going to make the transformation happen in a practice site, but we can and often are instrumental in making sure that the team at the site is prepared, motivated, and tenacious in their effort to succeed.

Primary care providers are critical for providing preventive care, ensuring coordinated care, and improving health outcomes for patients and this health care workforce must make significant progress in training – including physicians, nurse practitioners and physician assistants. Alliance's workforce development plans demonstrate how Alliance ensures that the health care workforce can fill new job categories, work in multidisciplinary teams and participate meaningfully in the management of patient and population health.

Alliance's Workforce Committee is tasked with assessing the workforce needs across all projects. Within the specific project trainings, overall themes are identified and advanced. These themes include Cultural Competency and Health Literacy Training and IT training as well as training needs to assure quality Clinical Integration. The Alliance has contracted with XG Consultants Group, Inc., a workforce consulting company to assist in identifying the training needs for the scope of the DSRIP projects. XG leads the development of the training strategy deliverables and coordinates efforts to gather data needed to analyze the training needs of the providers. One way this is accomplished is through interviews that are conducted with key individuals to understand the current situation, strengths, and barriers related to training needs. Within the Clinical Integration strategy, areas are addressed including training for providers across settings (primary care, ED, in- patent, outpatient) regarding clinical integration, tools and communication for coordination. Training for operations staff on care coordination and communication tools are addressed in the strategy. Identified best practices are reviewed to evaluate appropriate replication in other provider settings. Utilizing the training strategy developed by XG, the Workforce Committee works directly with the Clinical Quality and Improvement Committee to identify appropriate training methods, training content and frequency of training. Training methods may include web-based e-learning system, on-demand webinars, in-person trainings, as well as in-services. Alliance understands that training needs are ever evolving. The strategy that is implemented will be fluid and adaptable based on future needs for practice transformation to be successful.

An example of identifying and allocating resources to support key training activities acknowledges the Palliative Care project. The risk of Palliative Care in the primary care setting and lack of qualified/credentialed professionals with palliative care knowledge and expertise, increasing provider, patient, and community knowledge base around palliative care services is paramount. Providers and other care team members are educated on the concepts of generalist palliative care as well as teaching when and how to make referrals to a specialty provider, a home-based palliative care team, and when appropriate, the local Hospice partner. Supporting efforts for education were successfully illustrated by a recent regional symposium, "Palliative Care: Defining and Applying Best Practices," which brought the passion and nationally renowned expertise of Patricia A. Bomba, MD, FACP to a group of more than 150 clinicians, administrators and allied health professionals who represent diverse practices across the region. Alliance has also partnered with the Center to Advance Palliative Care (CAPC) and allowed registration for 100 PPS providers for membership, promoting access to CAPC tools and resources, including 37 CME/CEU courses on a variety of clinical and operational topics related to palliative care. In addition, PMCH and PPS staff will be engaged in trainings to increase role-appropriate competence and deploy formal palliative care education for clinicians and members of the multi-disciplinary team. Educating key clinical integration team members embedded in Projects 2.b.iv (Care Transitions) and 2.b.viii (Hospital to Home) to increase awareness of palliative care services for hospitalized patients and their families to reduce preventable readmissions is critical, and Alliance is reviewing training opportunities with the Area Health Education Center (AHEC) through a proposed curriculum relative to the DSRIP projects.

All providers and staff across the Alliance PPS will require a basic level of training on general content critical to practice transformation, but with a more concentrated training effort dedicated towards primary care, care management and social work providers:

1) The focus of the integrated efforts will be on increasing the availability and effectiveness of patient care in the outpatient setting, but all inpatient employees across the network of providers, especially clinical staff, will still require basic training content. As all project efforts evolve, the network of providers will need to be prepared to redeploy and retrain these workforce members as needed.
2) As outpatient activity increases, many new roles will be created to achieve success. Nursing staff, care navigators and care managers should receive prioritized, specialized training given their significant involvement in the transformation.
3) Next in order of priority for specialized training are those roles that interact most closely with care managers and the patients themselves. Primary Care Physicians, Nurse Practitioners, Registered Nurses, Medical Assistants, etc. – all members of the workforce require a combination of basic and specialized training to create sustainable transformation within the network of providers.
4) Finally, there are roles that need training in specific skills to support the development of a high-functioning medical neighborhood. These roles include finance staff to assist with contracting and value-based payments in addition to health information technology roles to manage the variety of EHR systems across the network, as well as best practices in data integration and sharing.
5) In addition to the specialized training required for the above roles, there is a broad-based need to raise awareness for DSRIP, Population Health, Cultural Competency/Health Literacy and other topics across the entire workforce.

