NEW YORK STATE | Department of Health

# DSRIP Mid-Point Assessment

## Primary Care Plan

**PPS Name:** Samaritan Medical Center

1. **Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.**
   - **PPS's over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primacy Care capacity)**
   - **How is the PPS working with community-based PCPs, as well as institution-based PCPs?**

**NCI Assessment of primary care capacity, performance and needs:**

The North Country Initiative conducted a comprehensive Community Needs Assessment to determine and develop DSRIP initiatives that included assessment of primary care capacity, performance and needs. Data obtained from the DSRIP Community Needs Assessment (CNA) details that residents are living without a primary care physician, with a Medicaid beneficiary primary care visit rate 20% below the state rate, 259.8 visits per 1,000 member months vs a state rate of 315.7 visits. Of Medicaid residents surveyed, 47.5% noted visiting an emergency department within the last year. The PPS region has an ER visit rate 32% higher than NYS rate, 69.7 vs a state rate of 46.7 and exceeds the NYS rate on every single adult prevention quality indicator (PQI) composite for avoidable hospitalizations. Of the 33 primary care sites participating in the PPS, none had achieved PCMH 2014 and only 33% (13) had achieved PCMH 2011, all others either had never attempted PCMH or have allowed 2008 certification to lapse.

While care coordination and connectivity with community based services is critical, the most significant immediate need if the region was to be successful at addressing preventive care for the Medicaid and uninsured population was to grow the primary care, dental and behavioral health licensed health professional workforce. NCI could not connect people to primary care that simply didn't exist. The NCI recognized that we must focus efforts to increase primary care, psychiatry and dental capacity. The Tug Hill Seaway Region has been federally designated as a Low-Income Medicaid Health Professional Shortage Area (HPSA). There are significantly fewer active primary care providers (74 compared to 120 NYS), dentists (44 compared to NYS 78) and mental health professionals (Psychiatrists 17 compared to 36 NYS) per 100,000 population, practicing in the Tug Hill Seaway Region than statewide or upstate New York as illustrated in the table below.

| Occupation | Tug Hill Seaway (per 100,000) | Upstate (per 100,000) | State (per 100,000) |
|---|---|---|---|
| Primary Care Physicians | 74 | 100 | 120 |
| General/Family Practice | 31 | 33 | 26 |
| Internal Medicine | 23 | 38 | 55 |
| Pediatricians | 12 | 18 | 26 |
| Obstetricians/Gynecologists | 9 | 11 | 14 |
| Dentists | 44 | 62 | 78 |
| Physician Assistants | 46 | 88 | 61 |
| Nurse Practitioners/Midwives | 60 | 94 | 76 |
| General Psychiatrists | 17 | 20 | 36 |
| Psychologists | 16 | 32 | 52 |

*Source: Martiniano R, Siwach G, Krohl D, and Smith L.* New York State Health Workforce Planning Data Guide 2013. *Rensselaer, NY: Center for Health Workforce Studies, September 2013.*

**Plan for addressing identified needs that has been carried out:**

Physician champions and care coordinators have been identified for each practice to ensure PC is center of continuum of care for assigned patients. The PPS is resourcing all primary care providers within the PPS with PCMH Coaches and CCEs to meet Meaningful Use and NCQA Level 3 PCMH by end of DY 3 to ensure that all Medicaid populations with-in the PPS have access to advanced primary care. In addition, all PCs will be required to actively share information through connection to the HIE with Direct alerts and patient look-up (during the assessment phase, only 18 of the 39 PC sites, less than 50%, are utilizing HIE), and to a patient registry population health management (PHM) system.

Expanding primary care capacity has been and continues to be an important and successful focus of NCI as detailed in the next section. In addition to support all new and existing providers to address the need for high quality chronic and behavioral health care in the primary care setting, staff training on PCMH including evidenced based prevention and chronic disease management is being required and conducted including preventive care screening for PHQ-9 and Substance abuse for all Medicaid patients with a dedicated referral process. Actively utilizing EHR's and other IT platforms, the NCI PPS is transforming the delivery system to provide a high-quality, efficient and patient-centered system for our PPS.

**a. PPS's overarching approach to expanding Primary Care capacity and ensuring the provision of required services (including , as appropriate, addressing gaps in primary care capacity)**

The PPS's approach to expanding care capacity has been from the beginning to commit significant funding to the recruitment of primary care providers to the region in addition to promoting after hours and weekend care and integrating primary care and behavioral health. The NCI developed and launched a provider recruitment incentive program which has had significant success. The NCI developed a Provider Incentive Program aimed to assist partners with the recruitment of professionals to the region. To date, approximately $3M has been distributed to partners for the successful recruitment of 11 PC Physicians, 2 Nurse practitioners, 3 PAs, 2 Dentists, 2 Psychologist, and 2 Psychiatrist. Each of these recruits not only increase the overall capacity but also the capability to provide integrated care for our Medicaid population. NCI's participating FQHCs have had significant success utilizing these incentives that have previously made it very difficult for them to compete for scare physicians from outside the region.

