



Primary Care Plan

2016-2017

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INTRODUCTION

The Finger Lakes Performing Provider System (FLPPS) is the second largest Performing Provider System (PPS) in New York State (NYS), and covers a 13-county region, which includes almost 6,700 providers and 19 hospitals. FLPPS is a new corporation with 501(c)3 status that was created for the purpose of the implementation of Delivery System Reform Incentive Payment (DSRIP) activities. The PPS is a collaboration between two major health systems in the region, RU System Inc. d/b/a Rochester Regional Health (RRH) and University of Rochester Medicine (URMed). FLPPS divided its geographic area into five sub-regions known as Naturally Occurring Care Networks (NOCNs): Finger Lakes, Monroe, Southeastern, Southern and Western. These regions were created based on the delivery of care patterns identified during the development of the community needs assessment to improve communication and the development of an Integrated Delivery System (IDS).

The FLPPS Primary Care Plan is based on the foundation that the connection of our patients to patient centered medical care is fundamental to the goals of DSRIP. The FLPPS primary care strategy is based on achieving the Triple Aim:

- Improving the quality of care and patient experience
- Improving population health with fewer emergency department (ED) visits and readmissions
- Reducing wasteful cost

In addition, FLPPS will only be able to accomplish its goals by focusing on improving primary care provider and staff well-being, the “fourth aim”. We will engage primary care providers and staff in order to understand their needs, hopes and fear as they relate to effective care, system transformation and value based payment (VBP). The provider-patient relationship, one of the cornerstones to achieving the Triple Aim, as well as the “fourth aim” of provider wellness, can only be achieved through meaningful dialogue, education and support.

FLPPS will support transforming traditional primary care to a team-based medical home model, inclusive of a strong care management infrastructure and behavioral health (BH) integration, while prioritizing communities with the greatest health inequities. Connecting our patients to appropriate care and addressing social determinants of health through culturally competent Community-Based Organizations (CBOs) is another component of the FLPPS strategy that will facilitate improvements in health outcomes for our patient population and enable system transformation

In an effort to outline our Primary Care Strategy in this plan, FLPPS will address the following six fundamentals:

1. An overall assessment of current primary care capacity, performance and needs, and a plan for addressing those needs
2. How primary care expansion as well as practice and workforce transformation will be supported with training and technical assistance

3. How primary care will play a central role in an IDS
4. How the PPS will enable primary care to participate effectively in value-based payments
5. How the PPS's funds flow includes and supports Primary Care practices
6. How the PPS is progressing toward integrating Primary Care and Behavioral Health

FUNDAMENTAL #1: OVERALL ASSESSMENT OF CURRENT PRIMARY CARE CAPACITY, PERFORMANCE & NEEDS, AND A PLAN FOR ADDRESSING THOSE NEEDS

PRIMARY CARE CAPACITY OF FLPPS NETWORK

The FLPPS region is geographically the largest PPS in NYS, spanning 94 miles from the northern border along Lake Ontario to the Pennsylvania state line and 112 miles east to west. Approximately one-fifth of the region is lakes and rivers, which often impede travel from one region to another. The FLPPS Network serves approximately 300,000 Medicaid patients across 13 counties in upstate New York. A majority of FLPPS patients and Primary Care Providers (PCPs) are in Monroe County (see *Figure 1*). Extensive gaps in primary care access and behavioral health services are driven by a shortage of licensed providers and non-licensed providers and inadequate transportation resources.

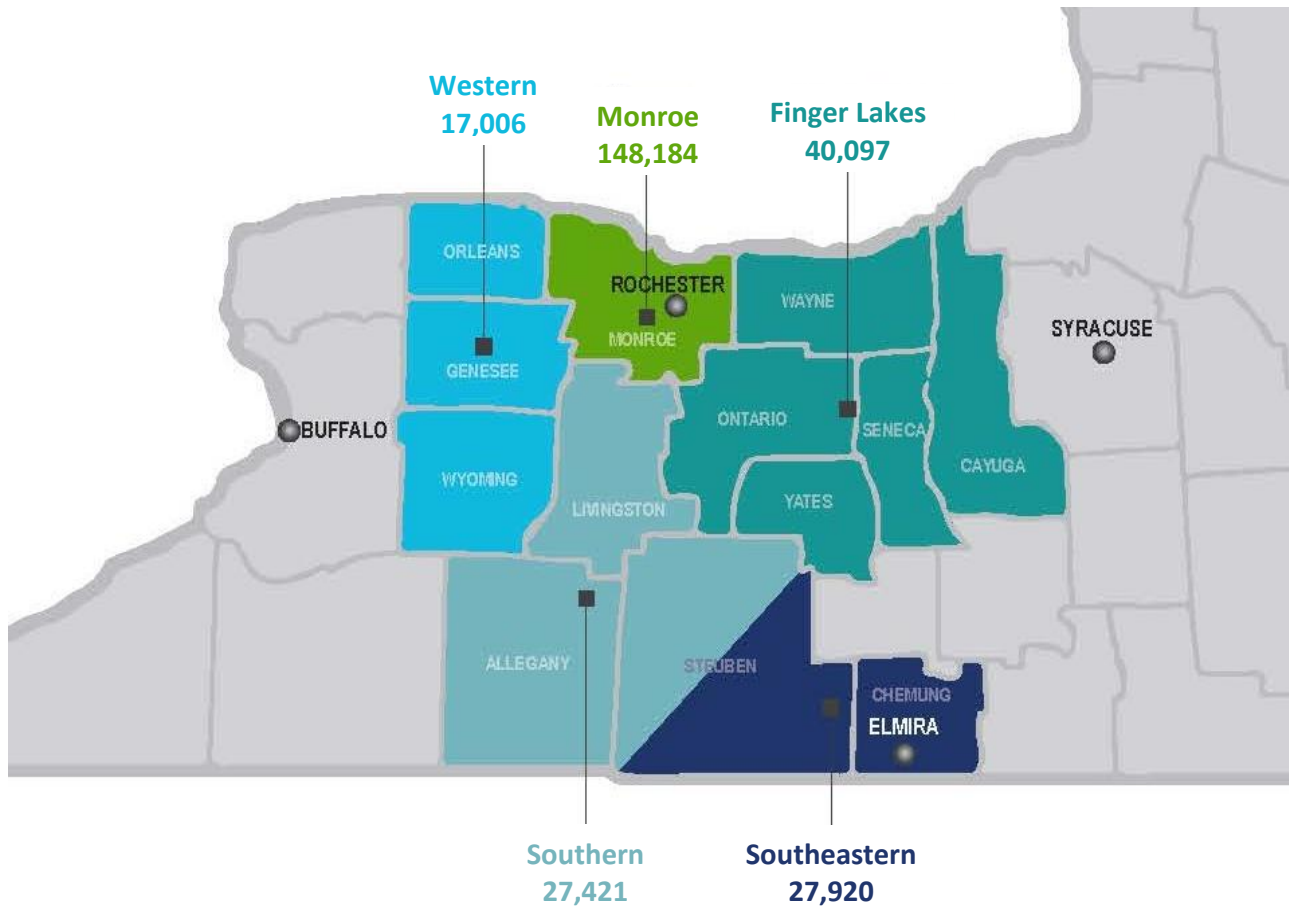


Figure 1 - FLPPS Geographic Regions in NY

Eleven out of 13 counties in the region, and portions of Monroe County, are Primary Care Health Professional Shortage Areas (HPSAs), (see Figure 2). Additionally, 12 out of 13 counties in the FLPPS region are Mental Health HPSAs.