Information technology is critical to improving coordination and connectivity between primary care providers and other providers of care, and need to become robust enough to support clinically integrated initiatives. Technology investment has been made with increased focus on capability utilization and cross-system integration could close gaps and facilitate DSRIP requirements.

A key issue in supporting integration of care is the need for information sharing between these different care providers. The current existence of numerous electronic and paper-based information systems hampers the intention of integration. To achieve seamless and secure information transfer between different information systems, and create an environmentally effective environment, Alliance performed a HIXNY exercise for all providers.

The RHIO has capabilities that have grown with the needs of the community and the alignment with SHIN-NY requirements. As the needs of the PPS grow, the RHIO will either add capabilities to meet the needs of the PPSs in our region, or we will partner with commercial health information technology developers to augment the capabilities of the RHIO.

Key RHIO functionality	Alliance providers' rate of participation:
Sharing ADT with the RHIO	38%
Sharing C-CDA	5%
Sharing patient consent with RHIO	29%

Many primary care providers lack a connection to HIXNY. These providers are intended to be the core recipient and user of information from the RHIO through the Patient Centered Medical Home model, so an

early emphasis will be placed on connecting primary care providers who have not yet connected to the RHIO.

Furthermore, the breadth of the connectivity is very narrow in terms of number and scope. Alliance will augment the number of providers that are connected as well as the nature of their connection to make the information sharing more meaningful to support the DSRIP projects. Alliance will improve the nature of their connection by adopting common clinical data set standards to capture and share more meaningful information.

Key data points for shared access are identified and the key interfaces that will have an impact include:
- Supporting post-discharge follow-up through transmission of C-CDAs, which is critically important for the Care Transitions & ED Triage projects
- Improving access to care through electronic transmissions of referrals
- Providing an integrated history of the patient to inform medical decision making
- Delivering orders and results to inform medical decision making
- Sending alerts and notifications to prompt timely interventions and actions at key points in care

Plan
1. For the 7 lead partners, key systems were identified at each DSRIP entity that provided data needed for operationalizing the projects as well as for reporting and measures:
    - Registration systems
    - EHR systems in each care setting
    - Other ancillary applications (lab, radiology, sub-specialty systems)
2. Determine level of connectivity between DSRIP entity EHRs and RHIO (HIXNY)
    - Types of data exchanged (ADT/CCD/Clinical/Other)
    - Consent information and other dataflow
3. Determine high-level gap analysis of DSRIP-required data and current systems and processes

Results
- Met with key stakeholders at each of the 7 lead partners
- Collected data on key systems that will support DSRIP reporting
- Met with HIXNY to inventory and categorize data currently being sent from DSRIP providers
- Reviewed and analyzed all collected data to perform a gap analysis against DSRIP data requirements
- Reviewed findings with each contributing member and the DSRIP IT Steering Committee

Assessment Conclusions
- The measures/metrics for some DSRIP projects can be collected with currently available data sources (primarily, those that are claims-based)
- Projects and measures that require access to behavioral health, home health and other ancillary data are currently the least available
- These will require additional analysis and investment in process, Information Technology
- For the patient engagement measures, significant gaps in IT and processes exist across DSRIP entities
- The PPS will need to procure a Population Health Management solution to successfully conduct analytics, track and report on DSRIP measures and projects
- The PPS will also require a DSRIP-enabled Project Management solution to successfully report many of the Domain 1 and other System Performance metrics

Actionable Items
- Conduct solution selection for PHM analytics and reporting
- Conduct rapid system selection for DSRIP project management tool
- Refine and finalize the roadmap (including defining other key providers)
- Define proven ways to collect patient engagement metrics
- Conduct lower level assessment to get deeper into the systems:
- Define key source systems that could provide information for measures and projects
- Determine detailed gap analysis of missing, or currently un-reportable data by project and measure
- Conduct data quality analysis on data currently flowing into HIXNY to insure this data could be utilized in a PHM tool

Alliance is working to ensure that existing statewide resources are being leveraged appropriately. Alliance initially used the State-provided Primary Care Analysis to provide a landscape of the PPS network in both absolute terms and as compared with other PPS networks. The detail in the file enables identification of providers who are accepting new Medicaid members and particularly those with extended hours. Having available primary care providers is essential to the success of the DSRIP program and especially the ED Triage project. The PNDS file was also used to identify providers who are in multiple PPS networks so that outreach could be adjusted accordingly. The publication of the Primary Care Analysis brought attention to the Provider Network Data System (PNDS) file that is publically available and refreshed quarterly. The most recent file (December 31, 2015) has been downloaded and used to identify prospects for addition to the Alliance network within the PPS geography. Alliance plans to download and analyze subsequent versions as the Primary Care Plan is implemented.