**b. How is the PPS working with community-based PCPs, as well as institution-based PCPs**

The PPS is working with community-based PCPs in the same manner as the institution based PCPs. NCI is physician led thus has high engagement from community based FQHCs and independent PCP practices. These practices are engaged in multiple projects and all are striving to reach PCMH, have committed to care management and are implementing the PPS adopted clinical guidelines for cardiovascular disease and diabetes. The Chairman of the NCI board is an independent community-based primary care physician as is the 3.a.i Impact Model lead practice physician and two of the PPS DSRIP Medical Directors. These community based physicians have proven to be forward thinking, engaged and highly capable leaders.

**2. How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?**

- **What are your PPS's plans for working with Primary Care at the practice level, and how are you supporting them to successfully achieve PCMH/APC? (Resources could include collaboration, accreditation, incentives, training/staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.)**
- **How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?**

The PPS is requiring all primary care providers within the PPS to meet Meaningful Use and NCQA Level 3 PCMH by the end of DY3 to ensure all Medicaid populations within the PPS have access to advanced primary care. Of the 42 primary care sites participating in the PPS, 3 have submitted for PCMH 2014 and 2 have been recognized. The remaining practices are on track to transform, submit and receive PCMH Level III recognition by the 3/31/2018 DSRIP deadline. Each practice has been provided with a PCHM CCE coach from the PMO who provides technical assistance with the implementation and submission of PCMH. Additionally, the PPS is leveraging the support of eHealthcare Consulting for practices that are located more remotely.

Physician champions have been identified and trained and care coordinators have been resourced for each practice to ensure primary care is the center of the continuum of care for assigned patients. The care managers are resourced for care connectivity internally, as well as connectivity to care managers and other primary care or community support services. These care managers are resourced to identify and refer eligible patients to health home services and where necessary, embedded health home care managers will be placed in the practices to fill care gaps. Community health workers, care managers and patient navigators are developing and implementing PPS wide protocols and processes for engagement of community support services (i.e. housing, transportation, CDEs, dentists) and focused referrals of health home services, home care agencies, palliative care, and primary care practices. With the assistance of HIT staff, systematic record transitions and patient engagement activities (meeting PCMH requirements) are being developed and implemented by primary care and BH providers. Cross functional teams are being established, ensuring patients receive appropriate, integrated care including medical and behavioral, post-acute care, long term care and public health services.

In addition, all PCs are either already or in process to actively share information through connection by the HIE with Direct alerts and patient look-up, and to a patient registry population health management (PHM) tool. Primary care sites will use the PHM to identify patients who are appropriate for care management. The practice will establish a systematic process and criteria for identifying this target population including

considerations for the following: behavioral health conditions utilizing substance abuse screening and PHQ2/9, high cost/utilization, poorly controlled or complex conditions, social determinants of health, and referrals by outside organizations, practice staff or patient/family/caregiver. Actively utilizing EHRs and other IT platforms, the NCI PPS is transforming the delivery system to provide a high quality, efficient, and patient-centered system for our PPS.

The NCI is resourcing funds to primary care practices for care management services to ensure project deliverables are met in accordance with the overall DSRIP goals. This deliverable based funding is assisting practices with the development of care coordination teams to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management. The NCI is also incentivizing the practices to achieve PCMH when they receive their recognition from the NCQA. Incentive payments through engagement as subject matter experts are also available to the practices through their response to PPS developed RFPs (i.e. project 2biv care coordination at primary care and project 3ai – all three models of integration).

