Primary Care Plan Update 2017

Better Health for Northeast New York

September 29, 2017

Introduction

The New York State (NYS) Delivery System Reform Incentive Payment (DSRIP) Program´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent by 2020. To transform the system, the DSRIP Program focuses on the provision of high quality, integrated primary, specialty, and behavioral health care in the community setting, with hospitals used primarily for emergent and tertiary levels of service. The integration of services and the path to value-based care puts primary care at the center of the health care delivery system. Primary care is the cornerstone of the DSRIP Program and is critical to NY State's success in the overall improvement and coordination of health care.

Instructions

The DSRIP Primary Care Plan Update is an opportunity for each PPS to highlight, and inform the New York State Department of Health (the Department) and the DSRIP Project Approval and Oversight Panel (PAOP) of, progress towards and challenges to the improvement of Primary Care under the DSRIP program.

For each fundamental, the PPS is asked to provide a series of brief updates in the space provided (approximately 250 words) to questions under each fundamental in its final Primary Care Plan submitted in 2016. The PPS should reference its previously submitted Primary Care Plan when completing this Update. Completion of the Primary Care Plan Update includes the progress the PPS has made within a fundamental, an outline of any challenges related to implementing the Primary Care Plan strategies, an explanation of any changes that need to be made to the Primary Care Plan, and other related questions where applicable. The Department requests that the PPS be as concise as possible in its responses; where elements are not relevant to their Primary Care Plan, 'N/A' should be written. Under fundamentals where no strategic changes have been made, please describe how the PPS' initial strategies continue to support that fundamental. Throughout the Update, some fields have been auto-populated for the PPS' convenience based on figures available to the DSRIP team. The Department requests that the PPS review these fields for accuracy and make revisions where necessary. The completed template is **due September 29, 2017** to the DSRIP Team at dsrip@health.ny.gov with subject line: 'Primary Care Plan Update'.

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Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

a. From April 1, 2016 to March 31, 2017, describe any overall strategic changes the PPS has made and the impact of these changes on the PPS' final Primary Care Plan submitted in 2016.

From April 1, 2016 – March 31, 2017, Better Health for Northeast New York (BHNNY) has implemented strategic changes to better support and meet the needs of primary care partners. As of February 2017, the AMCH PPS is officially the new corporation, BHNNY. The governing body is the Board of Directors (BOD), with seven committees to oversee PPS activities. In addition to seats on the BOD and the Project Advisory Committee, representatives and experts from organizations across the continuum of care, including Primary Care partners, will serve on BHNNY's governance committees. This governance structure is consistent with key elements of the structure described in the AMCH DSRIP application and the collaborative contracting model. This enables us to remain an affiliate of Albany Medical Center, and provide more efficient and timely support to our PCP partners.

BHNNY has partnered with the MCO, CDPHP to create BHNNY Cares, a comprehensive care coordination care management program. BHNNY Cares leverages MCO resources to expand access; creating a sustainable resource for PCP access; establishing linkages to a care management team; and increasing provider access to patients through a more engaged network. BHNNY will also support community based BH crisis stabilization programs, with increasing PCP access to mobile crisis teams. BHNNY has formed linkages with other PPSs in various ways. Examples include exploring the feasibility of selecting a single population health management system and a common contract framework for contracting with the local RHIO for a population gateway, and initiatives to provide educational opportunities for PCPs. As further described in Fundamentals 1-6 BHNNY's strategies also include: Vendor support of PCMH and/or APC recognition for interested PCP partners; Development of clinical roadmaps to capture data elements aligning with priority outcome metrics; Expansion of plans to educate and support VBP for partners; Alignment with AHI's model for the development of a Recruitment and Retention Fund to support efforts of partner organizations; Resources and guidance specific to 3.a.i models 1, 2, & 3; Initial steps to pilot Project ECHO, a tele-mentoring program enabling specialist knowledge-sharing with PCPs; Collaborative meetings with ED, PCP and Behavioral Health providers to improve care transitions.

BHNNY focuses increasingly on improving P4P measures, which are aligned with the activities that are incentivized through BHNNY's Phase II funds flow model (1/1/17-3/31/18.) As part of Phase II funds flow model BHNNY developed a comprehensive list of primary care focused activities to incentivize primary care practices to support expansion of services at their sites. These include activities specific to PCMH must-pass elements and maintaining recognition, transitions of care, PC/BH integration, etc. It is anticipated that an outcome-based approach will continue for the Phase III funds flow model.

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

- PPS' over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)
- How is the PPS working with community-based Primary Care Practitioners (PCPs), as well as institution-based PCPs?

a. Describe the PPS' progress in addressing primary care capacity and needs from April 1, 2016 to March 31, 2017. Include efforts to extend hours and increase access to primary care services:

Between April 1, 2016 and March 31, 2017, BHNNY collaborated with community-based and institution-based PCPs to expand capacity and access. BHNNY's primary care partners report that 3 providers were hired and that at least 2 additional providers are needed at this time. Some vacancies have also presented unexpectedly. Partners also implemented various initiatives including expansion of hours, open-access scheduling, walk-in blood pressure screening, and opening of an urgent care center adjacent to a primary care location. Patients seen at the urgent care who do not have an established PCP are able to be linked with a PCP at this office.