Additionally, Primary Care Analysis has been used in conjunction with the recently enhanced Salient Interactive Miner tool to determine the performance measure results for the Medicaid members attributed to each provider. This enables recognition of areas of strength in the PPS network and critical opportunities for improvement. The Clinical Risk Groupers now available within Salient to better understand and account for variations in risk amongst the population are also in use. The documentation laid out the data sources for each component of the Primary Care Analysis was found to be particular helpful in empowering Alliance to produce internal supplemental analyses.

Strategy for how primary care will play a central role in an integrated delivery system

The organizational structure of the PPS provides opportunities for broad participation among medical staff members, with a mix of specialties and a variety of relationships with the hospital, including employed, contracted (e.g. medical directors, hospital-based physicians), and independent practitioners. Alliance is a collaborative network of more than 1,400 providers led by three health systems (Ellis Medicine, St. Peter's Health Partners and St. Mary's Healthcare, Amsterdam); two federally qualified health centers (Hometown Health Centers and Whitney M. Young, Jr. Health Center); and a large and highly diverse group of community based organizations.

The goal of a clinically integrated care network is to provide patient centric, coordinated care appropriate to each person without gaps or duplication of services. To be successful, linkages are developed between primary care, behavioral health, and specialists to easily facilitate the transfer and coordination of care, with the assurance that data is being captured. Care protocols are being developed to include the continuum of care (i.e., inpatient, outpatient, home care, skilled nursing facilities, etc.) to maximize their impact on

patient health and resource utilization. The use of modern technology such as secure texting for physicians and care managers, utilization of the Health Information Exchange, an electronic referral process, and use of patient portals are all tools available to ensure optimal communication relative to a well - coordinated plan of care.

Key opportunities for integration are addressed through the multiple diverse workgroups reflected by providers across the network as well as community based organizations to review gaps in care delivery and barriers.

Alliance strengthens the continuum of Primary Care and ensures meaningful linkages to necessary secondary and tertiary services. As noted in more than one of the projects, a significant aspect of health care influencing both quality and cost is the effective transition of patients from one setting of care or one set of providers to another during an episode of care. Settings of care (the provider or place from which the patient receives health care) include hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, community health centers, rehab facilities, home health agencies, hospice, long-term care facilities, and other institutional, ambulatory, and ancillary care providers. In each setting, multiple clinicians care for each patient, sometimes independently and other times as part of an interdisciplinary team. Improving care transitions has the potential to save lives, reduce adverse events and disability due to gaps or omissions in care, and reduce unnecessary costs.

In order to address barriers to effective care transitions that include cultural, educational, and language differences; provider fatigue, time constraints, interruptions, complex medical conditions, ineffective communication, incompatible information systems, and lack of privacy, a key workgroup was established in support of Project 2.b.iv Care Transitions intervention model to reduce 30 day readmissions for chronic health conditions. The workgroup is led by skilled Alliance staff members and represented by community and provider organizations who care for patients across the continuum and they:

- Define and tighten care transition
- Operationalize existing transition initiatives
- Explore achievement methods to enhance quality care and minimize risks regarding any setting
- Review current, and secure practice standard assessment tools
- Activate inner circle partnering
- Review and adopt components of national models and intervention strategies

Communication between providers is an essential component of effective care transitions, especially during handoffs at admission and discharge from hospitals. Addressing communication handoffs across care settings, the workgroup is reviewing best practice technologies such as the use of secure texting for case managers and physicians to utilize within the systems. Another workgroup has a hospital to home focus regarding evidence based patient education tools, which are well under development for high risk diagnoses and are actively implemented across all care settings from primary care practices to skilled nursing facilities, and ensure standardization and continuity of information for patients.