Staff training on PCMH including evidence-based prevention and chronic disease management will be conducted. Other trainings to support PCPs include:

- 11 trained PCHM Certified Content experts to include staff from the PMO office, one from each of the 6 hospital Article 28 clinics, the 2 FQHCs and an independent PCP office to ensure direct support for the practices with their PCMH practice transformation
- 6 SBIRT trainers in the region and over 200 trained in SBIRT
- 3 trained as Tobacco Dependence Treatment Specialists
- 8 individuals from the Collaborative Care (IMPACT Model) PCP sites have been trained through the University of Washington AIMS Center as Depression Care Managers and 1 Consulting Psychiatrist has been trained
- 1 private, independent practice is participating in the OMH Learning Collaborative for Collaborative Care, thus receiving additional technical assistance and training to learn and implement the Collaborative Care model. Additionally, they are eligible for a special monthly case rate per patient enrolled. The practice participating is also serving as the PPS' subject matter expert, thus sharing what they have learned to assist others in the PPS with implementation.
- 25 individuals (PCMH staff, PCP, NP, RN, LPN, Psychiatrist and Office Manager) from the 4 IMPACT sites completed a full day, onsite training with the University of Washington AIMS Center
- Over 100 trained in evidence-based blood pressure measurements
- 23 Care Managers trained as Chronic Care Professionals through the online, self-directed program with the Health Science Institute
- NCI customized videos to include DSRIP 101, Health Literacy and Cultural Competency and MEB promotion, prevention and treatment

- Ask Me 3 patient education campaign to assist with patient engagement & literacy
- Compliance, privacy & security: The PPS Chief Information Security Officer and Compliance Officer are providing technical assistance in collaboration with The Compliancy Group to help partners meet required DSRIP and regulatory compliance and security standards so they can continue to remain focused on patient care

Additionally, the NCI has utilized the state wide learning symposiums, the state-wide CIO leadership group (the NCI CIO is the co-chair) and other state sponsored resources/learning opportunities in order to gather and disseminate guidance, strategies, and best practices to our primary care partners.

Finally, recruiting, retraining and retaining professionals through strategic, effective methods such as human resource planning, incentivizing providers, providing education, training and career advancement, as well as workforce projections will improve the practice environment. The NCI is aligning and intersecting with existing state program efforts such as Doctors Across NY, Physician loan repayment, and healthcare workforce retraining initiatives to recruit, retrain and retain professionals. The NCI developed a Provider Incentive Program aimed to assist partners with the recruitment of professionals to the region. To date, approximately $3M has been distributed to partners (11 PC Physicians, 2 NPs, 3 PAs, 2 Dentist, 2 Psychologist, 2 Psychiatrist have been recruited). A LCSW and CDE incentive program is currently in development and will be launched soon as well.

The NCI continues to leverage FDRHPO's long-term pipeline efforts for career exploration and educational expansion with partnering institutions of higher education and is also exploring opportunities to expand and grow the local Graduate Medical Education (rural tract focus) by engaging tri-county region hospitals and FQHCs as rotation sites with at least a 3-year minimum commitment from residents upon completion of their training. The region recently submitted an application for the GME Development of Rural Residency Program grant issued by NYSDOH.

Lastly, the NCI is collaborating with proven workforce strategy vendors such as the Iroquois Health Alliance, the Northern Area Health Education Center and the Fort Drum Regional Health Planning Organization to analyze the IDS, identify workforce gaps, and leverage community resources, thus equipping our healthcare professionals with the skills and training to operate in a preventive, community-based system.

**3. What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?**
- **How will the PPS strengthen the continuum of primary Care and ensure meaningful linkages to necessary secondary and tertiary services?**
- **How is Primary Care represented in your PPS's governance committees and structure and clinical quality committees?**

The Samaritan Medical Center/North Country Initiative PPS's strategy for how primary care would play a central role in an integrated delivery system was identified and developed before DSRIP. The North Country Initiative is hospital capitalized, physician led organization operating with a Delegated Model of governance. The North Country Initiative was originally formed in 2011 as a collaboration of hospitals and independent

physicians who realized that change in the regions healthcare delivery system was needed. This group of forward thinking and engaged physicians and healthcare executives determined to create a vision and chart a new course for clinical care and for health in the region. The North Country Initiative partnering hospitals and physician leadership went through an intensive planning process in 2012 and 2013 and evolved into the basis for the existing governance through collaboration and trust focused on improving the regional healthcare delivery system. NCI has a robust history of success with implementing change, demonstrated through regional project implementation in areas like quality improvements, IT advancement, and physician engagement.

Therefore, when the Community Needs Assessment (CNA) through the work of the regional Population Health Improvement Plan (PHIP) identified areas of focus in this region, the NCI PPS seized the opportunity through DSRIP to facilitate the changes in healthcare that would lead to high-quality, low-cost, patient centered care. For instance, the region performed poorly compared to NYS on Prevention Quality Indicators and therefore existing providers committed to modifying their practice of care to address quality prevention through PCMH and to place a strong focus on cardiac, diabetes, COPD and mental illness and substance abuse prevention due to the prevalence of these diseases and the impact of avoidable admissions and emergency room visits. Similarly, the CNA identified the need for standardized protocols and capacity to grow for care management/coordination. Primary Community Based Care is the center of all PPS strategies and plays a leadership role across all decision-making processes of the integrated Delivery System (IDS).

