Primary Care Plan Update 2017

Care Compass Network

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.

After the submission of last year's Primary Care Plan, the state asked CCN to revise and resubmit the plan, and in CCN's midpoint action plan, CCN committed to develop that new revision and submit it by September 29, 2017. In view of this revision and the process of writing it, many of the narratives that follow do not conform exactly to the April 1, 2016 to March 31, 2017 timeline, and the major strategic changes to last year's plan are now evident in the new version CCN is submitting to the state.

As a rule the new Primary Care Plan represents not so much a largescale change in direction for CCN, but rather, a clarification and sharpening of the initial vision that, in the 2016 strategy, lacked detail. CCN has reorganized its Primary Care Plan around three key strategic goals: promote better access, develop all-new capabilities necessary for an integrated delivery system, and collaborate with community based care providers. CCN uses a range of tactics to achieve these goals, many of which fall into three buckets: workforce, education, and contracting.

Therefore, in the 2017 Primary Care Plan, CCN has included a range of initiatives and partnerships that begin to flesh out these strategic goals as DSRIP moves into its pay-for-performance years. These new inclusions represent CCN's shifting focus from speed and scale concerns to outcomes and beneficiary experiences. CCN has, for instance, given out its second round of Innovation Grants that supplement a wide array of performance goals for partners contracted to DSRIP projects. CCN has also developed a robust workforce recruitment plan this year in response to widespread workforce shortages that prevent delivery system transformation. Finally CCN has brought Dr. Wayne Teris on board as its new Chief Medical Officer whose mission will be, among other things, to promote clear and frequent communication between clinical partners in the field and the core PPS staff. These initiatives represent a maturation in CCN's primary care plan that is keeping pace with the changing priorities of DSRIP state-wide.

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:

Since April 2016, CCN has made strides toward addressing primary care needs across the region. We have pursued the overarching strategy laid out in our primary care plan across multiple domains: in contracting, in network analysis, in our innovation awards, and through PCMH certification. We have initiated Phase II Contracting with our partners, which include an introductory program that incentivizes partner-level performance on DSRIP metrics, including Adult and Child Access Measures for Non-Use of Preventative Care. These contracts also ensure that clinical and CBO partners are directly rewarded for improving their attributed members' engagement with primary care as well. This spring, CCN also began its Primary Care Network Analysis which is still underway. This analysis leverages recent data from partner EHR systems to identify Medicaid members who are not currently engaged in a PCP relationship.

As the primary care plan indicates, CCN has leaned on its Innovation Award program to prioritize interventions that provide alternatives to the Emergency Department, both for routine care and for high utilizing populations. One key product of the Innovation Fund over the past year has been UHS's expansion of walk-in hours in the Binghamton area. UHS complemented this expansion with a new online scheduling platform called Clockwise, MD that increases patient access and satisfaction with their primary care services.

Finally, PCMH certification has steadily progressed over the last year and a half. As a function of PCMH, as of March 31, 2017 there are 7 sites in the PPS who had achieved PCMH 2014 Level 3 certification. This means those 7 sites have increased access since the Patient Centered Appointment Access PCMH element (providing routine care and urgent care appointments outside regular business hours along with routine and urgent same day appointments) is required to achieve certification. More than 50% of contracted sites have now reached Level 3 certification and CCN is now shifting its focus to optimizing licensure and workflow at PCMH sites.

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

CCN's challenges in primary care revolve around the diverse quality of its geographic and demographic makeup, and widespread workforce concerns across most roles on the continuum of care. The diversity of CCN's network creates tremendous fragmentation, and though CCN has secured strong relationships with all six major corporate providers - and the IPA with the largest Medicaid panel - it remains the case that this fragmentation poses logistical and operational challenges to a truly integrated delivery system of effective, efficient primary care. Moreover, much of CCN's attributed population live in Primary Care and Mental Health HPSAs which complicates the primary care landscape with issues of limited access, limited transportation, limited hours of availability, and generalized primary care shortages for CCN's Medicaid members.

Workforce in particular has presented a difficult challenge to virtually all partners, in terms of recruitment, retention, and optimization. The Iroquois Healthcare Association, with whom CCN partnered for a robust analysis of compensation and benefits, found that workforce shortages were especially profound in those roles closest related to primary care coordination and behavioral health.

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?

CCN's initial Primary Care Plan focused heavily on PCMH certification. This focus reflected CCN's initial strategic phase which recognized the alignment between PCMH certification and DSRIP's early Speed & Scale goals. As CCN has matured into the middle years of DSRIP, the strategic focus has shifted into broader and deeper interventions that push past the foundation of PCMH and address the difficult challenges our region faces in creating a truly integrated delivery system for primary care. These shifts represent, not so much a pivot, as a key step in the development of CCN's posture toward the region and its partners. As of 11/17/17, 89% of the eligible participating sites have received certification or have submitted their application to NCQA for certification. Of the remaining sites, 7% have verbally confirmed they have submitted their application but are in process of providing supporting documentation to CCN and the remaining 4% are pursuing the extension with the plan to submit by December 31, 2017. Based on this, CCN is confident the PCMH recognition goals will be met.