BHNNY collaborated with Adirondack Health Institute to model after their primary care provider retention and recruitment strategy. One retention and recruitment effort is in a pilot phase. The objective, with special focus on safety-net practices, is to support primary care organizations with financial incentives for retention and recruitment of new physicians and non-physician practitioners. This is supported by the BHNNY Workforce Coordinating Council. BHNNY is piloting this framework to provide financial incentives to sustain providers while panel size increases and the credentialing process is underway. Once this framework has been finetuned, BHNNY will open to other primary care partners, focusing on hot spot areas. BHNNY will continue to work with partners and BHNNY Cares to identify gaps.

BHNNY's Phase II partner contracting (1/1/17-3/31/18) includes a robust set of activities applicable to PCPs, and other providers that may facilitate access to PCPs. These include improving access to care, sustaining core PCMH functions, improving care coordination, establishing linkages with Health Homes and other care management agencies, clinical quality improvement, and improving services for patients with chronic illness(es).

b. Describe the PPS' challenges from April 1, 2016 to March 31, 2017 with addressing primary care capacity needs:

Key challenges faced by partners across the PPS include provider recruitment and retention, developing a sustainable business model to support expansion of services, multiple competing performance improvement initiatives, etc. Providers consistently raise these issues as they look to offer weekend and evening services that could potentially decrease avoidable ED use. Health Professional shortages and disparities in geography also create challenges. Significant numbers of new Medicaid patients face delays in finding a PCP who is able to accept new Medicaid members within a reasonable time period. In 2015, a PPS wide survey that was conducted to assess access to primary care services showed that the average third next available appointment for new adult patients among our key safety-net practices was 24 days. Health Professional Shortages Areas also pose a challenge. Analysis of PPS data available on MAPP has provided us information on maldistribution of primary care services by specific ZIP codes within our PPS region. Not surprisingly, Albany and Greene counties with urban and rural populations have the highest number of ZIP codes with maldistribution of PCPs to attributed members. Within Albany County, 5 out of the top 10 ZIP codes have limited PCP coverage based on members/PCP analysis, including 4 ZIP codes without a participating PCP located in their respective ZIP codes. Furthermore, ratios of attributed members to PCP are significantly higher in Columbia and Greene Counties than the average ratio across our PPS.

c. Based on the PPS' progress and challenges addressing Fundamental 1 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 1 outlined in the final Primary Care Plan submitted in 2016?

To address the challenges outlined above, BHNNY began aligning its initiatives with other primary care focused initiatives to enhance partners' ability to meet CPC+ and participate in VBP contracting. Goals for CPC+ have strong synergy with DSRIP goals. Related to CPC+ initiatives, TA and QI activities have been made available, or facilitated by BHNNY: A partner with experience in leading CPC initiatives held a session with the BHNNY Primary Care Advisory Group to review process, roles, and responsibilities; Partners pursuing CPC+ Track 2 have received further educational opportunities relevant to this lift – a statewide training on integration of primacy care and behavioral health services, and ; an opportunity to participate in the Advancing the Integration of Behavioral Health into Primary Care for Small Practices project. BHNNY has provided partners' with HANYS Practice Transformation services to enable to them to strengthen their QI processes to meet APC QI program needs. Identification of overlapping utilization and quality measures from these initiatives has been beneficial in streamlining efforts for earning the maximum amount of incentives. Additionally, 4.b.ii (cancer screening,) aligns with three Group 3 CPC+ measures. Care management enhancements that must be implemented for CPC+ will ultimately facilitate care management of the DSRIP patient population.

In late 2016, as part of the Statewide Health Care Facility Transformation Program grant application process, BHNNY conducted focused consumer listening sessions and solicited direct feedback from key stakeholders regarding the feasibility of additional primary care site location, neighborhood need, community support and scope of services. Although not being awarded the grant, BHNNY utilizing the valuable community/partner feedback to evaluate the feasibility of supporting primary care expansion opportunities in two 'hot spot' areas.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
Several BHNNY initiatives rely on community-based PCP engagement: 1) BHNNY Cares: working closely with practice-based care management team by addressing social determinants of health, increasing provider access to patients through a more engaged network, and facilitating engagement with NCQA Level 3 PCMH Practices. BHNNY has also supported linkages to care management agencies, health homes, and orientation to the health home referral process. 2) Project ECHO: this tele-mentoring platform uses a hub (specialists) and spoke (community providers) knowledge sharing network and videoconferencing to conduct virtual clinics. Asthma is BHNNY's pilot clinic with specialists at AMCH and PCPs from CMH. Initial meetings with Leadership in the two health systems participating in the pilot have been met with interest. 3) BHNNY's Phase II contracting (1/1/17-3/31/18) includes a robust set of activities applicable to PCPs. These include clinical quality improvement and improving access for patients with chronic illness(es). Partners were invited and encouraged to come to the table for initial sessions of contract development. 4) For partners who chose to obtain PCMH recognition, BHNNY allocated funds to support efforts in achieving recognition. Additionally, the PPS has defined metrics as part of Phase II funds flow distribution that align with and support the PCMH standards must pass elements and critical factors which will assist practices with sustainability efforts once PCMH 2014 is achieved. 5) BHNNY has supported partners' attendance of trainings to support their existing or planned efforts with integrating behavioral health into the primary care setting. 6) BHNNY has facilitated linkages of community health workers to hot spot PCPs to support CVD initiatives.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	429