**How will the PPS strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services?**

With the CNA identifying care connections as an area of focus, it led to the acknowledgement and work toward meaningful linkages to necessary secondary and tertiary services. In addition to the growth of care

management/coordination in inpatient settings, work has begun with an emphasis on care coordination being established between community-based supportive series and PC, between preventive services and PC, and between PC and outpatient mental health and alcohol and substance abuse, through the placement of Care Managers at all PC settings in the PPS. At a high level, these care managers use technologic platforms such as EHRs and RHIO's to coordinate patient care across multiple settings to include clinical, both inpatient and outpatient, as well as creating and maintaining linkages between necessary services to include behavioral health, health homes, and community based resources.

Discreet screening data fields for chronic disease and behavioral health needs have been developed and are supported in PC's EHR systems across the region. Referral processes to behavioral health providers have begun to be addressed through the integration of primary care and behavioral health. Referrals to chronic disease programs such as NDPP and CDSMP are being developed and adopted by all primary care practices to ensure patients have the necessary supplemental support needed to manage disease for their improved health and efficiency of care.

The NCI PPS utilizes the North Country Health Home (NCHH), which has been included throughout the planning and has a key role in the NCI IDS. Downstream providers are at many of our secondary and tertiary service sites, as well as embedded care managers in settings such as Primary Care, Emergency Departments, and CBO's. The strategic locations lend to the ability to meet the patient where they are at and either use it as

an opportunity to link them to primary care or to use the primary care setting as an opportunity to connect them with the support services designed to address social determinants of health.

For project 3bi-Cardiovascular, specialty involvement includes one independent cardiology group which includes two cardiologists and two nurse practitioners, two hospital employed cardiologists, and two pharmacies. Our Partnering Specialists are used within our 3bi scope of work for the following:

- Subject matter expertise in Cardiovascular disease, to include Hypertension
- Subject matter expertise in Medication Adherence, medication reminders, tier level drug coverage, drug interactions and safety concerns
- Selection of National Evidence Based Guidelines
- Proper Blood Pressure attainment training
- Referral follow up and information required
- Care Coordination assistance
- Blood Pressure Screenings
- Quality Measure tracking and capture

For project 3ci-Diabetes, specialty involvement includes two pharmacies, one independent and two hospital based Certified Diabetes Educators, dieticians at multiple locations, two independent ophthalmology groups, one independent Optometrist, and multiple diabetes prevention sites. Our Partnering Specialists are used within our 3ci scope of work for the following:

- Subject matter expertise in diabetes, to include prevention
- Subject matter expertise in Medication Adherence, medication reminders, tier level drug coverage, drug interactions and safety concerns
- Selection of National Evidence Based Guidelines
- Referral follow up and information required
- Care Coordination assistance
- Prevention programs and support
- Quality Measure tracking and capture
- Nutrition and dietary expertise
- Diabetic retinopathy exams and follow up

**How is Primary Care represented in your PPS's governance committees and structure and clinical quality committees?**

The NCI PPS is a robust network of providers across the care continuum with Primary Care playing a significant leadership role. NCI has its governance structure fully in place, with a highly engaged clinician led Board of Directors, with 16 clinicians serving on the 23-member board (70%). The 16 clinicians are 2 behavioral health providers, 7 independent providers, and 7 hospital employed providers, with 11 of the 16 being primary care clinicians. NCI's full committee structure brings together partners from across all sectors of the PPS with Primary Care including, hospitals, long-term care facilities, primary care practices, specialty practices, behavioral health, alcohol and substance abuse providers, OPWDD providers, prevention providers, independent living centers, advocacy groups, education partners, public health, FQHCs, local government units and multiple other CBOs serving the target population.

The North Country Initiative medical management governance committee is led by clinicians (10 MD's, 2 Physician Assistants, and 1 Pharmacist; of these 5 are independent physicians, 6 are hospital employed, 1 is a psychiatrist at a community based behavioral health facility, and 1 is an independent pharmacist) and has the responsibility for the regions clinical projects. In addition, NCI has secured three DSRIP Medical Directors, all of which also actively see Primary Care Patients and are undergoing PCMH 2014 recognition. These PC Physician Champions lead the Medical Management Committee which holds specific responsibility for 3.b.i. and 3.c.i and has full oversight of all standardize protocols for DSRIP and has selected clinical pathways and evidence based national guidelines for; Hypertension, Diabetes, and Cardiovascular disease; risk stratification models for high risk patients; and, behavioral health screening (substance abuse and PHQ9). In addition to the ongoing work of monitoring and researching evidence based medicine, this committee is responsible for monitoring and ensuring that the clinical goals and initiatives are being realized.