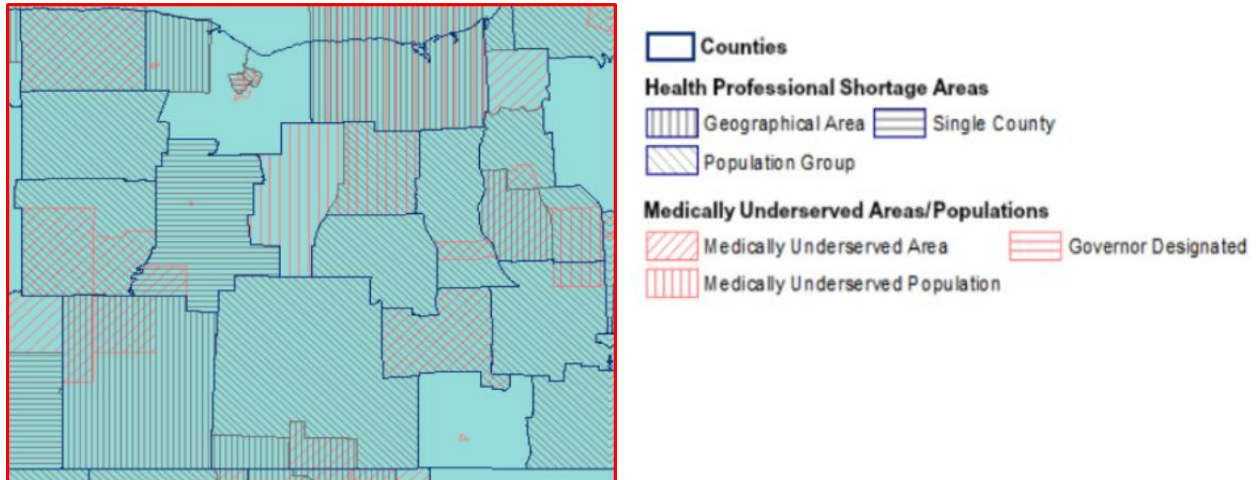


Figure 2 - Primary Care HSPAs

According to data released by the NYS Department of Health (DOH) in June 2016, the current FLPPS Network includes a total of 993 PCPs. Of those providers, 20.9 percent offer extended hours and 76.5 percent are accepting new Medicaid patients¹ (see Figure 3).

According to an internal FLPPS Network analysis, FLPPS identified approximately 1,026 PCPs in the Network. Discussions with FLPPS community stakeholders and other data sources indicate that far less than 76.5 percent are actually accepting new patients when functional access and timeliness of care are considered. We are working diligently to determine the factors for differences between DOH and FLPPS data, in order to continue to map and refine our Network.

	<u>DOH June 2016 Data</u>	<u>FLPPS Internal Analysis</u>
Total PCPs	993	1,026
# Safety Net	234	781
# Employed by Hospital	669	683
# Employed by Hospital or FQHC	714	740
Percent Employed	72%	72%

Figure 3 – DOH and FLPPS PCP Analysis

¹ DOH Network Analysis

The FLPPS primary care network includes physicians, nurse practitioners (NPs) and physician assistants (PAs) in focus areas from family medicine to pediatrics. The approximate composition of PCPs in the FLPPS Network is 44% Internal Medicine, (including geriatrics), 33% Family Medicine and 23% Pediatrics (see *Figure 4*). Anecdotal reports indicate that we do not have a lack of access with pediatricians. There are also FLPPS measurement year 1 (MY1) Domain 2 access measures that are trending positively in the area of pediatric access. The data below will help us focus more on truly understanding shortages in adult medicine access.

Provider Type	Internal Medicine	Family Medicine	Pediatrics
MDs	35%	25%	20%
NPs/PAs	9%	8%	3%
Total	44%	33%	23%

Figure 4 – FLPPS Primary Care Providers in Network

The largest percent of PCP representation is found in Monroe County, with approximately 70 percent of the total PCP network, when compared to other counties in the region. Approximately 57 percent of the Medicaid lives are found in Monroe county, demonstrating the vast differences in PCPs across the different regions in the FLPPS Network. FLPPS plans to asset map the FLPPS Network with provider type, site and FTEs to refine the actual capacity.

NEEDS OF FLPPS PATIENT POPULATION

According to regional data, patients in the FLPPS region rely heavily on acute care services. This data implies that patients are using less primary care and behavioral health preventive care services. The prevention quality indicator (PQI) attributable to chronic diseases (diabetes, respiratory and heart) accounted for 86 percent of all potentially preventable inpatient hospital and emergency room admissions

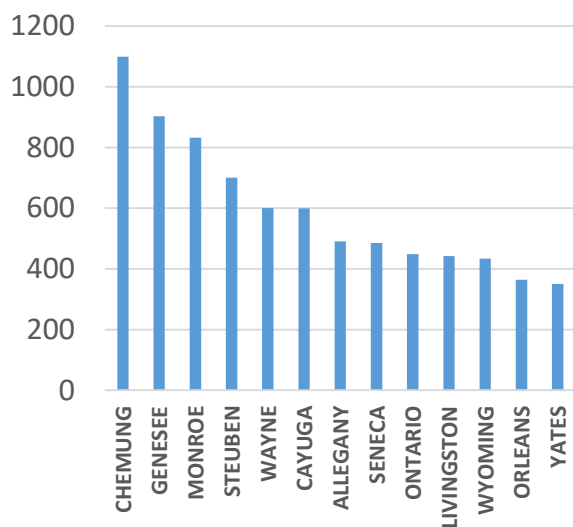


Figure 5 – Number of Super-Utilizers – Persons per 100,000

hospitalizations in 2014. In 2015, diseases of the circulatory, respiratory, digestive and endocrine systems, accounted for approximately 25 percent of inpatient claims and encounters for Medicaid hospital admissions. These data points can be considered directly related to the gaps in primary care access for the Medicaid population. The number of super-utilizers per 100,000 people varies among the 13 counties with the highest rate in Chemung County, followed by Genesee County and then Monroe County, as evident in *Figure 5*. According to the Medicaid roster data, Chemung County has enough PCPs available to meet the number of patients in the region. However, super-utilizer data demonstrates that

Chemung county has the highest rate per 100,000 patients of super-utilizers. This implies a large gap exists in this region relative to primary care services. Addressing the needs in this particular county will be a focus for the future primary care strategies for FLPPS.

Additional analysis of the super-utilizer data shows that approximately **48 percent of FLPPS’s super-utilizers do not have an assigned PCP**. This reality indicates an opportunity to improve care by connecting these high utilizers with PCPs prepared to manage complex patients. In addition, FLPPS will use this data as input into the Care Management strategy to ensure that these patients are screened for Health Home eligibility and enrolled as eligible.

Data for July 1, 2014 thru June 30, 2015 (see *Figure 6*) also demonstrates that a significant portion, approximately 42 percent, of FLPPS attributed lives fall into the non-utilizer and low-utilizer categories (low-utilizer is defined as less than or equal to three primary care visits and non-utilizer is defined as zero primary care visits within 12 months). This demonstrates another opportunity to connect patients with primary care, especially the non-utilizers.

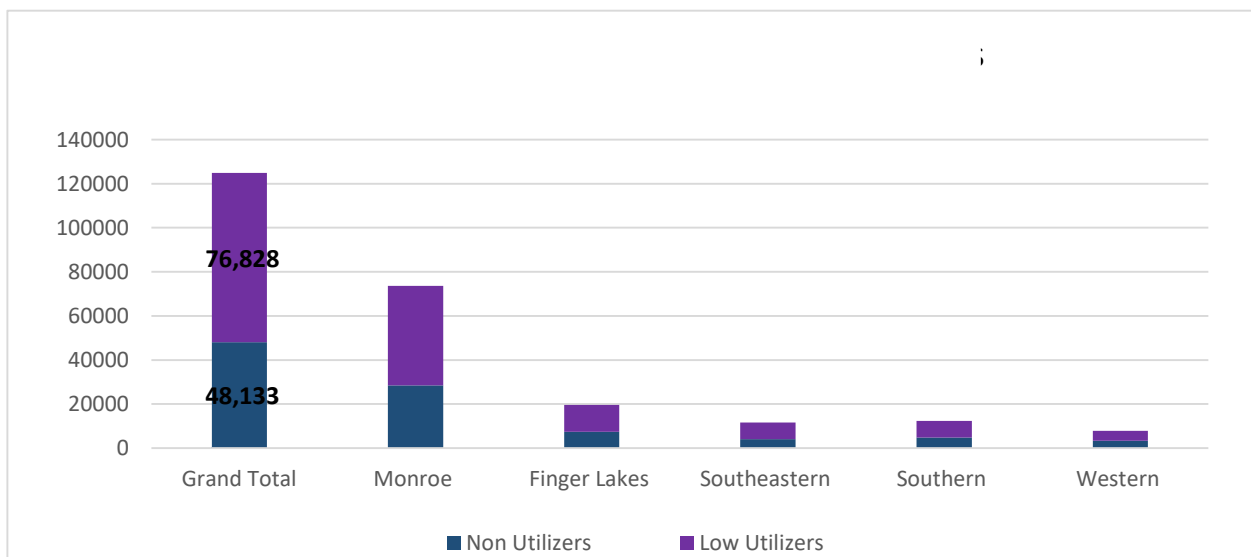


Figure 6 – NOCN Data for Non-Utilizers and Low-Utilizers

Furthermore, according to Healthcare Effectiveness Data and Information Set (HEDIS) access measures, adult access data in MY1 was below target. FLPPS assumes that there are major barriers to primary care services within identified NOCNs such as lack of transportation, inadequate access, etc. that are contributing to the low, negative rates.