Care Transition protocols are studied including key actions:
- Communication between the sending and receiving clinicians regarding:
  - Assessment and reassessment
  - Fall and injury risk screening performed in all settings

- o A common plan of care - In order to ensure effective care transitions, an individual plan of care and transfer arrangements with patient and/or caregiver must be discussed, planned, and reviewed. The critical elements of the care plan developed in one setting are transferred to the next setting and to ensure that the essential steps are executed.
  - o Medication reconciliation
  - o A summary of care provided by the sending institution
  - o The patient's goals and preferences (including advance directives)
  - o An updated list of problems, baseline physical and cognitive functional status, medications and allergies
  - o Contact information for the patient's caregiver(s) and primary care practitioner
  - o Preparation of the patient and caregiver for what to expect at the next site of care
  - o Reconciliation of the patient's medication prescribed before the initial transfer with the current regimen
  - o A follow-up plan for how outstanding tests and follow-up appointments will be completed
- ■ An explicit discussion with the patient and caregiver regarding warning symptoms or signs to monitor that may indicate that the condition has worsened and the name and phone number of who to contact if this occurs
- ■ Community supports, including housing, should be in place prior to the member's transition, and providers are knowledgeable and prepared to support the member, including interface and coordination with and among clinical services and community-based providers
- ■ Excellent coordination and communication activities must take place to ensure the safety and well-being of the patient

Alliance has collaborated with care teams across the PPS to establish a best practice in timely notifications with hospitalizations. Outreach is initiated by embedded care managers in acute care, primary care and post- acute care in the event a patient is hospitalized. This process ensures the complex psycho-social factors issues are being addressed concurrently, appropriate referrals are facilitated, and the care team is knowledgeable about the post-acute plan of care. Additionally, patients who are identified as high risk for readmission may be assigned a facility's Coach by a Health Home, a hospital program, or through a nursing agency based on the Eric A. Coleman model© and conduct the 30 day program.

Another active strategy put in place regards the extremely frail patient who is unable to access the primary care provider office in a timely manner. Referrals may be made to a nursing agency and/or to the transitional care physician program. The clinically integrated network provides offers this service to the most fragile patients usually in conjunction with certified home care and/or palliative care program. In the event the patient's condition improves, they are referred back to their primary physician for medical management.

Meeting the behavioral health needs of patients is decisive in reducing emergency department use. Evidence suggests that there has been a gap in addressing complex psycho-social issues within the medical community. As part of Alliance multi-dimensional strategy, health homes are being leveraged to assist in reducing this deficiency. The role of health home navigators in the emergency room setting was well established in one of the facilities, successfully trained in another, and is being implemented with a third institution. A navigator role is to provide the resources and support necessary to increase self-management for emergency room patients and reduce and eliminate unnecessary utilization and promote access to appropriate behavioral health, medical and social care. They may also identify Medicaid or Medicaid-eligible

patients and link them to appropriate insurance, community resources, and providers -securing appointments, coordinating referrals, providing contacts for transportation, and facilitating Medicaid enrollment.

Communication, reporting, and transparency are priorities. Continuous communication between all parties about the care being provided to ensure that providers are not working at cross-purposes or duplicating services is critical. User-friendly, real- time reporting that compares performance to their peers on a local, regional, and national basis can educate and motivate physicians to improve their performance will be available.

Primary Care is also represented in Alliance's governance committees and structure and clinical quality committees. Alliance has developed a Board of Members and a Board of Managers, which are a cross-section of PPS partners, including leadership in all DSRIP projects and representation from ambulatory providers, and community and human service agencies serving the target population, as well as key hospital providers. The diversified governance structure promotes coordination and brings organizations and services together into an integrated health system ensuring representation from a variety of stakeholder groups that understand the delivery of healthcare along its continuum, including physicians and community based organizations. The structure and representation of the Board is assessed annually and will evolve as lessons are learned from experiences to know how best care to care for the population.

The Alliance Board of Managers is comprised of 13 individuals representing the 5 Member organizations (3 Hospital systems and 2 FQHCs), community medical practices and community based organizations. The Board composition includes 6 physicians, of these, 5 are PCPs and 1 specialist. Furthermore, other governing committees include key primary care representatives from independent physician group practices, federally qualified health centers, and health systems as noted below:

The Alliance for Better Health Care Workforce Committee assists the Alliance Board with its responsibilities for the organization's mission, vision and strategic direction and specifically addresses the timely achievement of DSRIP Workforce requirements related to Workforce budget spending, workforce impact analysis, new hire employment analysis, and completion of workforce milestones.