Most significantly, CCN has developed a comprehensive workforce strategy in response to the shortages and retention problems across the region relating to primary care. This strategy includes a two-phase process supporting the recruitment of new primary care and behavioral health professionals as well as the creation of a robust menu of trainings that will help primary care professionals across the network continue to operate at maximum licensure. CCN has also worked to more specifically engage its corporate partners - who house the vast majority of the network's primary care practices - in pilots and Innovation Program funded demonstrations that directly engage primary care needs, as with the telemedicine project in Lourdes and the expansion of hours at the UHS walk in.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
The vast majority of CCN's primary care providers practice in the South, East, and West RPUs where our major corporate partners provide them an institutional home. In the North, however, where many PCPs work in independent clinical settings, CCN has had to develop a different support strategy that addresses the specific capacity and quality needs of the community-based provider. For instance, CCN has contracted with a vendor, Research & Marketing Systems (RMS), to assist in lifting these community-based practices to PCMH certification through education, site visits, and technical support. The most significant investment CCN has made to engage community-based PCPs besides its PCMH contracting and support has been through the Innovation Grant funded VBP pilot program being established by Cayuga Area Plan/Preferred (CAP), the ACO/IPA that organizes many physicians in the North RPU. This program provides community-based providers an incentive and infrastructure to enter into Level 1 and Level 2 VBP arrangements, improving their performance metrics in the short term, and setting them up for VBP success in the long term. This pilot also expands CAP's care management capacity, helping to maximize clinical licensure and improve patient-provider relationships, and therefore, outcomes.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	56

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:	363
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	48
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:

CCN offers financial assistance to partner organizations with Primary Care Practice sites pursuing PCMH 2014 Level 3 for support, such as EHR programming, that is necessary to achieve PPS-standards and project or DSRIP goals. The amount of funds available to partner organizations depends upon their starting position relative to 2014 Level 3 certification. $20k is made available to those practices who have already attained 2011 Level 3 PCMH or higher certification, and $40k is made available to those providers who are starting their certification process with no previous PCMH achievement. All sites eligible for PCMH 2014 Level 3 are eligible to receive funding from CCN regardless of whether they are considered community based providers or are part of a large health system. CCN has also contracted with Research & Marketing Systems (RMS) for PCMH support, especially for the independent and smaller practices that make up much of the North RPU. In addition to providing educational seminars available to the entire PPS, RMS has supported the North RPU primary providers with site visits and individual support in a way that is directly responsive to the needs of these practices. For the other three RPUs CCN has leveraged its relationships with the major health systems to encourage their PCMH certification processes, many of which were already well under way.

Partners have been making steady PCMH progress across the board. To date, 59% of contracted practice sites have reached PCMH 2014 Level 3 certification.

CCN's training strategy is to provide employee skill development to any employee providing services in the PPS. This includes trainings identified through the projects such as motivational interviewing, peer support, care management coordination, change management, leadership, technology and performance management/lean six sigma. All of which provide support for staff working in the primary care practices. As part of implementing our training strategy, CCN has coordinated professional forums where clinicians meet together to share strategies and scenarios with one another. Along with this, CCN has designed a pilot program that will assist and incentivize a range of provider types – including primary care and primary care adjacent practices – in assessing and optimizing their workflows, workloads, and licensure thresholds in order to bring them into better alignment with DSRIP and VBP goals of efficiency and quality. This pilot program will develop reproducible workflows, formats, and templates that CCN would then make available to other partner organizations for modification and implementation in their own clinical contexts. CCN has also committed to meeting the complex training needs for transitioning primary care providers from a fee-for-service paradigm to value-based payment. By partnering with HWapps, CCN is working to provide widely accessible trainings on all kinds of topics that support primary care, from motivational interviewing to care management coordination to performance management.

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:

The primary challenge in getting primary care practices up to speed on PCMH certification is tied to CCN's regional diversity and the variance in provider contexts between RPUs. Because three of the RPUs are dominated by our large corporate partners as opposed to the collection of independent practices that comprise the North RPU, CCN has had to strategize both indirect and direct forms of engagement to drive PCMH adoption. In the South, East, and West RPUs, much of the PCMH lift has been driven by the partner systems themselves, with CCN playing a supplementary role by offering educational spaces and forums as well as monetary rewards for final achievement of PCMH Level 3. In the North, CCN has worked through pilot programs and contracted vendors to engage the region's only ACO and IPA to expedite progress on PCMH certification.