PERFORMANCE

Meanwhile, FLPPS continues to work collaboratively with its Partners to set up the appropriate primary care infrastructure to improve such measures. To date, 35.6 percent of FLPPS PCPs are at sites with PCMH (Patient-Centered Medical Home) 2014 Level 3 certification, (see *Figure 7*). Most of these are health system affiliated and Federally Qualified Health Center (FQHC) sites. FLPPS is on target to achieve 100 percent PCMH for Project 2.a.i (Integrated Delivery System) speed and scale commitments for 2014 PCMH certification by March 31, 2018.

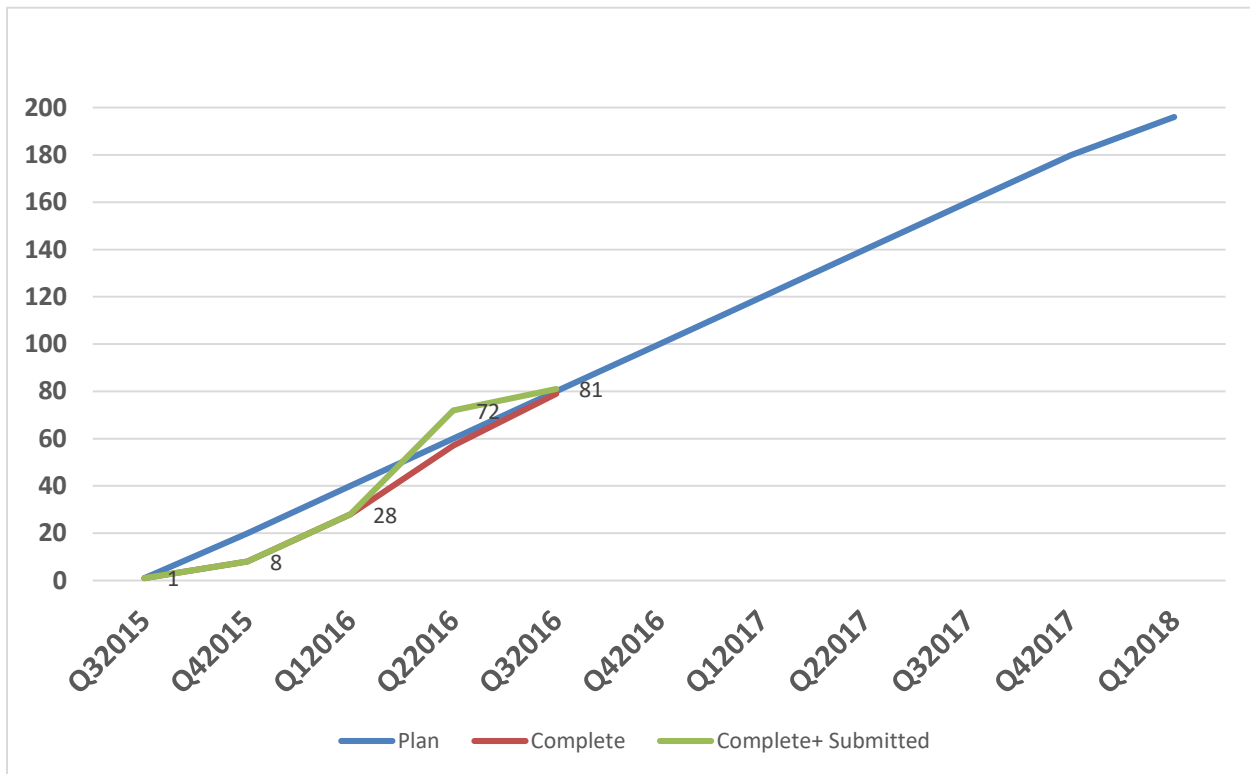


Figure 7 – PCMH Progress Toward Goal - Sites

PLAN TO ADDRESS THE PRIMARY CARE GAPS & SHORTFALLS IN THE NETWORK

FLPPS’s Primary Care Plan will be guided by the Clinical Quality Committee (CQC), which is a key decision-making body that functions as a governing committee of the FLPPS Board of Directors. Eight of the fourteen CQC members (57 percent), are primary care physicians. Four of these eight physicians are employed by health systems, with two practicing in the community. Two CQC members are community-based providers from FQHCs. One member is a physician from the Finger Lakes Health Systems Agency (FLHSA), the region’s local health planning agency, and one member is a physician from a managed care organization (MCO). In addition, the CQC is led by the FLPPS Executive Medical Director, as well as the two FLPPS Associate Medical Directors, all are community-based primary care physicians. The CQC provides clinical governance and oversight of the CQSCs, which represent ten of the 11 FLPPS DSRIP

projects, as well as oversight of the Population Health Workgroup. The CQSCs provided input into the development of the Primary Care Plan with information on the needs of our patients and the available capacity.

The Overarching Strategy to Address the Primary Care Gaps and Shortfalls in the Network

The overarching strategy to address the primary care gaps and shortfalls in the FLPPS Network is to:

1. Refine the primary care network data to build a true picture of capacity
2. Build a strong patient-centered medical home infrastructure that promotes primary care transformation and supports the DSRIP population health transformation
3. Expand in targeted shortfall areas with Capital Restructuring Financing Program (CFRP) funds, if awarded, and DSRIP incentive dollars
4. Develop a coordinated Care Management and Health Homes infrastructure with information technology (IT) support to connect all care coordination touching a patient
5. Expand telehealth supported by DSRIP innovation funds that improve access and capacity
6. Implement innovative workforce solutions that increase primary care capacity in critical areas

Examples include:

- The City of Rochester, within Monroe County, is a medical and behavioral health HPSA, and includes some of the nation's poorest neighborhoods. Both health systems located in Monroe County, RRH and URMed, have expanded in 2016 or have planned expansion to cover approximately 15,000 additional patients.
- Chemung County has the highest percentage of super-utilizers of ED and in-patient in the FLPPS Network. FLPPS will work to connect these patients to primary care services. Arnot Health System in Chemung County has expanded their hours of primary care operation. Analysis of further data will help us to work with the Health Home Care Management Agencies and Partners to connect these patients to primary care services.

Primary Care Data Improvement

FLPPS will complete a systematic assessment of primary care capacity, stratified by adult and children, through data analytics. The provider analysis will include effective full time equivalent (FTE) totals and service sites to determine capacity.

We will also validate this data using "secret shoppers". Recent studies have shown that reports by primary care practices over-estimate capacity by at least 30 percent. It is critical that capacity data is accurate within regions in order to truly understand what the capacity really is in different regions if we are to address it.

Additional efforts will include educating the patient population about availability of primary care services and doing an assessment to determine if our patient population is currently directed to practices that have availability within 30 days. The ED care triage project and the 30-day care transition project are venues for making these connections, particularly for high utilizers and low utilizers that are identified at point of service.

Primary Care Transformation

Team-based care models are being implemented throughout the FLPPS region to transform primary care, in varying degrees. This work is vital to achieving the goal of sharing the care for a population rather than focus on serving patients scheduled that day. Improved data will be vital as well as process improvement and team care facilitation assistance. Achievement of 2014 PCMH Level 3 helps to ensure that primary care providers are incorporating health information technology (HIT), care coordination, care management, and care transition strategies into their practices. FLPPS plans on using its strong primary care network to share best practices and build a Primary Care Transformation Roadmap. Addressing the transition from fee for service to operationalizing a VBP practice, will be part of that plan. Addressing the needs of providers during this transformation, including reducing administrative burden, paperwork and reporting, in order to improve PCP morale and capacity, will also be a critical part of that Roadmap.

Primary Care Expansion

Primary Care expansion is vital to FLPPS's success. FLPPS Partners have developed plans to make primary care more accessible as articulated below by NOCN.