The Alliance for Better Health Care Finance Committee assists the Alliance Board with its responsibilities for the organization's mission, vision and strategic direction through fulfilling its responsibility for ensuring it's financial health, formulating policies regarding, making decisions about and overseeing Alliance's financial performance and condition and performing such related functions as may be assigned to it by the Board. One community based primary care practitioner is a member of this committee.

The Alliance for Better Health Care Information Technology and Data Committee assists the Board of Members with its responsibilities for the organization's mission, vision and strategic direction and fulfills its responsibility in meeting the NY DSRIP plan IT requirements and related infrastructure to support the achievement of the NY DSRIP plan goals, including all data security requirements, assists the Board in formulating policies regarding, making decisions about, and overseeing the PPS IT solutions and infrastructure, including data sharing and nature of the relationship with HIXNY and informs the Board of cost estimates to provide IT solutions to inform the budget process from a capital and operating perspective. One community based primary care practitioner is a member of this committee.

The Alliance for Better Health Care Clinical Integration and Quality Committee provides a vehicle for organizing the collaboration of physicians, practitioners and other healthcare professionals along the continuum of care to continually improve population-based care process standards that increase value by coordinating care, reducing unnecessary practice variation, and optimizing the utilization of clinical resources. It is responsible for establishing operating standards and clinical guidelines to be used in the care of Medicaid beneficiaries and others served by the PPS. The Committee is responsible for determining whether the providers are complying with Alliance's operating standards and clinical guidelines. Project specific advisory quality sub-committees were established. Utilizing project specific dashboards, as well as input from the respective project work groups, these advisory quality sub-committees will assess project performance and flag issues to be raised to the Clinical Integration and Quality Committee. In turn, the Committee will monitor aggregated data, and project specific data and performance issues and make recommendations which will flow back to the project workgroups to continually improve outcomes.

The Committee is also responsible for creating an annual quality improvement plan, which prioritizes areas where Alliance overall could improve its performance against its own clinical standards and guidelines as well as against DSRIP program goals.

The Clinical Integration and Quality Committee membership has a 94% representation by primary care practitioners with 71% (12) represented by hospital based providers and 29% (5) represented by community based providers. The Committee's co-chairs are hospital based providers.

The Clinical Quality and Improvement Committee Project specific advisory quality sub-committees have been established. Utilizing project specific dashboards, as well as input from the respective project work groups, these advisory quality sub-committees assess project performance and flag issues to be raised to the Clinical Integration and Quality Committee. In turn, the Committee monitors aggregated data, and project specific data and performance issues and make recommendations which will flow back to the project workgroups to continually improve outcomes.

Strategy to enable PC to participate effectively in Value Based Purchasing

The PPS's strategy for Value Based Payments is to include PPS members in planning discussions to determine the best approach to VBP arrangements. The PPS will lead consultative and advisory efforts for primary care and other providers to understand VBP contracting. As of this writing (11/01/16), the Alliance has pursued participation in a VBP pilot and is awaiting further data from KPMG to determine which VBP model may be best suited to a VBP arrangement. A pilot based on Integrated Primary Care and chronic bundles, which falls squarely in the realm of active Primary Care engagement by all PPS participants is one of the two options being explored. The other option is a pilot based on Total Care for the General Population that would also require active engagement on the part of primary care providers.

Next steps include a further review of VBP arrangements with Medicaid Managed Care Organizations (MCOs), to develop a shared understanding of VBP models within the PPS and to understand how these arrangements may affect PPS Providers and Members.

IHANY has applied for an Accountable Care Organization (ACO) Certificate Of Authority (COA) which would allow the organization to act as an agent for contracting on behalf of the Alliance. IHANY has a strong analytic and informatics team that can support the provider's pathway to VBP. This department will develop comparative data to be used by the Alliance and participating PCPs to help determine the best

choice of VBP model and to assist with other VBP arrangements. This department along with our care management team have established linkages with hospital admitting departments and emergency departments to gain information in real time to facilitate primary care interventions when needed.

The goals of IHANY (there is a 90% overlap of IHANY and Alliance practitioners) were always to increase access to care, improve quality and outcomes, decrease costs, improve patient and physician satisfaction, decrease potentially avoidable utilization and create value for the consumer. Much effort has gone into creating a care model that values providing more health and less care in order to avoid the need for costly treatments. As physicians and health care providers transition from fee-for-service to Value-Based Payment, there will be more emphasis placed on a community-based care delivery system by using more data analytics to help monitor and guide patients to the proper care venues. Opportunities to develop wellness programs to reduce costs and improving the experience of care for consumers are critical.