In an effort to assist the medical management committee, project advisory committee, and ultimately the board of managers to guarantee our PPS realizes clinical outcomes and goals, a population health management tool is in the beginning stages of being utilized to provide per provider quality reporting. It will receive data from electronic health records and will be utilized to create a comprehensive dashboard for real-time monitoring of performance against DSRIP quality measures. The aggregated data will provide the PPS physicians and partners with timely feedback of their performance and give them the information they need to deliver proactive, comprehensive, and collaborative patient care and will provide the Medical Management Committee and board with the means to monitor for accountability and achievement of improvements tied to incentives.

NCI physician led governance continues to push for a culture change in healthcare from encountered based reimbursement to a system focused on care plans, care coordination, and preventative medicine. NCI works through committees particularly the Population Health Management committee, the Health Literacy and Cultural Competency Committee, the Medical Management Committee, the Board of Managers, and the Medical Directors to continue to shift the culture and beliefs of the region.

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

- **How will key issues for shifting to VBP be managed? (e.g. technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals/emergency departments (EDs), creating transition plans, addressing workforce needs and behavioral health integration)**

To date, considerable progress has been made to educate and understand our partner's needs, beliefs and gaps concerning value based payments. The Value-Based Payment Baseline Assessment was developed to demonstrate the current state of value-based reimbursement among PPS partners. The assessment identified needs for the revenue that is linked to value-based payment, education, preferred compensation modalities for different provider-types, and MCO strategy. Currently there have been over 100 responses to this survey, detailing a wide variance in our partners understanding and ability to take on VBP.

NCI continues to be dedicated and committed to VBP and our partner's knowledge around this critical shift in healthcare payments. To date, NCI created and sent out multiple educational opportunities that include: Debrief on NYS VBP Roadmap, VBP Glossary, VBP Strategy webinar, Case studies, VBP Fast Facts. NCI also promoted and sent many of our partners to the VBP boot camps and whiteboard videos.

Our continued commitment is shown through future plans to increase education. NCI is committed to our PPS MCO Strategy, education through VBP case studies, growing our experience and partnership with region's Accountable Care Organization, enhanced leadership of VBP committee, and VBP trainings.

While our educational/training opportunities continue to be robust, NCI acknowledges that it's not all about education. Specific resources and tools have been identified. Care Coordination, Population Health Management, and Quality improvement/tracking, are a few of those highlighted requirements. NCI is pleased with our PPS achievements in those categories thus far. Currently NCI is implementing a population health management tool that will allow us to aggregate and track both quality and cost measures across the PPS. NCI has also begun to implement a significant care coordination platform that is being executed on three different levels. Our care coordination platform is built around a standardized approach to training, policies and protocol's that each entity will have a responsibility for.

NCI's provider population is made up of approximately 90 entity partners with approximately 150 individual sites. There are behavioral health sites, hospitals, community-based organizations, primary care practices, FQHCs, County sites, EMS services, health homes, hospice, housing providers, long-term care facilities, OPWDDs, Pharmacy, Non-PCPs, Urgent Care, and Home Health agencies all of which realize that healthcare is changing and are committed to the required transformation. NCI and its partners are well positioned to be able to be successful in VBP arrangements. Our PPS remains committed to be sustainable and provide effective quality care to the individuals they serve. Our strategy will always remain flexible to account for any future training requirements or enhanced knowledge needed to remain successful.

The following key issues for shifting to VBP will be managed by:

**Technical assistance on contracting and data analysis**
As noted above, NCI is currently implementing a Population Health Management Tool, Lightbeam. The Lightbeam Population Health Management (PHM) platform is designed to extract and aggregate real-time, discrete clinical data from multiple sources. The platform will provide a longitudinal view of patient populations by bringing together data from both in-patient and ambulatory settings, as well as from claims.

Through the implementation process, the platform will be interfaced with the thirty-four distinct electronic medical records (EHRs) used by providers who are actively participating in PCMH, PQRS, ACO, VBP contracts and DSRIP reporting and performance measurement. This platform will be used to help patients at high risk for adverse events get access to the care management services they need to engage in their own care. This tool will also give our PPS access to the needed information like cost data and specific disease states that will aid in our VBP initiatives and strategy.

NCI, also plans to utilize the North Country Health Compass. North Country Health Compass mines population or public health data to drive health outcome prioritization for specific neighborhoods, and select population segments within communities, counties, and the region as a whole. This data will be critical for both our PPS

and our MCO partners to understand the needs of our communities. This data will ultimately address our current needs but also allow us to track progress over the life of contracts and beyond.