Monroe NOCN: Monroe County

RRH is planning the Northeast Health Center Expansion, located near Rochester General Hospital. It will consolidate five existing disparate medical clinics into a center with co-located internal medicine, pediatric care, dental and ophthalmological care. The center will also include a telemedicine network office and care management/outreach office. Additional pharmacy and laboratory services will address the barriers of transportation. Plans also include a high risk ambulatory primary care clinic for ED diversion and management of high utilizers of care with multiple chronic co-morbid conditions.

URMed opened Manhattan Square Family Medicine in January 2016 in the City of Rochester, with four Family Medicine physicians. The facility has 15 exam rooms utilizing a team based/PCMH concept design. An on-site laboratory is included. The Complex Care center opened in March 2016 and serves 200 patients now, and will expand over the next four years. A Highland Family Medicine expansion is planned through two additional suites and seven staff members. Culver Road Medical Group, Strong Internal Medicine and East Ridge Family Medicine have expansion plans as well.

Anthony Jordan Health Care, an FQHC, will expand in 2017 for the Anthony L Jordan Center, on Hudson Avenue to enable additional space for one clinical team, utilizing a team care model. This center resides in the city of Rochester. Anthony Jordan Health Care will also add one exam room to the Canandaigua site to allow behavioral health services at that site.

Finger Lakes NOCN: Wayne, Ontario, Yates, Seneca and Cayuga Counties

RRH is planning a Clifton Springs Medical Village, located near Clifton Springs Hospital. This initiative will include the creation of a medical village, comprised of co-located medical, behavioral health and specialty care. The expansion will include primary care, ophthalmology, dentistry and holistic wellness care. The expansion serves to increase preventive health care and access to primary medical and dental

care, including expanded hours of operation and collocated services, addressing the barrier of transportation. The center will address the need for open access as an attractive alternative to inappropriate use of the ED for primary care.

Finger Lakes Community Health, an FQHC, opened Newark Community Health in January 2016. The facility includes women's and men's health, pediatrics, dental, counseling and telehealth specialty access. Multidisciplinary teams and an extensive telehealth network in all sites has enabled growth of about 10 percent per year throughout the sites. Telehealth programs and technology have enabled the clinic to overcome barriers such as transportation, language differences and a migrant lifestyle. The telehealth programs include teledentistry, telepsychiatry, telemental health, telepulmonology among others. Plans are in place to build a new health center in Sodus.

Southern & Southeastern NOCNs: Livingston, Allegheny, Steuben and Chemung Counties

Oak Orchard Health, an FQHC, opened the Hornell Medical Site in Steuben County in December 2015. The site includes two pediatric care providers, two dental care providers and two primary care providers. There are plans to add a family medicine or internal medicine provider in Hornell as well.

Arnot Health put in place flexible scheduling and extended evening hours this year at their four primary care practices in order to improve access. An analysis will be performed of Chemung County, our highest percentage per 100,000 lives of super-utilizers, to determine how to best connect these patients to primary care services, given the lack of expansion plans.

Western NOCN: Orleans, Genesee and Wyoming Counties

Oak Orchard Health plans to add a pediatrician and family medicine physician in Warsaw. They are also considering the addition of another family physician in Albion.

Care Management

The FLPPS project implementation plans, including process flowcharts, depicted the role of Care Management, including Health Homes, as part of the vital hub to support PCPs in the Medical Home Model. FLPPS is analyzing Health Home capacity, support and workflow in the 13 counties to ensure that there is integration and continuity of care for our patients for both medical and social services. Partners are exploring different models of Health Home integration to ensure that there is seamless support for the patient as well as the PCP. Benchmarking best practices will be part of the Care Management Strategy, which will be an important part of the Primary Care Plan.

Telehealth

THE FLPPS region is the largest PPSs geographically in NYS. Considering the HPSA status in many of the FLPPS counties, harnessing technology will be key to extending the reach of current providers and improving care for the patients that our Partners serve. Telehealth as a mode of care will be expanded through the FLPPS region. This will improve communication and service coordination for patients with chronic conditions and allow for expanded resource capacity of staff and providers. The Primary Care Plan will include a support plan for providers including: 1) Sharing best practices,

2) Training needs, 3) Equipment, 4) Technology, 5) Billing system and support. FLPPS will leverage the existing telehealth expertise and experience of our Partner, Finger Lakes Community Health, for assistance.

The Project Extension for Community Healthcare Outcomes (ECHO®) uses tele-education to bridge knowledge gaps between specialists at academic health centers and primary care providers from remote areas. ECHO® has been implemented nationally to address multiple medical conditions, including behavioral health issues in both adult and geriatric populations within primary care settingsⁱ. The University of Rochester Medical Center (URMC) has been conducting biweekly ECHO® PSYCH sessions for its affiliated primary care practices, and discussions have begun with this group to open the registration and availability to all primary care providers in the FLPPS region who would benefit from this program. URMC conducts ECHO® sessions with a focus on a wide variety of conditions. The ECHO® collaborative could have a significant positive contribution towards accomplishing each of the triple aims of Medicaid redesign. Its utility and value in rural, typically underserved areas is of particular importance.

Learning Collaboratives

Learning collaboratives will be an important initiative for FLPPS. These collaboratives, including web-based, will extend knowledge and employ best practices within our PPS. This sharing of knowledge will be an integral part of the FLPPS Primary Care Plan.

County Health Partnership – Preventive Care

FLPPS's Primary Care Plan will also include partnerships with the 13 counties to address the prevention agenda, and how to support PCPs with healthy behaviors and additional programming. We are in the process of collaborating with the county public health departments on the state preventions agenda and the Community Health Improvement Plan (CHIP)/Community Service Plan (CSP). We are seeing where there is an intersection with FLPPS project work to best serve our patients.

Special Needs Group

One of our next steps, in the Primary Care Plan, is to address the special needs of the children in FLPPS as well as the developmental disability sub-population relative to their primary care needs.

FUNDAMENTAL #2: PRIMARY CARE EXPANSION & WORKFORCE TRANSFORMATION SUPPORT OF TRAINING & TECHNICAL ASSISTANCE

There are a number of training and technical assistance strategies that FLPPS has developed for primary care expansion, and practice and workforce transformation. All primary care practices in the system are required to have PCMH 2014 Level 3 by March 31, 2018. To meet this deadline, applications must be submitted no later than September 30, 2017.

PATIENT-CENTERED MEDICAL HOME

FLPPS has a dedicated PCMH team that supports primary care practices in the process of meeting the 2014 PCMH goals. They are PCMH certified experts that have been in place since January 2015. FLPPS provides consultative support for the health systems and FQHCs in the Network via access to templates and report examples that facilitate documentation. In addition, FLPPS will review and audit processes, as these Partners continue to support their internal efforts prior to DSRIP. FLPPS technical support is primarily focused around smaller, community-based practices. This includes coaching practices through meaningful use, electronic health record (EHR) optimization, best practices and quality improvement, while guiding these practices through the National Committee for Quality Assurance (NCQA) PMCH recognition application process.

WORKFORCE

Faced with the challenges of PCP shortages in our Network, FLPPS will pursue innovative partnerships between our Partner organizations and FLHSA. FLPPS will also pursue innovative partnerships with universities and colleges to address recruitment and training of physicians (family physicians, general internists, geriatricians, med-pediatrics and pediatricians), nurse practitioners, physician assistants and other advanced practice providers. The FLPPS Primary Care workforce group held key stakeholder meetings to review data and generate several possible pilot solutions to the primary care workforce challenges. FLPPS is partnering with FLHSA to develop these solutions:

1. The office of Primary Care Physician Recruitment and Retention focuses on solving the physician shortage in FLPPS's 13-county area. The office intends to use a long-term succession planning view in line with activities around recruitment and retention, while reducing administrative and retention burdens on the PPS. To do this, FLPPS plans to learn more about the Monroe County Medical Society's prior model and understand the current recruiting and retention strategies across the PPS. With this information FLPPS will develop best practices. Loan forgiveness programs will be part of the possible solutions to recruit more providers to work in safety net practices.
2. FLPPS will leverage its registered nurse (RN), nurse practitioner (NP), and physician assistant (PA) workforce to increase panel size. RNs and NPs are an important resource to improve capacity in areas that have a shortage of PCPs. In order to increase NP and PA availability, FLPPS intends to further bridge partnerships between educational institutions and primary care practices, especially in HPSA primary care areas. The institutions identified to build a partnership to better

understand their training sites are University of Rochester for NPs and Rochester Institute for Technology for PAs. North County Initiative PPS has successfully implemented an incentive model for increasing capacity in primary care practices, and FLPPS plans to learn and benchmark from this initiative for possible implementation within FLPPS.