e. Additional Information

Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:	490
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	99
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	0

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

- What are your PPS plans for working with Primary Care at the practice level, and how are you supporting practices to successfully achieve PCMH or APC recognition? (Resources could include collaboration, accreditation, incentives, training and 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?

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

Considerable progress has been made toward the achievement of practices transforming from 2011 to 2014 recognition and/or Advanced Primary Care (APC) accreditation. In September 2016, the PPS launched efforts to hire a vendor to support practice transformation. During the selection process, vendors were asked to focus their proposals on how they would provide tailored assistance to safety net primary care practices. HANYS was chosen as the vendor to support our transformation efforts. In total, BHNNY PPS has 76 participating primary care practice sites. To date, of the 76 sites, 38 have achieved 2014 Level 3 recognition. Many of our partners achieved recognition by the initial completion date of March 31st including Center for Disability Services, Albany Family Medicine at Community Care, Scotia-Glenville practice at Saratoga, and 2 sites from Whitney Young Health Center as well as 12 of 15 sites from Columbia Memorial Hospital. There are currently 15 sites that submitted their application to NCQA between the months of September and October 2017 and are in pending status; one primary care practice plans to submit prior to December 31, 2017. There are an additional 7 primary care sites that will submit by the NYS DOH/NCQA deadline of 1/31/2018 for a 2-year recognition. BHNNY has one practice pursuing APC recognition. Lastly the BHNNY PPS has 14 primary care sites that have no timeline for submission and plan to re-evaluate for the 2017 NCQA standards. Also, as part of Phase II funds flow model, developed a list of activities to incentivize primary care practices to sustain core functions of PCMH including enhancing access to care, care coordination, care management, and ongoing performance improvement activities.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

Overall staffing shortages of clinicians, care coordinators, and non-clinical staff, at primary care sites pose a challenge for the PPS to be able to effectively work with primary care practices to meet NCQA/APC milestones. These staffing shortages in conjunction with multiple competing priorities and initiatives such as CPC+, lead to varying degrees of engagement in the PCMH process. The staffing shortages not only make it difficult for partners to meet milestones for submission, but also eventually sustain the recognition once achieved.

Technical expertise is also a challenge and something that our partners have struggled with as they have not had the financial means to support this role. Particularly, they have found challenges in the development and implementation of policies and procedures and documentation management for submission to ensure that they are on the right track to meeting the expected requirements. The financial impact on the organization for the preparation for submission and staff time that it takes to meet the milestone requirements also poses a challenge.

c. Based on the PPS' progress and challenges addressing Fundamental 2 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 2 outlined in the final Primary Care Plan submitted in 2016?

For partners who chose to obtain PCMH recognition, BHNNY has allocated funds to support two distinct trajectories called Tier I and Tier II. In Tier I, BHNNY is providing an opportunity for each of the partnering organizations to choose one site within their organizations, with the highest Medicaid lives, that are interested in participating in one to one training. In total, there are 7 practice sites that have chosen to participate in Tier I support. For Tier II, a comprehensive curriculum was developed by HANYS that addresses various components of the PCMH standards. BHNNY is providing all 11 organizations an opportunity to participate in the group training/learning collaboratives. The HANYS engagement will include a thorough current state assessment and gap analysis for Tier I participants as well as one on one training sessions, group learning collaboratives, train the trainer approach as well as a robust sustainability plan to ensure the maintenance of PCMH and/or APC. Additionally, the PPS has defined metrics as part of our Phase II funds flow distribution that align with and support the PCMH standards must pass elements and critical factors which will assist practices with sustainability efforts once PCMH 2014 is achieved. The PPS is also looking to implement a population health software that will assist partners better manage the health of their patients using real time data and access to community care plans. Lastly, the PPS has implemented a comprehensive care management program called BHNNY Cares to align with and support PCMH based care coordination care management activities.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
Since partners have very limited financial and staffing means, it has been imperative to transformation efforts and its success, to provide them with a resource such as HANYS to achieve PCMH and/or APC recognition. One of the most effective strategies we have provided to partners is the fact that we have specifically tailored the HANYS support to fit the individual needs of the organization versus a "one size fits all" approach. Partners have found that having someone to work with directly either on a one to one basis or via webinar, as well as having a resource review documentation as well as show samples of how other practices have successfully transformed their sites has been key to their success. We have also worked with our partners to align the multiple other initiatives that they may be involved with such as CPC+ and/or their existing workflows so as to not overburden them as well as create more chance for success in their endeavors. Additionally, we understand that sustainability is important for both continued transformation as well as achievement with value based payment arrangements. Therefore, in an effort to ensure maintenance of critical factors and must pass elements, we are incentivizing primary care practices through our Phase II funds flow methodology.