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?

There have been no drastic changes in strategy when it comes to CCN's approach to PCMH certification as many of the key challenges were built into CCN's initial strategy. As CCN's infrastructural investments have come to maturity, and as the second phase of contracting has gotten underway, progress toward network-wide PCMH Level 3 certification has accelerated.

Otherwise, the most significant strategic adjustment on CCN's part has been to develop a two-phase recruitment initiative in response to the difficulties many practices experience hiring on the necessary professionals that can enable a widespread integrated delivery system to get off the ground. The two phases subsidize the cost of recruiting professionals first in behavioral health arenas – thereby supporting primary care settings that have contracted on for 3ai – and then in primary care.

Finally, CCN's educational regimen, including workshops, forums, and seminars, have been responsive to the maturing needs of our network.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
The health networks in CCN have been effective partners in getting primary care providers to achieve PCMH 2014 Level 3 certification. They have been able to leverage their existing infrastructure and resources to connect their providers to EHR systems and RHIOs, and where they have needed support in those connections, CCN's IT team and funds flow have been critical to supplementing our partners efforts. With the RMS consulting services provided to sites in the North RPU, the practice sites have had the support from subject matter experts to proactively focus on areas that often are found to be challenging as part of the PCMH certification process, further assisting the practices in successfully achieving certification.

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:	141
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:	92

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	201

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:

CCN has ensured its progress toward creating an integrated delivery system in its network by continuing to draw from a diverse range of voices with direct experience in primary care fields for its governance and committees. The CGC has been an invaluable resource for creating linkages between healthcare providers, community based organizations, and the administrative staff at CCN. CCN has also recently brought aboard Dr. Wayne Teris as its CMO, who will dedicate 75% of his time toward shoring up the lines of communication between clinicians in the field and the staff and PMO at CCN to ensure that as DSRIP continues to mature, CCN's strategy will keep in step with the evolving primary care needs in the region. CCN has also launched some key initiatives that strengthen the continuum of Primary Care, including the development of a Health Coach role as part of our Care Transitions project, and an Innovation-funded program with Family Counseling Services (FCS) of Cortland County to shore up their Early Recognition Screening Program. With the Health Coach role, CCN has developed a critical piece of the patient information puzzle for PCPs, as they help patients navigate from the clinical office to other services that can meet more socially determined needs, in addition to placing patients in classes for disease management, and providing feedback to the patient's primary care provider after 30 days post discharge. In supporting the Early Recognition Screening Program at FCS, CCN is strengthening the connection between multiple school districts and effective preventative care. Primary care and specialty providers are encouraged to utilize available technologies such as direct mail to effectively communicate directly and securely regarding their mutual patients. Additionally, HealthlinkNY alerts clinicians, either through direct mail or displayed directly in EHR's, when patients are admitted and discharged from inpatient care or the Emergency Department. The large number of system employed providers in the South, East, and West RPU's (UHS, Lourdes, Guthrie) are able to directly view specialty and primary care records in their shared EHR, when both providers are employees of the same system. The same would be true for ED providers. The RHIO can be utilized to share information when needed, such as when the primary care and specialty provider are not both employed by the same system, or a patient in the ED is cared for by providers outside their own system. CCN is currently evaluating Care Management platforms as part of the CRFP program, and will soon be contracting with a vendor, which will enable more seamless transitions of care and communication between providers and venues. As of 3/31/17, almost 10% of PCPs are engaged in PPS governance. This includes representation on the CGC, and several Quality Subcommittees. The CMO attended recent North RPU and South RPU PCP / Behavioral Health events, and was able to begin engaging PCPs attending those events. In accordance with a third-party review by Deloitte, significant funds are being budgeted in 2018 to organize educational provider events and to leverage stipends to encourage active participation, collaboration, and buy-in from key clinical partners. The CMO will be engaging PCPs at these events, as well as ad hoc through visits to clinician offices and attendance at other CCN and community events, to actively promote increased engagement in CCN governance. The goal is to gain broad clinical input and perspective and align a broad set of clinicians.

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:

The initial challenge CCN has faced to implementing an integrated delivery system is one of communication. In a region as diverse and geographically wide as CCN's, the organizational challenge of attending to the needs of its primary care providers – let alone meeting those needs – is immense. This challenge is complicated by the difficulty of navigating the integration of six different health systems and a range of independent physicians. Besides communication this represents a massive technical challenge requiring a multi-faceted approach to IT and EHR adoption. These operational challenges are important for CCN to solve because they are obstacles to CCN's goal for primary care in the network: to anchor the integrated delivery system in the primary care clinicians' offices.

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?