COLLABORATION LEVERAGING STATE RESOURCES

FLPPS is coordinating its primary care transformation work with FLHSA. The FLHSA organization participated in the Center for Medicare and Medicaid Innovation (CMMI) grant to work on transformation with 65 practices involving 825 primary care providers. Many of these providers are currently participating in the FLPPS Network. The FLHSA is now part of the NYS PTN (Practice Transformation Network) providing technical assistance to another 300 providers in the region and scheduled to enroll another 700 providers in the CMMI TCPI (Transforming Clinical Practice Initiative). FLHSA will also be participating in the NYS State Innovation Model (SIM) project, where they will provide assistance to primary care practices to reach Advanced Primary Care (APC) status. This project will expand the opportunities for FLPPS providers who are excluded from TCPI because of participation in a Medicare shared savings program. FLPPS will support creation of care teams to expand primary care access and capacity and empanel patients to ensure consistent access to recommended services, including behavioral health services. The availability to enroll pediatricians in the TCPI program is a unique opportunity to ensure that the pediatric providers in the PPS have assistance in practice transformation as well.

The Finger Lakes Center for Primary Care Clinical Education (FL-PCCE) provides skills training to primary care clinicians throughout the Finger Lakes region, focused on those with greater than 35 percent of services provided to Medicaid patients. FLPPS has aimed to foster collaboration, through the PCMH work, with independent practices to learn from each other and share best practices.

The FLPPS PCMH team meets monthly with FLHSA to collaborate and ensure that the FLPPS Network appropriately maximizes state and federal resources for practice transformation, while not duplicating resources. In addition, the FL-PCCE is participates in meetings to facilitate their work with Medicaid practices on quality and practice improvement. A recent initiative between FLPPS and FL-PCCE was in Hornell, New York, (FLPPS's Southern NOCN), through a collaborative of three unaffiliated practices that met as a cohort to work on PCMH, behavioral health integration and quality improvement.

FLPPS is also part of the PCMH Collaborative, which is a group of mainly safety net primary care practices in the Rochester, New York, upstate region. The collaborative has met monthly since 2010 and focuses on PCMH and quality improvement within primary care.

There are a number of additional training and technical assistance initiatives that FLPPS utilizes, such as the Monroe County Medical Society Quality Collaborative, the Primary Care Development Corporation and the Community Health Care Association of New York (CHCANYS)/Health Center Network of New York (HCNNY) DSRIP tools. FLPPS will also use other state-wide resources, such as New York eHealth Collaborative (NYeC) for primary care strategy implementation and success.

FUNDAMENTAL #3: FLPPS STRATEGY FOR HOW PRIMARY CARE WILL PLAY A CENTRAL ROLE IN AN INTEGRATED DELIVERY SYSTEM

Primary care providers play a key role in the IDS strategy for FLPPS. As FLPPS continues to build a robust IDS, the focus on primary care is evident across all components of the IDS strategy. It includes primary care as a central element of IDS governance, project implementation, IT, CBO/consumer engagement and patient engagement/self-management.

GOVERNANCE

Primary care practitioners are well represented on both the Board of Directors and the CQC at FLPPS, ensuring that the primary care has meaningful input into the building of the IDS. The Board is comprised of 20 members, which includes five primary care providers who are employed by health systems, several of which also practice in the community. Eight of the fourteen CQC members (57 percent), are primary care physicians. Four of these eight physicians are employed by health systems, with two practicing in the community. Two CQC members are community-based providers from FQHCs. One member is a physician from the Finger Lakes Health Systems Agency (FLHSA), the region's local health planning agency, and one member is a physician from a managed care organization (MCO). In addition, the CQC is led by the FLPPS Executive Medical Director, as well as the two FLPPS Associate Medical Directors, all are community-based primary care physicians.

The CQC also provides clinical governance and oversight of the CQSCs, which represent ten of the 11 FLPPS DSRIP projects, as well as oversight of the Population Health Workgroup. The CQSCs provided input into the development of the Primary Care Plan with information on the needs of our patients and the available capacity. The objectives of these CQSCs include the review of clinical standards and protocols, according to the Domain 1 process requirements and Domains 2-4 DSRIP measures specification manual. Each subcommittee also conducts a review of action plans for poor performing providers, to be carried out with the support of the FLPPS Executive Medical Director. In addition, FLPPS has a Behavioral Health Subcommittee that reports to the CQC and is comprised of local mental hygiene directors, county administrators, primary care providers and behavioral health providers. This subcommittee addresses county-level access issues to behavioral health care, provides regulatory guidance and identifies solutions to behavioral health project implementation barriers.

The Workforce Operations Workgroup, which is chartered to ascertain and resolve workforce issues across the FLPPS Network, has a Primary Care Subgroup specifically dedicated to creating solutions for primary care capacity issues across the Network. This subgroup is led by a local primary care physician, who is the Chair of Family Medicine at a health system. The subgroup is comprised of eight total members, which includes six practicing providers, of which three (37.5 percent) are primary care practitioners and one (12.5 percent) is a community-based primary care physician.

PROJECT IMPLEMENTATION

The FLPPS DSRIP projects were selected based on the needs of the Medicaid population in the FLPPS region and primary care intersects directly with most of these projects. Care management and the navigation of patients to primary care services is at the heart of an IDS. FLPPS is partnering with Accountable Care Organizations (ACOs) and Health Homes to develop a care management strategy that will identify high risk patients and patients not connected to primary care services.

As the FLPPS project management office has made significant efforts to implement the projects in the region, barriers have been documented and are being woven into the Primary Care Plan. In particular, Project 2.b.iii (ED Care Triage) has identified the following access barriers to primary care and identified appropriate mitigation strategies:

- Providers are requesting an intake packet be completed before they make a new patient appointment
- PCPs are unclear about DSRIP initiatives and patient navigation processes
- No-show rate is higher for high risk Medicaid patient population and PCP offices are averse to accept these patients
- Health systems in Monroe County have had significantly limited navigation to new PCPs since December 2015 due to capacity issues
- RRH and URMed patient navigators have reported that some primary care providers are not accepting new patients or new patient appointments are given 16 to 90 days out
- There is no process to determine if a Health Home care manager is assigned to a patient, which will affect PCP workflow because a large percentage of these individuals could be referred to a Health Home care manager for follow up, as opposed to a PCP

In order to mitigate these identified barriers, FLPPS plans to:

- Establish meetings with FQHCs and health systems to review availability and the process to access new patient appointments as well as identify key contacts
- Recommend that FQHC and large volume providers report access via the provider portal and patient navigators will be able to determine availability in real-time
- Create a triage process to navigate patients with the highest need
- Utilize community navigators to support linkage to Health Home provider and PCP
- Provide education on DSRIP initiatives and support relationships between emergency departments and PCPs to promote access
- Build up capacity with Health Homes and ED communication to schedule appointments with a Health Home care manager (if applicable)
- Leverage the Regional Health Information Organization (RHIO) to share information, including Health Home enrollment

FLPPS will utilize other projects, such as Project 2.b.vi (Transitional Housing), and its Transportation Committee to help address some of the housing and transportation needs in the community. Project 2.d.i

(Patient Activation), will also leverage CBO engagement to identify the patients that need to be redirected to primary care. This work directly aligns with FLPPS's strategy to engage patients in the Network and ensure that effective connections are made to primary care via Patient Activation Measure (PAM) assessment results. In particular, organizations can use the PAM assessment's score and techniques such as motivational interviewing, to determine effective approaches to get disenfranchised individuals to use primary care. More specifically, the scores will support improvement on Domain 2 outcomes for this project that are key to the FLPPS primary care strategy, including:

- Reduce ED self-pay admissions by educating the uninsured (UI) of “affordable” primary care alternatives and/or assistance in obtaining health care coverage (private or public)
- Facilitate non-utilizers (no visits to primary care in 12 months) to see a primary or preventive care clinician
- Increase activation for the low utilizer's (individuals with a chronic or behavioral health diagnosis with less than three visits) by providing “coaching” and re-administering the assessment tool.

Overall, the approach to project implementation for FLPPS is broadly focused around increased primary care access via additional capacity or improved and efficient processes, as applicable.