e. Additional Questions:

Is the PPS contracting with any vendor(s) for PCMH recognition assistance? ☒Yes ☐No

Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:	109
Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:	Not Available

Is the PPS contracting with any vendor(s) for electronic health record (EHR) transformation assistance?
☐Yes ☒No

Fundamental 3: What is the PPS' 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' governance committees and structure, and your clinical quality committees?

Number of Engaged Primary Care Practitioners	490

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards implementing an integrated delivery system with Primary Care playing a central role. Be sure you address efforts to strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services:

Governance: Representatives and experts from organizations across the continuum of care including representation from our Primary Care providers serve on the BHNNY governance committees and offer valuable feedback as BHNNY continues to implement strategies to develop an integrated delivery system (IDS).

BHNNY Cares: As a core component of its IDS strategy, BHNNY has developed a comprehensive community based care management program, BHNNY Cares, that went live in late July 2017. This program is intended to promote linkages and facilitate access to primary care, behavioral health and health homes. Staff at BHNNY Cares Central is utilizing HIXNY to view the consented patient community health record and receive ADT alerts. Currently, BHNNY is negotiating with Health Catalyst to procure their Care Management and Data Analytics platform to facilitate care coordination across the IDS and support patient risk stratification. Additionally, BHNNY is collaborating with neighboring PPSs to explore opportunities to expand access to non-clinical services such as transportation, housing, etc.

Project ECHO: BHNNY has implemented Project ECHO, an evidence-based tele-mentoring program that trains PCPs to provide specialty care services. ECHO links PCPs and specialists in real-time communication, collaboration, and mentoring on an ongoing basis. Asthma will be the pilot clinic with Pediatric Pulmonary specialists at AMCH and Pediatric providers at Columbia Memorial Hospital.

BHNNY Behavioral Health IDS initiatives: BHNNY is funding five community based BH crisis stabilization initiatives, many of which entail collaboration and cooperation between key partners. For example, Residential Support Services, Inc is partnering with CDPC and ACDMH to develop a Crisis Diversion Program. BHNNY has consented to join the Capital Region BH Care Collaborative as an Affiliate Member to support partners' future VBP arrangements.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in implementing an integrated delivery system with Primary Care playing a central role:

BHNNY Cares: We have found some challenges in getting primary care providers to consistently make referrals for their patients to the care management agencies for community care management.
EDCT: Challenges identified by providers in managing patients with a behavioral health diagnosis were patients using the ED as their primary source of care, lack of access to primary care, and poor communication between primary care, EDs and behavioral health providers. In addition to lengthy wait times for follow up appointments, some primary care providers are hesitant to manage patients' mental health needs.
Project ECHO: Many PCPs do not see asthma as a challenging condition to manage in patients, however asthma admissions and medication measures indicate that there are some opportunities for improvement. The goal of education is to establish a large group of PCPs with expertise in asthma care.
PC/BH Integration: Relatively little guidance exists regarding how to effectively integrate behavioral health services into small primary care practices like Koinonia, especially considering their limited resources and the complexity of evidence-based models of integration.

c. Based on the PPS' progress and challenges addressing Fundamental 3 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 3 outlined in the final Primary Care Plan submitted in 2016?

BHNNY Cares: As part of the strategy to develop and champion BHNNY Cares, we will provide education to the Primary Care Advisory Group, Clinical and Quality Affairs committee and PAC at larger. Additionally we will be providing "road shows" to various hospitals, primary care groups, etc to train staff and promote referrals and linkages for patients.
EDCT: Because of this collaborative meeting, several strategies were developed. BHNNY incentivized EDs to provide a discharge summary within 48 hours of discharge and embed a care manager to facilitate communication between the entities. Primary care providers were incentivized to increase access, identify a point person to communicate with the ED care manager, and schedule timely follow-up appointments. In addition, assistance with transportation and strengthening the connectivity to health homes and care management agencies were identified as key next steps to improve transitions of care.
Project ECHO: BHNNY will send a team to New Mexico in May to receive required training. CMH will identify team members from Pediatrics to attend clinics as spokes. There will be 3 clinics held by 9/30/17. We will apply for CME and MOC credit.
PC/BH Integration: In connecting Koinonia with this Montefiore Care Management Organization program, we have facilitated their participation in a program that fills a guidance gap and supports small practices take a series of steps toward meaningful service integration. From a resource perspective, BHNNY incentivizes a variety of the activities of integrated behavioral health care.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices with implementing EHRs and reaching Meaningful Use Stage 2:

All of BHNNY's contracted PCP practices reported having a CEHRT with capabilities for bi-directional connectivity with the local RHIO, Hixny (Health Information Xchange of NY.) That said, it was reported that only 61% of providers would be attesting for Meaningful Use Stage 2, giving us some opportunity for improvement in the current year. In January 2017 after approval from the PPS Finance Committee and Board of Directors, HANYS was chosen as the vendor to support the PPS in its transformation efforts. All PCP practices are currently utilizing MU2 Certified EHRs and practices will be attesting for MU2, if they have not done so already, as part of the PCMH recognition process. Much of the required EHR functionality for MU2 is bedrock for success when achieving PCMH level 3 recognition.
The BHNNY EHR Subcommittee has also developed four clinical roadmaps (Behavioral Health, Cardiovascular, Asthma, and Emergency Department) to ensure critical data elements in support of BHNNY priority outcome metrics are captured as structured data in the EHR. This data can then be added to the practice's C-CDA and shared with Hixny. BHNNY is also contracted with Hixny to develop a PPS-specific population health gateway to provide clinical data and event notifications to our analytics and care management solutions. In addition, all BHNNY Cares Clinical staff have access to the Hixny provider portal to support their community management of our at risk patients being referred by our PCP practices and emergency departments.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices to connect to Regional Health Information Organizations (RHIO)/Qualified Entities (QE) and the State Health Information Network of New York (SHIN-NY):

Efficient electronic communication between providers is critical for successful implementation of the CI/CCM. In addition, enhanced HIXNY connectivity ensures meaningful linkages between PCPs and other regional providers with timely communications and information sharing. To date, all contracted PCPs have connected to HIXNY and actively share data and have subscribed to ADT alerts. The BHNNY EHR Subcommittee has also developed four clinical roadmaps (Behavioral Health, Cardiovascular, Asthma, and Emergency Department) to ensure critical data elements in support of BHNNY priority outcome metrics are captured as structured data in the EHR. This data can then be added to the practice's C-CDA and shared with Hixny. BHNNY is also contracted with Hixny to develop a PPS-specific population health gateway to provide clinical data to our analytics and care management solutions for our attributed population.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	629

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	10 (.013%)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	4 (.013%)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	6 (.014%)

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

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

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards VBP Readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan:

The PMO, in collaboration with the VBP workgroup, facilitated a focused assessment in 2016 that surveyed all funded partners about current state of VBP contracts, education and technical/data needs, perceived barriers to success, and preferred VBP compensation modalities. This information was used to obtain an updated current state, defined learning and technical needs, and is assisting with the development of the PPS-specific VBP educational series. The PPS had several organizations represented at the Region 1 VBP boot camps hosted by the State in 2016. Additionally, the PMO has provided the link to the recordings to the PPS network and encouraged all partners to view the sessions. An in-depth recap of each boot camp was provided at both the VBP workgroup and PAC. Based on feedback from the VBP workgroup, it was determined that organizations with robust experience with VBP arrangements should be recruited to present on real-life examples and to provide feedback on the process of their transition. Dr. Douglas G. Fish, will be presenting to the PCP audience at a planned collaborative VBP Symposium in December 2017 hosted by BHNNY, AHI, and the AFBHC PPSs. This program will have separate break-out sessions aimed at PCPs, BH, and CBO providers and has been approved for a total of 2.75 contact hours of continuing education credit toward fulfillment of the requirements of ASHRM designations of fellow (FASHRM) and distinguished fellow (DFASHRM) and towards certified professional in healthcare risk management (CPHRM) renewal.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working towards VBP Readiness among the PPS' primary care providers:

BHNNY has identified a few challenges as we work towards VBP readiness among the PPS' primary care providers. The first is that, although a collaborative meeting that brings MCOs and PCPs together, sounds like the ideal scenario, that meeting has proven to be difficult. Competing MCOs were not willing to share their thoughts, ideas, or best practices in an open forum. We have since evolved into individual MCO meetings that have been a great success allowing for MCOs to share their thoughts and ideas as well as provide insight as to the types of trainings and education they would like to see.
As BHNNY is a non-negotiating body, it has been challenging at times to gather information from our partners. As the milestone requirements have changed towards more of an educational approach, and as GNYHA has worked with PPS' across NYS to streamline this education, partners have a new sense of understanding of the PPS' role and are more open to sharing and learning.

c. Based on the PPS' progress and challenges addressing Fundamental 4 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 4 outlined in the final Primary Care Plan submitted in 2016?