**Ensuring primary care providers receive necessary data from hospitals/emergency departments**

NCI believes in obtaining the right information at the right time so that our providers can treat effectively with high quality, and reduced costs. To that point our PPS will continue our relationship with our region's health information exchange (HIE), HealtheConnections.

HealtheConnections brings together patient medical information from hospitals, medical practices, labs, imaging centers, and other health care providers to enable increased efficiency and overall quality of healthcare for patients across the region. The information is governed and managed by HealtheConnections through health information exchange (HIE).

Health information exchange is a secure flow of patient data among healthcare providers. The electronic medical records include histories, labs, images, reports, diagnostic tests, and other vital information that can be accessed with a patient's consent. HealtheConnections makes this information available and more easily accessible and as patients move from one healthcare setting to another, providers can view the patient's medical records from other healthcare professionals. The ability to share and exchange information is offered through a variety of services from HealtheConnections.

NCI acknowledges that this is not only about access to electronic data, it is also about adding a personal connection or a warm hand-off of patient data. To that point, NCI has built an enhanced strategy for care coordination that involves properly and effectively transitioning patients and their data to another healthcare entity to ensure proper continuity of care.

**Creating transition plans**

Reduction in unnecessary ER visits and re-admissions is a critical component to improving quality and reducing costs. The Care Connections Committee developed and approved a standardized care transition plan for our region. Each entity will be required to adopt and implement those protocols.

The care transition plans include key elements that are needed and requested by our receiving entities, so that they can provide the necessary follow up care leading to improved quality and reduced costs. The key elements of the care transition protocols are the following:

- Identification of Primary Care Provider
- Identification of Payer
- Identification of Care Manager/Care Team Members
- Risk Stratification
- EMR Flagging for risk
- Health Home referral
- Care Transition Plan
- Warm hand-off to receiving entity
- Electronic Record Transfer

**Addressing workforce needs**

Expansion of providers

The NCI developed a Provider Incentive Program to assist with the recruitment of primary care providers, behavioral health providers and dentists. This program is necessary to recruit and sustain services in our region which is classified as a health provider shortage are.

In DY1, there were 12 awards which resulted in the recruitment of 2 Nurse Practitioners, 4 Primary Care Physicians, 2 Physician Assistants, 1 Psychologist, 1 Psychiatrist, and 2 Dentists. In DY2, there were 10 awards, which resulted in the recruitment of 2 Primary Care Physicians, 1 Physician Assistant, 1 Psychologist, and 1 Psychiatrist. Another round of funding will be distributed in DY3. In addition, a new consulting psychiatrist was hired to resource the PPS. Additional programs are under development to ensure supervision is provided to LMSW and LCSW necessary to become LCSW-R.

Training and education

Value based payment arrangements require enhanced focus on clinical standardization and an enhanced focus on quality. Therefore, NCI's Medical Management Committee (MMC) has been leading the efforts in implementing Clinical Practice Guidelines and standardized training for preventative medicine. To date, the MMC has selected and began implementing clinical practice guidelines for Diabetes, Hypertension, Blood Pressure obtainment, Depression Management, Care Coordination, and Cardiovascular Disease.

- 11 trained PCHM Certified Content experts to include staff from the PMO office, one from each of the 6 hospital Article 28 clinics, the 2 FQHCs and an independent PCP office to ensure direct support for the practices with their PCMH practice transformation
- 6 SBIRT trainers in the region and over 200 trained in SBIRT
- 3 trained as Tobacco Dependence Treatment Specialists
- 8 individuals from the Collaborative Care (IMPACT Model) PCP sites have been trained through the University of Washington AIMS Center as Depression Care Managers and 1 Consulting Psychiatrist has been trained
- 1 private, independent practice is participating in the OMH Learning Collaborative for Collaborative Care, thus receiving additional technical assistance and training to learn and implement the Collaborative Care model. Additionally, they are eligible for a special monthly case rate per patient enrolled. The practice participating is also serving as the PPS' subject matter expert, thus sharing what they have learned to assist others in the PPS with implementation.
- 25 individuals (PCMH staff, PCP, NP, RN, LPN, Psychiatrist and Office Manager) from the 4 IMPACT sites completed a full day, onsite training with the University of Washington AIMS Center
- Over 100 trained in evidence-based blood pressure measurements
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- NCI customized videos to include DSRIP 101, Health Literacy and Cultural Competency and MEB promotion, prevention and treatment
- Ask Me 3 patient education campaign to assist with patient engagement & literacy