INFORMATION TECHNOLOGY

Primary care services and care management are core to the continuum of care that will allow FLPPS to better serve the patient population and develop a robust population health infrastructure. FLPPS is developing an IDS that will include interoperable data exchange capabilities, registries, and care management tools to manage and prevent chronic illness. This extensive IT infrastructure will support primary care providers as they continue to implement the primary care strategies outlined in this plan.

All FLPPS contracted PCPs (along with other provider types) that are Health Insurance Portability and Accountability Act (HIPAA) covered entities have contracted with the RHIO to complete a plan by March 31, 2017 that includes the following components:

- Direct messaging
- Alert notification
- Query portal access
- eResult delivery
- Bi-directional data sharing - EHR integration

This plan will enable PCPs to participate in real-time care coordination and a true patient centered care model. The RHIO is also in the process of creating customized alerts for PCPs that are part of larger health systems so they can manage alerts more efficiently and effectively and optimize PCP workflow.

In addition, this model will ultimately allow Health Home care managers to be fully integrated and connected to data to provide support for the services that are key to care management but outside the realm of primary care providers.

As FLPPS identifies providers that are not HIPPA covered entities but have a significant impact on outcomes, FLPPS will develop work plans to ensure that these organizations, such as CBOs, can collect and share information that is key to the success of the Network's population health strategy too.

FLPPS Partner portals will also be developed to provide performance based dashboards for PCPs so they can monitor performance on DSRIP quality outcome measures as part of the overall population health strategy.

COMMUNITY-BASED ORGANIZATION ENGAGEMENT & SOCIAL DETERMINANTS OF HEALTH

As NYS has recognized, it has been cited in numerous studies and publications that the social determinants of health must be at the center of the discussion when focusing on the improvement of population health as it relates to health outcomes. In fact, sources such as County Health Rankings Modelⁱⁱ demonstrate that clinical care accounts for only 20 percent of mortality and morbidity rates, while social and economic factors as well as health behaviors and physical environment each account for 40 percent. In light of this information, we recognize that no one service provider (medical or otherwise) can have a significant impact over the improvement of population health alone. There is tremendous power in building an IDS that incorporates the medical community along with social and human services.

Since its inception, FLPPS has understood the importance of integrating CBOs into the IDS and their role in addressing the social determinants of health issues of our population. FLPPS has made a concerted effort to engage CBO Partners and has begun to develop funds flow strategies to incent the work of CBOs in all areas of our region. The intent moving forward is to dedicate a team to the work of CBO and consumer engagement, using the VBP Roadmap as the primary mechanism to prepare CBOs for their formal inclusion in Medicaid VBP arrangements. The DSRIP project-based work, and the inclusion of CBOs, will assist in demonstrating the efficacy of an integrated system and similarly prepare CBOs for the transition as it simultaneously prepares medical providers. This body of work will include the strengthening of existing referral relationships, and the establishment of new relationships, so that our region's patients can benefit from tight coordination between social services, medical services and behavioral health services to provide a true person-centered approach to care.

Key to the integration is the linking of primary care providers and offices with the services offered by the region's CBOs. Primary care providers will have the ability to "prescribe" interventions and services that aid their patients in meeting basic life needs and addressing the social determinants that impact their health. Under consideration are models such as the use of screening tools with minimum criteria followed by linkage with access to social workers and/or community navigators who understand local resources (potentially via telehealth technology). This rapid navigation model would provide an intense support mechanism to the effectiveness of primary care in improving health outcomes. Meanwhile, FLPPS will reasonably track the efficacy of those referrals as it relates to their patient's overall health. The robust IT infrastructure that FLPPS is building will facilitate closed loop referrals and develop the creation of

longitudinal records that gives the entire Network a new viewpoint that encompasses all services impacting the lives in the region.

PATIENT ENGAGEMENT/SELF-MANAGEMENT

FLPPS recognizes the importance of incorporating the needs and voices of our patients as we transform the delivery system. To that end, consumer advocates must be present in our governance model and “at the table” as we develop programs that aim to improve care and patient satisfaction. As a Network, we will assist our providers in providing culturally competent care that is truly patient-centered. This effort will be led by the FLPPS Cultural Competency and Health Literacy Committee and supplemented by the activities of our consumer engagement activities.

FLPPS is also mindful of the future state of Medicaid, and the importance of considering all recommendations coming from the NYS’s Advocacy and Engagement SubCommittee under the VBP Roadmap. The Committee has specifically guided the DOH and providers to consider:

1. The creation of a member incentive program
2. The development of Patient Reported Outcomes (PRO)
3. Defining what the Medicaid member has a right to know about VBP

Some of these considerations include methods to activate members, educate around proper system utilization, set health goals and provide information on preventative care, healthy lifestyle habits and disease management. FLPPS intends to support our Network, and the DSRIP Waiver Program, through a targeted consumer engagement strategy that includes these recommendations. This will be done through the creation of Patient Advisory Councils, and the support of Small Group Patient Education Forums, Community Stakeholder Forums, Representation in FLPPS Governance Committees and Workgroups, and Patient Focus Groups (which will include Medicaid Members and uninsured individuals). Feedback and input from Patient Focus Groups will be brought forth throughout the FLPPS committee and governance structure to ensure the patient voice is heard in the decision-making process.

The intent is to recruit a diverse group of individuals that reflect the opinions of their fellow community members. It is important to include these members in our discussions to garner feedback from the people we serve. In addition, FLPPS will target vulnerable populations to educate on topics such as self-management of conditions, techniques for effective interactions with service providers, and prevention of avoidable diseases and acute episodes. This body of work will not only assist in keeping patients at the center of our focused efforts and transformation, but assist in strengthening the relationships between the individuals we serve and the FLPPS provider Network.

FUNDAMENTAL #4: FLPPS STRATEGY TO ENABLE PRIMARY CARE PROVIDERS TO PARTICIPATE IN VALUE BASED PAYMENTS

In the FLPPS Network, it is estimated that about 90 percent of primary care providers are participating in an ACO/IPA arrangement. As FLPPS identifies strategies to enable primary care providers to participate in VBP arrangements, it is important to consider the readiness of those providers already participating in ACOs and other similar arrangement versus smaller, private practitioners.

Due to the corporate structure of FLPPS, created as a 501(c)3 with two corporate members, which are two large competing health systems, the PPS will not be a contracting entity in VBP arrangements. FLPPS will serve as a supporting resource for its providers, with the goal of assisting providers via strategic planning, education and implementation of systems design to facilitate the transformation to VBP. A key role of the PPS will be to inform and educate the partnership relative to the transformation to VBP. Key components of provider education will entail:

- Change management and Leadership support
- Financial resource planning and financial modeling
- MCO engagement
- Partnerships, collaboration and service delivery
- Clinical/Quality metric design
- Patient outreach
- Care management
- PC integration with BH/MH
- IT
- Workforce and training

The transition to VBP requires a lot of support and education for providers to be successful in moving away from the current fee for service model. VBP represents a significant shift in how providers will need to think in terms of service delivery and patient care. Organizational leaders and providers will need to develop new missions and goals for their organizations and lead them through the significant changes that will be necessary to transform to VBP. Successful transformation will be dependent on setting the right tone at the top of the organization.

Internally, FLPPS has developed a VBP workgroup to address the needs of its providers as the Network prepares for VBP. External stakeholders, experts and clinicians, will be informing the workgroup as strategic planning and education continues to move forward. This workgroup consists of internal FLPPS team members who are responsible for the financial, clinical and operational elements that critically affect the transformation to VBP. The workgroup also includes the FLPPS Executive Director, Executive Medical Director, Director of DSRIP Operations, Project Manager (Project 2.a.i), Controller, Director of CBO Engagement, Senior Director of IT and Analytics, and Director of System Transformation. The workgroup has developed a charter and will develop a workplan for demonstration year two (DY2) and beyond. The workgroup will be segmenting its areas of focus into several elements which will serve as the basis for

supporting the PPS's transformation to VBP and will include: PPS Education, Partner Financial Sustainability/Payment Model Readiness, Clinical/Quality Focus Group, CBO Engagement and MCO Engagement.