The strategy remains education of our partners to help prepare them for VBP. BHNNY has, however, extensively expanded plans to educate and support VBP for our partners. The first learning collaboration will be held in collaboration with overlapping PPSs in the region. The content for this VBP collaborative initiative is being developed based on partner VBP readiness survey results presented to the BHNNY VBP subcommittee in November 2016. Partners identified the following areas of need, ranked 1-9 highest to lowest respectively, to best prepare for success under VBP contracting: 1). Data analytics 2). Program design to increase patient engagement and literacy 3). Data warehousing and data hosting 4). Support building new care models 5). Centralized care management 6). Clinical decision support 7). Claims processing 8). Primary care transformation 9). Call center. This educational initiative will fulfill PPS financial stability milestones 1-5. To assist PPS's set the frame work for this educational initiative, the Greater NY Hospital Association is developing a VBP training Curriculum. This was a statewide collaborative effort and content was developed based on results of VBP partner readiness needs assessment surveys.
The collaborative AHI/Alliance/BHNNY VBP education sessions plan the following curriculum through the end of the DSRIP period: 12/6/17 - Readiness, Payment Arrangements 1.0; March 2017 - Working with MCOs: organizations that successfully implemented VBP from both Payer/Provider perspective; September 2018 - Technology/Data 1.0; March 2018 - Payment Arrangements 2.0; September 2019 - Technology/Data 2.0; March 2020 - How did we do/wrap up.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers to engage Managed Care Organizations (MCOs) for VBP contracting:

The PPS formed a VBP workgroup that has met monthly since April 2016. The membership includes four MCOs and twelve partner organizations, half of which are primary care providers. As a result of perceived resistance to engagement by the MCOs in the workgroup, the workgroup was put on hold but reconvened with a different approach DY2Q4. Meetings will continue monthly with the MCOs meeting once quarterly, with the providers participating each month. The primary charge of the workgroup is to provide education and guidance to partner organizations and to collaboratively create a VBP roadmap. A letter was distributed to the MCOs to solicit recommendations on implementing VBP education to BHNNY's contracted partners. MCO feedback incorporated into the 2017 partner survey, where applicable.
The March 2017 VBP session on "Working with MCOs: organizations that successfully implemented VBP from both Payer/Provider perspective" will allow the PCP partners to learn from PCPs that have successfully made the transition to pay for performance contracts.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers in levels 2 & 3 VBP arrangements to address social determinants of health and engage Tier 1 Community-Based Organizations (CBOs):
The PMO is promoting partnership development between PCPs and CBOs via various forums to support PCP engagement with Tier 1 CBOs and addressing SDHs. In September 2016, the PMO held a networking webinar to encourage relationship building between the 2 provider types and plans to continue to duplicate similar sessions. The Community Engagement, Cultural Responsiveness, and Health Literacy Committee (CECRHLC) continues to meet with Tier 1 to understand services provided and linkages to providers in the region. BHNNY, in collaboration with the AFBHC and AHI PPSs is looking to ways to fund organizations that address SDHs and to help provide data that proves their sustainability. BHNNY's CECRHLC held an in-person meeting in October with breakout sessions, one of which focused on VBP education. The CBOs provided insight to the PMO on the following: 1. What methods do you find would be most beneficial/effective for educating CBOs and their consumers on VBP; and 2. What services does your organization provide related to SDOH and what health outcomes are/may be impacted? Feedback will be used to determine how to address their concerns. A perceived challenge related to PCP contracts refers to the VBP Readiness Survey. Of the 117 responses, only 7 organizations are in Level 2 and 3 arrangements, which is statistically insignificant. 91 responding organizations are not in VBP contracts. As we continue to educate our partners on VBP, a focus will be on encouraging the PCPs to enter into VBP contracts on the ground level and gradually moving into higher contract levels.

f. Additional Questions

Is the PPS planning to form a contracting entity (e.g. ACO Certificate of Authority)? ☐Yes ☒No ☐N/A

…If yes, has it been granted? ☐Yes ☐No

Has the PPS provided technical assistance to primary care partners planning to form a contracting entity (e.g. ACO or IPA)? ☐Yes ☒No

…If yes, describe: Click or tap here to enter text.

Fundamental 5: How does your PPS' funds flow support your Primary Care strategies?

- What resources are being expended by your PPS to support PCPs in DSRIP?

a. Describe how the funds flow model(s) support(s) primary care in the PPS network:

The PPS has created a funds flow methodology that supports the PPS network, specifically Primary Care. Several contract deliverables in phase one contracting incentivized Primary Care providers, including participation in a PCMH learning collaborative, completion of project-specific registries and patient engagement data, updated comprehensive baseline assessment, collaboration with Health Homes and EDs, policies and procedures on an array of topics (warm referrals, blood pressure checks, Behavioral Health screenings, crisis referrals, medication regimen simplification), as well as adoption of several best practice guidelines.

For the second phase of contracting (1/1/2017-3/31/2018), approximately 85% of funds have been allocated to partners that offer primary care services. The development of phase 2 contracts was a coordinated effort between the PMO, COPE Health Solutions, and partner organizations to ensure metrics were developed by clinicians in the network and help with buy-in from partner organizations. In addition to performance activities such as policy and procedure development, meeting participation, and patient engagement/ registries, phase 2 also includes metrics specific to required outcome measures. Partners will receive funding for outcome measures when the PPS achieves our performance goals.