The IHANY ACO is addressing this changing environment in part by promoting the Patient Centered Medical Home Model (PCMH). A majority of our current PCP practices have embarked upon becoming NCQA Level 3 2014 certified practices. Transition planning is an essential component of PCMH and one that will improve outcomes for all affected beneficiaries. Our physicians understand the importance of increasing patient access to care by offering same day visits, extended office hours, telephonic and electronic communication and coordinating specialty access. The PCMH Program will continue to be expanded as we evolve. There is also recognition that this model of care will drive improved coordination of patient care, increase input into decision making and make our ACO more valuable to all providers in the community.

Funds flow support PC strategies

The Alliance is creating a multidisciplinary ad hoc group to develop a contemporary Incentive /Bonus Pool methodology to both reward and incentivize Primary Care providers and other clinicians and collaborators that help the Alliance achieve its Pay for Performance (P4P) outcome measures over the next three years. How we pay for care is rapidly shifting from fee – for – service (FFS) to value based payment, and a number of key Medicare and Medicaid programs are driving this transformation. The Alliance is positioned to partner with PCPs to provide benchmarking and quality improvement tools to support and improve patient care and rewarding those physicians based upon their contribution, performance and outcomes. The methodology for developing a funds flow incentive program is rooted in Guiding Principles that serve as the foundation for distributing funds.

The Guiding Principles should:
- Be flexible and allow the Alliance and Providers to adjust to variability in DSRIP funding and adaptable to support the sustainability of the Alliance PPS over time.
- Reward all Providers who contribute to meeting DSRIP goals successfully based on their contribution to meeting DSRIP goals.
- The Funds Flow methodology should be anchored in the Governance structure.
- Be consistent with the funds flow related terms of the Alliance's PPS Participant Agreement.
- Be transparent to all PPS Providers. It should be inclusive of the agreed upon approach for the distribution of all DSRIP funds and made a part of each Provider's Participant Agreement.
- Be communicated in a manner that promotes buy-in, engagement and trust of the participating Providers and other Stakeholders, all of which are crucial to the success of the PPS.
- Be based upon DSRIP performance requirements and should link the distribution of payments to contributions toward successful achievement of DSRIP goals.

- The specific payment for each Provider, or their contracting organization, is adjusted based upon their performance against specific criteria defined in their written agreement with Alliance.
- Support the implementation of DSRIP projects and incentivize the successful efforts of Providers to achieve DSRIP goals as they deliver healthcare related services to the Medicaid and Uninsured members of the DSRIP patient population.
- Promote and support agreed upon efforts of the Providers to collaborate across the continuum of services and the integration of services beginning at the local community level.
- Support a longer-term strategy for transition toward value based payments and should become a vehicle to support transformation and drive achievement of quality, cost-effectiveness and satisfaction of the DSRIP patient population.

Our goal is to allocate specific DSRIP funds to provide Incentive Payments to Alliance Providers and Collaborators to help change behavior and reward for contributions that have been made to improve the quality outcomes and patient satisfaction. There is recognition that the significant sums of money available for incentives will provide a foundation for helping to change overall physician and institutional behavior to be more focused on outcomes as opposed to FFS production. The funding of DSRIP incentive payments will provide specific funding, and a defined approach, that is intended to motivate Providers to achieve, or contribute to the achievement of, DSRIP milestones and outcomes. The rewarding of behavior should be sufficient to engage and to support primary care physicians to invest in their practice transformation and adopt a patient centered focus to care.

Progression towards integrating Primary Care and Behavioral health

At present, the availability of integrated care for individuals with medical and behavioral health needs is limited. Issues vary in the primary care provider (PCP) and in the behavioral health (BH) care settings. In primary care, behavioral health needs are not always met and screening is sporadic. In the behavioral health setting, patients often go without medical care given a mistrust of the health care system. The National Association of State Mental Health Program Directors issued a report in 2006 that indicated that adults with serious mental illness (SMI) die, on average, 25 years earlier than the general population. The excessive premature mortality rate is due to disproportionately high rates of mortality from preventable conditions such as cardiovascular and pulmonary disease, likely due to increased rates of smoking and obesity. Additionally, people with SMI experience higher rates of homelessness and poverty and face symptoms associated with SMI, such as disorganized thoughts and decreased motivation that impair compliance and self-care.