In order to successfully develop and implement a strategy to enable PCPs to effectively participate in VBP, it is important to understand that there are varying levels of financial readiness required to participate in VBP arrangements. We are in the process of assessing VBP readiness, to identify the appropriate support strategies based on the current readiness and ownership structure of providers. It is essential for smaller practices and private practitioners to work together and/or collaborate with larger health systems to be able to successfully participate in appropriate levels of VBP arrangements. FLPPS plans to provide educational opportunities for all PCPs in the Network to ensure that they have the information necessary to make appropriate decisions about level of financial risk these providers are able and willing to take.

The transformation to VBP will require significant financial resources to support the new systems, workforce, workflow designs, and payment methodologies that will be inherent in VBP. The finance workstream of VBP planning is comprised of identification of the financial resources that will be necessary to support the transition to VBP and financial projections modeling. Identification of the financial resources will include establishing the minimum financial reserves necessary to enter into VBP contracting arrangements. IT systems implementation and workforce support are also financial resources necessary to make the transition to VBP. Identifying the level of risk that an organization is willing to tolerate in VBP will be determined through risk sharing analyses to ensure that organizations develop VBP contracts best suited for them. Financial models that incorporate the new reimbursement structure under VBP will also be beneficial for organizations to better understand VBP contracting. The support of financial resources will better prepare providers to make the transformation to VBP.

Clinical and quality measures are key components of VBP arrangements. It is crucial for providers to fully understand the data and reporting requirements along with the goals of such measures. This also requires providers to familiarize themselves with the standard quality metrics for bundles of care. In an effort to reduce the duplication across different programs, NYS has made it a priority to align its VBP roadmap with DSRIP quality outcomes. PCPs need to understand what these measures are and how to best develop the appropriate internal strategies to meet the goals associated with these measures. In order to support providers in this endeavor, FLPPS has developed and continues to improve contracting and funds flow strategies for DSRIP funds that prepare providers to bear risk and be held accountable for reporting and meeting these outcomes. Providers should transform delivery and clinical protocols so that they can achieve the quality metrics that will be included in VBP arrangements.

FLPPS plans to educate and support providers to better understand how to align their services with bundled payments for VBP arrangements and the key components of care transition plans and full spectrum of care coordination. Providers, in small practices, will also need to identify which organizations they should collaborate with to better serve their patients for these bundled payments. These are all key points in the development of an IDS at FLPPS, in which PCPs play a key role. FLPPS also wants to ensure that PCPs and hospitals have the access and capabilities to develop partnerships with each other and other

provider types in the Network, to ensure appropriate care transition plans are developed and carried out. FLPPS has focused efforts on regionalization to understand referral and partnering relationships, that can lead to future ACO arrangements and readiness for VBP. The PCMH expert team continues to provide education on team-based care to prepare for future VBP arrangements as well. Successful treatment of patients in the Medicaid population will require coordination with behavioral and mental health. The integration of behavioral health and primary care is a particular area that will require some shifts in traditional approaches to care and provider's way of thinking. FLPPS will leverage Project 3.a.i (Integration of Behavioral Health and Primary Care) to educate and prepare behavioral health and PCPs to develop the appropriate infrastructure to enter into successful VBP arrangements.

A major initiative of an integrated delivery network is to improve care management and increase communication along the continuum of care. One of the roles of the primary care physician in the IDS is managing and coordinating the care of patients to keep patients out of the ED for unnecessary visits. Focusing on preventative healthcare will decrease the cost of providing healthcare to patients in the emergency setting in the future. Under the Advanced Primary Care (APC) model in the VBP Roadmap, it is anticipated that primary care providers will benefit from this arrangement in the form of shared savings when the cost of patient care is decreased for decreased ED usage. Successful care management of the Medicaid patient population will be critical to shared savings on patient medical costs. This care management will allow PCPs to successfully make the transition to VBP.

VBP arrangements will clearly impact workforce for PCPs as the focus of care continues to transition to the primary care setting. These providers will need to prepare with the adequate levels and numbers of trained staff to ensure success in VBP. FLPPS understands this need and the importance of including workforce in its VBP strategy, and this is something that aligns with current workforce strategies across the Network. Additional strategies specifically tied to VBP goals will be developed as FLPPS continues to better understand the readiness of the providers in its Network.

The appropriate IT infrastructure is key in VBP success. FLPPS has integrated IT components into its VBP strategy to help support the PCPs in the Network. The PPS will support the PCP network by providing educational sessions around building the IT infrastructure and appropriate management while using it to make decisions. The overall population health platform and strategy will provide additional support for PCPs to better prepare for VBP arrangements as well. FLPPS is currently reviewing options to hire consultants to help deploy IT strategy for appropriate VBP arrangement levels. For successful care management, PCPs will require resources that include information management, workflow support, financial analysis, data analysis, population health management and connectivity/information exchange, all of which are included in the overall IT strategy as described in previous sections.

The main focus of the current strategy for FLPPS to enable primary care providers to participate effectively in VBP arrangements is centered around Partner education. MCOs and providers need to commence discussions around VBP strategies and work in a collaborative manner to achieve the goals of VBP. Meanwhile, FLPPS continues to actively meet with MCOs in the coverage area. One of the FLPPS's partners has successfully completed a safety net value based contract with an MCO. FLPPS is also collaborating

with FLHSA in a SIM grant for advanced primary care to further prepare the Network for VBP. FLPPS will continue to focus on efforts to better understand the level of readiness of the PCPs in its Network and continue to refine its Primary Care Plan strategy around VBP.

FUNDAMENTAL #5: FLPPS FUNDS FLOW SUPPORT FOR PRIMARY CARE STRATEGIES

During the early DSRIP planning stages, FLPPS developed budget categories to ensure adequate funds are available to support the success of Partners across the PPS. The categories that will allow FLPPS to flow dollars to Partners based on different requirements include: sustainability, contingency and Partner share of funds. The primary category that has been used to flow funds to Partners is the Partner share of funds, which was established to allow up to 65 percent of all incentive payments to flow directly to Partners. These funds have been used for the first phase of contracting and funds flow to Partners. The current contracting and funds flow strategy incorporates the work of PCPs to ensure that the goals set forth in the Primary Care Plan are successfully carried out while providing sufficient resources to these providers. To date, FLPPS has flowed approximately 12.7 percent of Partner share dollars to PCPs and clinics, and 84.7 percent to health systems, which employ 67 percent of our PCPs. These funds have incentivized activities that are actively supporting the PCP network for the shifts in care expected as a results of transformation funded by DSRIP. In the initial contracting and funds flow stages, FLPPS primarily incentivized engagement and planning activities to provide adequate funds for Partners to begin developing the initial infrastructure required for success in future achievement of PPS metrics and milestones. In the more recent contracting cycles, more specific PCMH deliverables have been identified that primary care providers are expected to complete in order to receive associated dollars. Other projects and/or workstream deliverables have also been identified for contracting purposes that incorporate PCMH activities and overall primary care strategies.

FLPPS is currently developing a set of second phase of contracting and funds flow strategies, that will further incorporate and more directly incentivize the work related to the PPS primary care strategy and related PPS-level outcome measures. As part of Phase II contracting, an Innovation Fund is being developed that will provide an opportunity for those providers in the Network that have developed objective and measurable innovative approaches to clinical care delivery, to apply for funds outside of the traditional funds flow and contracting process. These funds will incentivize transformation efforts and measure success for qualifying Partners. FLPPS is also in the initial stages of rolling out Special Contracting Arrangements for Project 3.a.i (Integration of Behavioral Health and Primary Care) and Project 2.d.i (Patient Activation) that will focus on immediate needs for those two projects, which include primary care providers as well as care management functions.