In the Table below, Primary Care Provider is a summary of the 3 groups listed below it. Totals are consistent with PIT categories from quarterly reports and may not include all providers that fall within other PIT categories. FQHCs (reported in other PIT cateogires) have been included.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$15,164,150.10	**100%**
Primary Care Provider	3,627,040.68	23.92%
Hospital-Ambulatory Care	$3,075,158.68	20.28%
Federally Qualified Health Centers (FQHCs)	$68,144	0.45%
Primary Care Practitioners	$483,738	3.19%
PMO Spending to support Primary Care	$403,000	2.66%

c. Based on the PPS' progress and challenges addressing DSRIP performance from April 1, 2016 to March 31, 2017, what strategic changes have been made to the funds flow model outlined in the final Primary Care Plan submitted in 2016?

No significant strategic changes have been made to the funds flow model as originally submitted but the strategy has now been operationalized. The strategy has been to heavily focus on primary care access and expansion. Examples include BHNNY Cares and PCMH Advisory Services as outlined below. Phase 2 contracts have allocated over $12M to partner organizations with a significant portion to those that offer primary care services. It is still anticipated that phase 3 contracting will include predominantly outcome measure metrics to ensure the PPS network is actively working toward the end goal of providing better patient care, reducing unnecessary ED visits and inpatient readmissions, and increasing population health.
The PPS has contracted with CDPHP to launch BHNNY Cares; a care management/care coordination service which will assist Primary Care partners with organizing patient care activities and result in more effective care.
The PPS has also engaged HANYS PCMH Advisory Services to assist with efforts to support primary care practices in achieving PCMH or APC status. As part of this engagement, the PPS will provide Tier One (one to one support for up to 9 practice sites) and Tier II (learning collaboratives for up to 78 practice sites) funding support to our primary care partners.
Additionally, the PPS has begun work to develop a Recruitment and Retention Fund to support efforts of partner organizations to recruit and retain primary care practitioners.

d. Additional Questions

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving PCMH or APC recognition? ☐Yes ☒No

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving defined performance measurement targets? ☐Yes ☒No

Fundamental 6: How is the PPS progressing toward integrating Primary Care and Behavioral Health (BH) (building beyond what is reported for Project 3.a.i. within the quarterly report)?

- Including both collaborative care and the development of needed community-based providers.

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i. within the quarterly report):

BHNNY PPS has made significant progress integrating primary care and behavioral health services. Many partners have begun integrating services, including Capital Care Physicians Group, Community Care Physicians, Harmony Mills Pediatrics, Shaker Pediatrics, and Northern Rivers Family of Services. Moreover, BHHNY's hospitals, Albany Medical Center, Saratoga Hospital, and Columbia Memorial Health have expanded integration efforts to more sites or by implementing multiple models of integration. Koinonia Primary Care was selected as a participant in Montefiore Care Management Organization's Evaluation of a Continuum Based Framework for Behavioral Health Integration Among Small Primary Care Practices. Seven sites were pediatric sites, and six of those were from multi-site organizations. 20 sites were Family Medicine sites, and 18 of those were from multi-site organizations. Five sites were Internal Medicine sites, and all of those were from multisite organizations.

BHNNY convened a Behavioral Health Quality Improvement Subcommittee under the Clinical and Quality Affairs Committee, which supports behavioral health quality improvement initiatives to improve P4P measures performance, including those related to the integration of primary care and behavioral health. The charge of this subcommittee aligns with the BHNNY Phase II contract metrics, many of which support improvement on P4P behavioral health quality measures. BHNNY has already met eight project milestones for the integration of primary care and behavioral health services, including the use of coordinated evidence-based standards of care, EHRs with integrated medical and behavioral health records, and for the IMPACT/Collaborative Care Model identifying depression care managers and consulting psychiatrist. BHNNY has since submitted all project milestones.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health (not including regulatory issues):

BHNNY's participating providers have encountered challenges with implementation across all three models of integration. Overall, partners in each model report challenges with long term sustainability with the model related to concerns about billing and reimbursement. Practices implementing Models 1 and 3 face recruitment challenges for behavioral health providers at all levels, from depression care managers to psychiatrists. The lack of behavioral health providers, especially prescribers, coupled with high salary requirements hinders full integration of behavioral health services in primary care settings.

Smaller organizations are having a more difficult time implementing the model due to limited resources, though this is being partially leveraged by Koinonia Primary Care's participation in the Montefiore Care Management Organization's Evaluation of a Continuum Based Framework for Behavioral Health Integration Among Small Primary Care Practices project.