- Compliance, privacy & security: The PPS Chief Information Security Officer and Compliance Officer are providing technical assistance in collaboration with The Compliancy Group to help partners meet required DSRIP and regulatory compliance and security standards so they can continue to remain focused on patient care

**Behavioral health integration**

To date, much progress has been made toward the integration of Primary Care and Behavioral Health with a continued focus on the potential of this initiative to improve health outcomes of our region's patients. Addressing both the clinical needs and behavioral health needs of a patient is essential to being successful in VBP arrangements. Our partners are working on filling this need by creating opportunities to receive behavioral health and clinical advice in the care setting of their choice. Many of our partners are involved in bringing behavioral health to primary care offices or implementing primary care at a Behavioral Health site.

Currently Primary Care sites are undergoing a standardized training for Depression Care. This training teaches Collaborative Care. Collaborative Care is a specific type of integrated care developed at the University of Washington that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. Collaborative Care focuses on defined patient populations tracked in a registry, measurement-based practice, and treatment to target. This training will be fully implemented in those offices participating with the IMPACT Model.

**5. How does your PPS's funds flow support your Primary Care Strategies?**
- **What resources are being expended by your PPS to support PCPs in DSRIP?**

The NCI PPS has 31 safety net and 12 non-safety net primary care practices participating. Of the safety net sites, 25 are hospital based and 4 are Federally Qualified Health Centers. Project participation varies by PCP. The total number of participating sites by project can be found in the table below.

The PPS has targeted the PCPs as integral in care coordination and therefore, $700,000 per year has been allocated to these practices in DSRIP Years 2-4. In addition, PCMH recognition is a requirement of DSRIP and therefore, the PPS is giving financial support to each of the participating PCPs who are moving towards this recognition. For non-safety net PCPs, $25,000 will be awarded upon NCQA Level 3 PCMH recognition. For safety net sites, $50,000 will be awarded for the primary site and an additional $25,000 per site within the same entity. Provider Recruitment funding has also been distributed and, by DSRIP Year 3, will total $2.8 million. Over $2 million of these funds have already been approved for distribution to PCPs for their recruitment of primary care physicians, physician assistants, and other billable providers.

Phase 2 incentive dollars from the PPS will primarily be driven by the achievement of patient engagement targets as well as performance measures. The PPS' funds flow distribution methodology accounts for the allocation of funds based on the impact to the Medicaid population as well as the entity type's impact on the project. Below is a table to show the percentage of funds PCP's within the safety-net and non-safety net categories will receive.

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**Table 1: PCP involvement by DSRIP project and total percent impact as compared to all participants**

| Project | Number of PCP participants | Total SN PCP Percent Impact on Project | Total NSN PCP Percent Impact on Project |
|---|---|---|---|
| **2.a.i** | **43** | **34%** | **23%** |
| **2.a.ii** | **42** | **100%** | **100%** |
| **2.b.iv** | **38** | **52%** | **49%** |
| **2.d.i** | **5** | **7%** | **0%** |
| **3.a.i** | **31** | **86%** | **100%** |
| **3.b.i** | **38** | **99%** | **96%** |
| **3.c.i** | **38** | **99%** | **88%** |
| **3.c.ii** | **38** | **60%** | **57%** |
| **4.a.iii** | **8** | **16%** | **31%** |
| **4.b.ii** | **38** | **53%** | **47%** |

**Table 2: Total funds awarded to primary care practices and hospital-based primary care clinics**

| | DSRIP Year 1 | DSRIP Year 2 | Percent of Total Awarded |
|---|---|---|---|
| **Total Project Costs (Implementation & Services)** | | | |
| Provider Recruitment and Retention Strategies | $ 798,427.93 | $ 1,295,000.00 | 82% |
| Care Mgmt to Practices including Hospital Based | $ - | $ 700,000.00 | 100% |
| **Incentive Payments** | | | |
| Phase One | $ 678,456.89 | $ 340,252.64 | 43% |
| Phase Two: Pay for Process (PCMH) | $ - | $ 1,325,000.00* | 100% |
| **TOTAL** | **$ 1,476,884.82** | **$ 3,660,252.64** | |

***Payment will be made in the year NCQA Level 3 PCMH recognition is received**

Other resources that the primary care offices have received and will continue to be resourced, are the work of a compliance officer as well as a chief information security officer. These two employees of the PMO office have been to each practice and will continue to provide services to ensure compliance, privacy, and security for not only the benefit of the practice, but for the entire Clinically Integrated Network (CIN). Going forward, the PPS will also fund the cost of The Compliancy Group for Security Risk Assessments over the course of DSRIP, as well as providing a dedicated compliance coach for a 2-4 month period at each of the practices. This will help partners meet required DSRIP and regulatory compliance and security standards so they can continue to remain focused on patient care. In addition, much of the PMO work and staff can directly be linked to support of the practices, to include the development of several trainings, the path toward VBP, and the overall coordination of all projects across DSRIP.