When a patient touches many providers, the medical, behavioral and social support services are generally fragmented. Many PCPs and BH providers are not accustomed to integrating care. Whether this stems from expectations regarding productivity or from the divide in cultures (e.g. training, visit length, problem focused short-term treatment vs. longer term treatment in the behavioral health setting), most providers within these two disciplines must be re-trained to provide integrated care.

Alliance PPS providers and CBO partners seek to responsibly help patients schedule appointments for behavioral health services when a behavioral health screening indicates the need for such services; however, "warm transfers" to behavioral health providers from primary care are not done in a systematic manner. PCPs are uncomfortable screening patients given the lack of referral sources for transfers, making a true warm transfer difficult. Alliance partners are committed to overcome these barriers.

Alliance PPS partners will seek to ensure that all patients (age-appropriate due to validation of screening tools) are screened for anxiety and depression in the primary care setting using the PHQ-2 and the PHQ-9 when indicated (Model 1 Integration). If a patient screens positive on a PHQ-9, the PCP will either manage the patient's care or conduct a timely warm transfer to behavioral health where the patient is assessed using a comprehensive screen and appropriate services are provided. The PCPs will be fully trained to utilize the PHQ screening tools, affecting warm transfers to an appropriate behavioral health provider and conduct follow-up with patients. To the degree that a patient has ongoing behavioral health needs, the PPS partners will integrate care for that individual in an effort to meet their medical, behavioral and psychosocial support needs.

Additionally, Alliance PPS partners will co-locate and integrate care within the BH setting according to evidence-based standards that incorporate, but are not limited to, care management for high-risk/high-cost individuals (Model 2 Integration). Care management services will include medication management and care management processes. The PPS partners will ensure that patients receive primary care in the behavioral health setting, as well as referrals to specialty care. This is important given the prevalence of chronic conditions among individuals with SMI.

Alliance PPS partners are passionate about their desire to create "No Wrong Door" entry points for patients in need of BH or SUD care in our communities. This includes but is not limited to patients that enter the health care system as a self-referral or caregiver referral or from a Community Based Organization, PCP, Specialist, school-based health care provider, urgent care, crisis or inpatient setting, county jail or any other referral point within the health care delivery system or community. Alliance partners have developed a workflow to accommodate this approach and are actively working to implement it.

To date, the Alliance workgroup for the Integration of Primary Care and Behavioral Health (3.a.i) has identified behavioral health screening instruments including the PHQ-2 and PHQ-9 with appropriate warm handoffs to BH and substance use disorder (SUD) providers when indicated. One of the Alliance's FQHCs, Whitney M. Young Health Center, has developed a comprehensive assessment tool that incorporates Screening, Brief Intervention and Referral to Treatment (SBIRT) assessments to screen for substance abuse along with anxiety and depression all in one assessment tool. This has been identified as a best practice and is under consideration by other partner organizations For patients that screen positive as part of this process, the workflow includes a warm handoff to a BH provider (mid-level or MD as available) within the Health Center.

Another one of the Alliance's partner FQHCs, Hometown Health Center, currently offers behavioral health and primary care within the FQHC site with significant access to behavioral health services by collaborating with Northern Rivers, a human services agency. While there is integration between providers already, a more systematic process, IT resources including EHR optimization, a patient navigator, and peer supports are needed to achieve true integration.

Ellis Hospital, another Alliance partner is in the process of relocating the Ellis Mental Health Outpatient /PROS (Personalized Recovery Oriented Services) clinic to a location that is across the street from Hometown Health Center and Planned Parenthood. The Ellis Mental Health Clinic will work collaboratively with both Planned Parenthood and Hometown Health Centers, in addition to co-locating primary care within the clinic, and will offer a new crisis stabilization urgent care program. This "mental health urgent

care unit" will provide walk-in access to behavioral health services which do not rise to the level of the hospital emergency department's Crisis Unit. Additionally, behavioral health services will be integrated within certain Ellis Medical Group Primary Care clinics. Integrating both modalities will assist in capturing clients that have not selected a primary care physician and/or have yet to receive necessary behavioral health treatment, yielding expanded access to integrated primary care and behavioral health.

In this instance, initial focus will be on clients within the Mental Health Clinic that are not identified with or connected to a primary care physician. Utilizing current resources such as the health home and its care navigators will assist in coordinating medical and behavioral care for clients as well as linking up with social support services within the community.