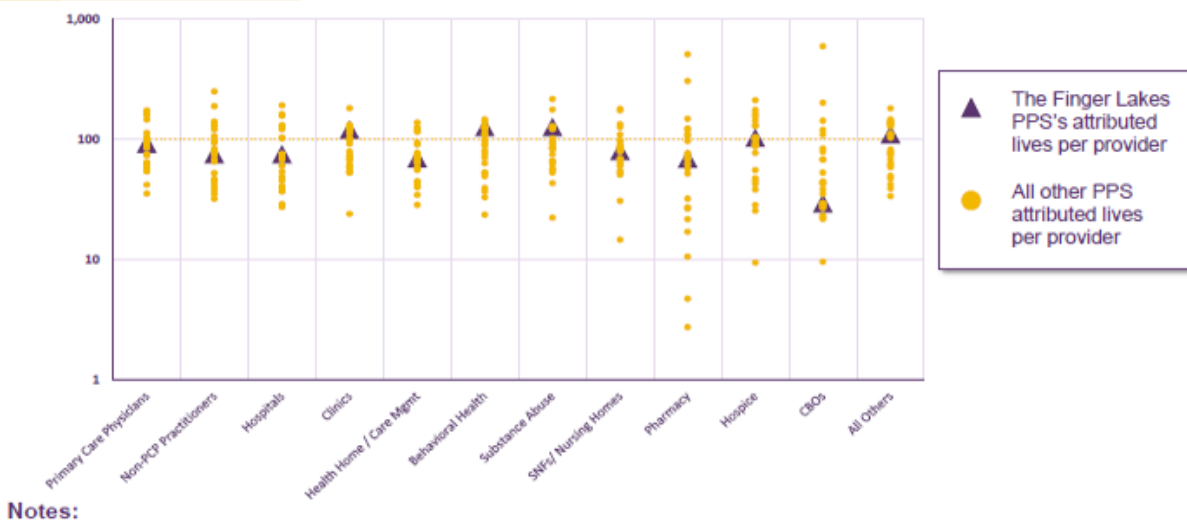
Lastly, FLPPS is also in the midst of a process to identify the available and appropriate shared services for the 13-county region. Using funds received for the PPS achievement thus far, the PPS will invest in standardizing and expanding the needed non-clinical shared services that are essential in improving primary care and reducing costs, such as building non-clinical wrap-around services for care management. A shared services infrastructure will be built to maximize responsible stewardship of the limited Medicaid dollars and ensure long term sustainability of all services (both clinical and non-clinical) post DSRIP. Overall, FLPPS continues to identify opportunities to ensure that primary care providers receive the appropriate incentives to support the efforts to meet goals of the primary care strategy for the region.

FUNDAMENTAL #6: FLPPS PROGRESS TOWARD INTEGRATING PRIMARY CARE & BEHAVIORAL HEALTH

Approximately 35 percent of FLPPS Medicaid members are defined as behavioral health recipients. Those with behavioral health diagnosis are high users of health care services. Behavioral health recipients drive 63 percent of all ED visits. Behavioral health recipients represent 65 percent of admissions to hospitals and on average have a 2.1 times longer length of stay in hospital than non-behavioral health recipients. 10.6 percent of behavioral health recipient population have no recorded primary care visit and represents an opportunity for future primary care engagement.

Integrating primary care and behavioral health is a FLPPS priority, as this is crucial to understanding our patient’s holistic needs and improving health outcomes. The challenges towards integration include the current statutory regulatory environment and behavioral health workforce shortage. For FLPPS, behavioral health and substance abuse providers serve an above average number of attributed lives when compared to other PPSs (see *Figure 8*). This volume impairs providers’ ability to provide appropriate and timely care to their patients.

Statewide distribution of attributed lives served by each provider (average = 100)



Notes:

- This analysis includes all providers

Figure 8 – Attributed Lives served by Provider Type

Within these challenges, FLPPS is moving forward on a path towards integrating care. One hundred eighty-seven sites have contracted with FLPPS during the DY1 performance periods. Of these sites, approximately 59 plan to participate in Project 3.a.i. (Integration of Primary Care and Behavioral Health) in DY2. Forty-four sites report having behavioral health staff available and on-site now. The majority of sites selected Model 1 for implementation, although there are a handful of sites who plan on implementing Model 2 (reverse integration- behavioral health host site). These Model 2 sites are finding it challenging to get started as they lack a partner with whom they can share space based on the current

restrictions among distinct provider entities. We will continue to work within the confines of statutory regulations to further develop these Model 2 sites, and advocate for regulatory relief of shared space restrictions.

FLPPS has identified and supported eight Article 28 licensed primary care sites that have, or are expected to apply for, increased licensure threshold under Project 3.a.i. (Integration of Primary Care and Behavioral Health), with the aim of integrating behavioral health services under the DSRIP Project 3.a.i. licensure threshold. We expect these sites to be integrated by the end of this calendar year. Approval of these LRAs (Limited Review Application) will allow these sites to conduct warm handoffs, and to see an increased number of patients with behavioral health concerns, rather than referring them elsewhere. Despite this initiative, concerns remain for many of our licensed primary care and behavioral health providers alike, considering the lack of guidance on shared space arrangements for two separately licensed entities to co-locate their services within the same facility.

Currently, we have two organizations that have implemented the Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) Model (Project 3.a.i. Model 3): The University of Rochester Medicine (Highland Family Medicine) and Anthony Jordan Health Center. We have a third site that was accepted into the DSRIP Collaborative Care Learning Network, with plans to fully implement IMPACT by the end of calendar year 2016. We will continue to work towards identifying sites that may benefit from this model and promote the sharing of experience and knowledge provided through the Learning Network activities.

Collaborative efforts to disseminate lessons learned include the URMHC hosting the 1st Western NY Collaborative Care Summer Symposium on June 24, 2016. The symposium was well attended by providers throughout the FLPPS region. The agenda included presenters from the University of Rochester and the University of Washington’s Advanced Integrated Mental Health Solutions (AIMS) Center, and featured a roundtable discussion on overcoming collaborative care implementation challenges.

In order to mitigate the project risks related to the FLPPS behavioral health workforce shortage, our Behavioral Health Workforce team has introduced a series of meeting sessions with the aims of identifying our current state specific provider type shortages (priority positions), identifying opportunities to address barriers to current supply and developing a strategy to address supply constraints in the future state. Out of our initial discussions emerged two key focus areas: the need to expand the reach of current providers, and the need to work closely with local academic institutions in further developing a workforce strategy for community-based providers.

URMC has been conducting ECHO® clinics for geriatric practices, as well as a geriatric mental health version for our nursing homes participating in Project 3.a.v. (Behavioral Interventions Paradigm in Nursing Homes).

Telepsychiatry and the extension of clinical services provision beyond the typical reach accomplished with brick and mortar facilities has enabled some of our FQHCs and primary care providers to gain access to specialist care, including behavioral health care, where local providers are scarce or non-existent. One of our rural based FQHCs, Finger Lakes Community Health, has embedded telepsychiatry and telechild

psychiatry in its nine health center sites to decrease barriers to care and increase access to care. FLPPS has also begun to examine the use of existing local telepsychiatry programs to fill the role of psychiatric consultant within those sites who will be implementing the IMPACT model of collaborative care, as support to the primary care practice and the Depression Care Manager in treating and tracking efficacy for patients with depressive symptoms.

Lastly, we understand the necessity to collaborate closely with local academic institutions in workforce development. The University of Rochester (UR) has sponsored scholarship programs for care managers, baccalaureate degree-prepared nurses and mental health nurse practitioners. UR also has master's programs in mental health counseling and marriage and family therapy, which will assist in providing trained behavioral health providers that would become key members of the team of integrated care professionals and paraprofessionals. St. John Fisher College has a Psych NP program as well as the UR School of Nursing. St. John Fisher College, recently received a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to train graduates from their nursing, pharmacy, and counseling programs in Screening, Brief Intervention and Referral to Treatment (SBIRT). FLPPS is currently collaborating with that program's leadership on how to best work together and integrate this rich workforce resource into primary care and other health care settings where screening for alcohol and substance abuse is most needed. We are also collaborating with other PPSs. We are reviewing Montefiore Health System's continuum-based framework as a potential tool to assess provider readiness for the integration of behavioral health into primary care.

CONCLUSION

Our Primary Care Plan will continue to evolve as we move through its implementation. We have had multiple inputs into this primary care strategy from large and small primary care practices, administrators, local healthcare community organizations and committees. The next step will be a listening tour with individual primary care practices to facilitate face to face conversation. This approach will provide a forum for understanding the current state of primary care in our region, as well as the challenges and barriers to overcome as we further develop our strategy to support primary care through DSRIP and system transformation on the road toward value-based payment.

ⁱ The Impact of Project ECHO on Participant and Patient Outcomes: A Systematic Review

Carrol Zhou, MD, Allison Crawford, MD, Eva Serhal, MBA, Paul Kurdyak, MD, PhD, and Sanjeev Sockalingam, MD, MHPE. [Acad Med.](#) 2016 Aug 2

ⁱⁱ Source: University of Wisconsin Population Health Institute. County Health Rankings 2013. Accessible at www.countyhealthrankings.org