**6. How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?**
- **This would include both collaborative care and the development of needed community-based providers.**

To date, much progress has been made toward the integration of Primary Care and Behavioral Health with a continued focus on the necessity of this initiative on the health outcomes of our region's patients. Like all work within DSRIP, the identification of the need for the integration of primary care and behavioral health, came from the Community Needs Assessment and has been a long-time focus of Fort Drum Regional Health Planning Organization (FDRHPO). The PPS works collaboratively with a well-established and well attended FDRHPO Behavioral Health Committee. The committee meets monthly and membership represents both clinical and community based organizations. The committee identifies local and regional gaps, develops strategies to address gaps and makes continual progress toward achieving DSRIP deliverables. There are several keep areas in which the PPS is progressing toward the integration of care:

Expansion of providers

The NCI developed a Provider Incentive Program to assist with the recruitment of primary care providers, behavioral health providers and dentists. In DY1, there were 12 awards which resulted in the recruitment of 2 Nurse Practitioners, 4 Primary Care Physicians, 2 Physician Assistants, 1 Psychologist, 1 Psychiatrist, and 2 Dentists. In DY2, there were 10 awards, which resulted in the recruitment of 2 Primary Care Physicians, 1 Physician Assistant, 1 Psychologist, and 1 Psychiatrist. Another round of funding will be distributed in DY3. In addition, a new consulting psychiatrist was hired to resource the PPS. Additional programs are under development to ensure supervision is provided to LMSW and LCSW necessary to become LCSW-R, which is the licensure necessary to bill in Article 28 facilities. Another program will resource and incentivize identified staff to become certified diabetes educators.

Access to care

The PPS has several sites that are leading in integrated primary care and behavioral health, which has helped in moving other providers in the right direction. Due to the identification in the Community Needs Assessment to integrate these services, some of our Medical Village (2aiv) projects have chosen to apply for the integrated license, but in the meantime they are locating both behavioral health and primary care under the same roof until it is feasible to specifically integrate the two services. This is a direct effort to make it more accessible, therefore easier for the patient.

Telemedicine units have already been deployed to several of our primary care sites and are continuing to be deployed to additional ones. These units allow for access to behavioral health services during all hours of operation regardless of the primary care's patient count, while also ensuring that all behavioral health providers are being utilized at their full potential impact for the region.

Training and education

Our current behavioral health providers, as well as community-based providers have been, and will continue to be trained in MEB topics. Around 200 individuals across the region have completed SBIRT training. The PPS has developed a Health Literacy and Cultural Competency video for providers and is in the process of creating a video to create provider awareness around mental, emotional and behavioral health promotion, prevention and treatment. The PPS will also utilize footage to create Public Service Announcements for the community at large. Regional partners have also facilitated community forums to address substance use issues, to educate the public, to address concerns and provide updates on prevention and treatment efforts.

In addition, Depression Care Managers are being identified at each primary care site and are being trained. Five individuals have completed the Depression Care Manager training and another three are in the process. 50 individuals completed an IMPACT Model/Collaborative Care webinar with the University of Washington AIMS Center and 4 primary care practices including physicians, nurse practitioners, care managers and a psychiatrist (approximately 25 total) completed a full day, onsite training with the University of Washington AIMS Center in July.

Clinical changes

Clinical changes are also taking place across the region. Specifically, every primary care site in the PPS is now screening for PHQ2/9 as a standard of care. All primary care practices are also receiving technical support from the NCI/FDRHPO project team. 2 practices in the region have already received Patient Centered Medical Home (PCMH) Level 3, 2014 standards. The fourth standard within PCMH, Care Management and Support, has a direct focus on behavioral health and social determinants, which drives progress toward collaborative care and the inclusion of community-based providers.

Analyzing and Planning

As always, the PPS is committed to continued analysis and region-wide planning to meet the behavioral health needs of the region. A draft metric database has been developed based on DSRIP metrics and Behavioral

Health Committee feedback. Data collection will include Project 3.a.i., 4.a.iii, regional substance abuse and mental health data as well as regional indicators impacting performance data. PPS data specialists are in process of reviewing databases and will create dashboards and timelines for data sharing with the committee and PPS partners to assist with workflow optimization, outcome metrics, and continued progress toward integrated care, treating the whole body.