Partners implementing Model 2 report limited primary care provider availability for collaboration with behavioral health organizations. On the other side of integration, some primary care physicians considering implementing Model 3 are hesitant to manage behavioral health conditions due to their unfamiliarity with medications and treatments. This challenge is being leveraged with additional trainings for BHNNY partners. Other challenges have included that a significant delay in finalizing Phase I contracting process with participating providers resulted in delays in some project implementation. Finally, there have been challenges integrating care throughout multisite partner organizations, as a number of these have focused their efforts on implementation at a few specific practice sites and not across entire organizations.

c. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health specific to regulatory issues:

BHNNY partners in each model of integration have expressed challenges around regulatory issues. Primarily, this is come in the form of uncertainty around regulatory barriers. Partners expressed a lack of certainty around regulations related to which providers can bill which integrated services to which payers and in which settings. Partners expressed similar confusion around if and how shared space regulations and limits on billing for different services on the same day and are relevant to their implementation efforts in a range of settings. Initially, partners expressed confusion around licensure thresholds, although guidance documents provided by DOH/OMH/OASAS have been very useful. Partners implementing Model 2 have expressed challenges obtaining an operating certificate, namely that the process is lengthy and delays implementation. Some challenges have been specific to behavioral health partners. For example, some Substance Use Disorder providers have expressed confusion around how federal statutory limitations on sharing data on substance use disorder diagnoses and treatment affect the provision of integrated substance use disorder treatment. Moreover, partners implementing Model 3 have expressed challenges related to the inability to reimburse for care management activities.

The PPS addressed regularity issues regularly. In 3ai Subcommittee/workgroups, partners discussed and presented solutions to regulatory issues including billing, reimbursement, and compliance; and PMO staff presented on regulatory issues and solutions, including licensure thresholds. The PMO provided guidance resources to partners addressing regulatory issues, including the NYSDOH Integrated Health Services webinar and Integrated Care FAQ. BHNNY also supported partners attendance at one of two prominent integrated care training conferences.

d. Based on the PPS' progress and challenges addressing Fundamental 6 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 6 outlined in the final Primary Care Plan submitted in 2016?

Based on BHNNY's progress and challenges addressing Fundamental 6, BHNNY has initiated a number of approaches, strategies, and initiatives. For example, in order to address partners' identified training needs, BHNNY identified two trainings on integrating behavioral health and primary care services, and is sponsoring providers from each participating partner to attend one. These trainings are: HANYS Behavioral Health and Primary Care SWOT: Strategies for Success, and Harvard Medical School/Cambridge Health Alliance's Integrating Mental Health and Medical Care conference. The BHNNY PMO also provided partners with further resources and guidance documents by model. Participating partners have also been presenting to the 3ai Subcommittee their implementation initiatives.

As Project 3ai approaches completion of the implementation phase, BHNNY is focused increasingly on improving performance on P4P behavioral health measures via both the established integrated care models and other initiatives. In order to promote system-wide change throughout multi-site organizations, we have begun to request site-level data on performance measures, rather than organization-level data alone. Site-level data collection should encourage participation at a greater number of sites. In order to assist with the identification of providers available to provide integrated care, BHNNY has facilitated meetings between primary care and behavioral health partners. Finally, in order to address the lack of primary care providers for Model 2, BHNNY continues to develop a primary care provider recruitment and retention plan/fund.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	4	0	32
Model 2	2	2	0
Model 3 IMPACT	0	2	1

f. Please check all trainings that the PPS provides directly, or supports partners in delivering, to Primary Care Providers for Behavioral Health Integration within DSRIP projects from April 1, 2016 to March 31, 2017:

☒Alcohol Use screening
☐ Billing for Integrated Care
☒ Collaborative Care for Depression, i.e. IMPACT model
☒ Depression screening
☒ EHR Integration
☒ Health Homes
☐ Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
☐ Mental Health First Aid
☒ Outcomes Measurement
☐ Patient Consent and Privacy regulations specific to Behavioral Health populations
☐ Person-Centered Care
☐ Peer Services
☐ Population Health
☒ PSYCKES
☒ Quality Improvement Processes
☐ Regulatory Issues
☐ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
☐ Serious Mental Illness
☐ Tobacco Cessation
☐ Trauma Informed Care
☒ Other Mental Health screening (please specify): MCHAT
☐ Other Substance Use screening (please specify): Click or tap here to enter text.
☐ Other

Describe:

Click or tap here to enter text.

GLOSSARY OF TERMS

Community-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is not employed by a hospital or hospital-system

Engaged Provider: Providers reported in PIT/PIT-Replacement as engaged on at least one project

Institution-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is employed by a hospital or hospital-system

PPS-defined Network: Provider Network in the MAPP DSRIP PPS Network Tool filtered to Practitioner-Primary Care Provider (PCP) for Provider Category or PPS-defined Provider Category

Primary Care Practice: Individual sites providing primary care services

Primary Care Practitioner (PCP): Individual practitioner providing primary care services

Primary Care Provider: Entity providing primary care services

RHIO/QE Connectivity: Providers sharing data with RHIO/QE or have an active BAA in place with the RHIO/QE