St. Peter's Health Partners is in the process of implementing an aggressive BH and PCP integration program, by bringing BH into up to eight of their primary care sites and bringing primary care into their mental health Clinic located at Samaritan Hospital in Troy. This integration will include bringing behavioral health providers from the Rensselaer County Department of Mental Health into two of the St. Peter's Medical Associates primary care offices. The initiative includes significant involvement with the Samaritan Health Home and allows for access and referral to all of the Health Home's downstream agencies.

St. Mary's Health Care in Amsterdam (SMA) has already integrated BH and primary care but has plans to expand their efforts by including additional primary care sites. SMA is now working with additional community partners to fully meet the needs of the patients in their community. The SMA health home is fully engaged with this process.

Each partner organization is in the process of reviewing regulatory requirements for co-location and determining how to proceed based on the type of entity they are and the specific regulatory barriers that they need to overcome. Additionally, several Alliance partners are in the process of evaluating telemedicine technology for advanced consultation with a psychiatrist.

Alliance is piloting a program to embed care managers, usually, licensed mental health professionals, e.g. LCSW or LMHC staff, within three primary care offices and provide the training and IT infrastructure necessary to support the needs of the offices that will allow the nurses and physicians in the PCP offices to work to the full capacity of their license to increase capacity and address the social determinants of health appropriately for their patients.

Other strategic opportunities from a workforce perspective include enhancing existing residency programs to provide a learning experience for residents treating behavioral health patients, securing close collaboration with existing primary care providers in the community, and building upon strategies of other practices implementing open access practice enhancements.

Alliance encourages its partners to utilize the services of community based organizations when available and for community based organizations to make their value and range of services known to the hospital systems and primary care providers in our communities. Alliance has included degree of collaboration with community organizations as a factor in the funds flow process and often facilitates meetings among these organizations. Alliance is available to provide the technical support necessary to ensure that community organizations are linked to primary care and to allow for a smooth referral process.

In addition to the efforts described above, Alliance also participates in the Development of Withdrawal Management project (3.a.iv.). This project focuses on enhancing access to substance use disorder treatment and also emphasizes the "No Wrong Door" philosophy. While, some of the initiatives included in this project center around SUD providers, one critical component includes increasing the number of primary care providers willing to prescribe suboxone. Alliance is in the process of developing an Ambassador program and has identified a physician who will act as a physician champion to encourage PCPs to get an x-license and to use it. Community SUD providers are willing to engage in this process by referring their stable patients to PCPs and by offering support and guidance when needed with the guarantee that if a patient slides back to instability, the PCP can refer the patient back to the SUD provider.

Alliance will offer support to the PCPs who accept this responsibility in the form of education, training and access to the physician champion as a resource. Additionally, now that regulations have changed allowing an increased threshold above the previous 100 patient maximum of the number of patients that can be treated under the x-license, Alliance will encourage PCPs to apply to obtain a license for the increased patient maximum.

Alliance has an active workgroup in place for the population health project geared toward strengthening the mental health and substance abuse infrastructure across our systems. The group is led by the Commissioner of Mental Health for Rensselaer County and includes representatives from Alliance partner organizations including several community based organizations. This group is focused on promoting trauma enforced care using tools such as the Adverse Childhood Experiences (ACEs) questionnaire with the goal of educating primary care providers and others how to administer the tool and then follow up based on the results. Alliance plans to promote the use of this approach and associated tools to promote Mental, Emotional and Behavioral (MEB) wellbeing in our communities for the most vulnerable populations.

In order to fully integrate care for individuals seen in the behavioral health setting, Alliance reviews evidence in the literature indicating that services should include, but not be limited to:
- Improved screening and treatment for behavioral and physical health across the care continuum
- Stratification of high, moderate and low-risk patients with behavioral health diagnoses
- Care management services designed to integrate care across behavioral, medical and psychosocial needs
- Listing medications in patient records which can be shared across the provider continuum
- Education and counseling regarding tobacco cessation, exercise and nutrition, diabetes
- Cholesterol Screening for diabetics
- Diabetes monitoring (including individuals with Schizophrenia/BPD using antipsychotic medications)
- Cardiovascular Monitoring for People with CVD and Schizophrenia
- Follow-up care for Children Prescribed ADHD Medications
- Follow-up after hospitalization for Mental Illness
- Adherence to Antipsychotic Medications for People with Schizophrenia
- Appropriate referrals and follow-up for chronic conditions with a focus on COPD, CHF, hypertension, diabetes, asthma and HIV/AIDS
- Use of evidence-based standards and protocols for medication management and care engagement processes