As with some of the other fundamentals, the changes to CCN's primary care strategies have largely been a question of evolution rather than a change in direction. From the outset CCN has considered the composition of its governance and committees to be the foundation of ensuring that primary care interests are at the core of CCN's efforts to create an IDS. CCN has maintained this commitment to making sure that primary care interests are pervasively and directly represented in governance, through board membership as well as the Clinical Guidance Committee, and most recently, through the creation of a new Chief Medical Officer role.

CCN has also honed in on developing its early screening strategy as a means to facilitate meeting the challenges of communication and integration across the network. Early screenings are the cornerstone of effective preventative care and a crucial component in helping primary care providers adequately manage their patients needs across the continuum of care. Therefore CCN has made it a priority to reimburse early screenings in a range of contexts, from the 3gi Palliative Care project to the integration of behavioral health and primary 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:

CCN has met with all contracted Partner Organizations within the PPS to assess the status of EHR implementations. We have a program that financially incentivizes organizations that do not have an EHR that meets the PPS standards (supports Meaningful Use, HIPAA, and connects to a RHIO). All Primary Care locations contracted with our PPS previously installed Meaningful Use certified EHRs, so we have not had to assist them in their implementation.

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):

CCN has met with all contracted Partner Organizations within the PPS to assess the status of RHIO connectivity. We have a program that pays the technical fees to connect with a RHIO, as appropriate. The PPS has created a standard that all Primary Care practices must minimally be contributing the NYS standards to the RHIO, and ideally should have a bi-directional data exchange with a RHIO. The number of Primary Care Practitioners connected to the RHIO/QE entered below is the current number as of September 29, 2017.

All PCPs are currently connected to a RHIO/QE and contributing data. We are in the process of determining the extent to which each Partner Organization is contributing data against the PPS standards. All Partner Organizations are contractually required through our Partner Agreement to maintain the standards of the PPS and would face sanctions if they do not.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	374

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	9,4%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	8,4%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	1,1%

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 PPS issued a VBP Needs Assessment in early 2017 to update the previously-issued VBP survey in late 2015. This will gauge movement on VBP across the PPS. The PPS held a payer forum in August, 2016 with United HealthCare to provide education across the PPS. Over 40 people, representing more than 30 partner organizations were in attendance. Additionally, this spring the PPS awarded over $500k to the Cayuga Area Plan/Preferred to incentivize their entrance into a VBP arrangement for 5000 Medicaid lives at increasing levels of risk, starting with Shared Savings (Level 1) in DY3 and increasing to Shared Risk (Level 2) in DY4. The PPS has also begun evaluating the concept of direct incentive for Partners entering into VBP arrangements, but these plans had not yet been finalized by March 31, 2017. In Summer of 2017, the VBP Incentive Support Program had been developed as a framework through which to incent partners across the PPS to enter into VBP arrangements with MCOs. After thorough reviews by the CCN VBP Sub-Committee and the CCN Finance Committee, a program is being presented to the CCN Board of Directors on December 12, 2017 outlining a $10,000,000 investment into VBP. The program is structured through a PMPM model whereby an organization receives a base rate depending on the level of the VBP arrangements. Level 2 VBP arrangements have a higher base rate than Level 1 VBP arrangements. To that base rate, modifiers are added for the quantity of Tier 1 CBO Relationships (defined as contracts for Social Determinant of Health interventions), the percentage of that organization's Medicaid revenue in VBP (thresholds at 50% and 90%), and lastly there is an add-on for alignment with CCN's Pay-For-Performance DSRIP measures. The maximum PMPM is $7.00 and the minimum is $2.50. Partner Organizations are required to submit a limited data set as an attestation for participation in the VBP arrangement with the MCO. In this way, the PPS will be able to track MCO dollars in VBP, partner participation, as well as risk appetite.

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

The key challenge CCN has faced in preparing its network for VBP has been the inability of the PPS to direct PCPs to engage in VBP arrangements. As CCN is neither an ACO or an IPA and therefore lacks the direct relationship needed to enforce VBP contracting from the top down. Fortunately, most of the PCPs in the PPS are employed by the health systems that compose CCN's primary corporate partners, and these organizations are working with CCN to pave the way for VBP contracting among their PCPs. CCN has also begun to strategize a response to this challenge that provides direct support through incentives and data analytics.

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?

CCN has not made any largescale changes to its VBP strategies since the Primary Care Plan of 2016. Rather, in the year since then CCN has sharpened, clarified, and specified the way that strategy would take shape across the network. The most significant of these clarifications has been the addition of a direct incentive for Value-Based Contracting which is expected to reach $10 million and is scheduled to go into effect January 1, 2018. In Summer of 2017, the VBP Incentive Support Program had been developed as a framework through which to incent partners across the PPS to enter into VBP arrangements with MCOs. After thorough reviews by the CCN VBP Sub-Committee and the CCN Finance Committee, a program is being presented to the CCN Board of Directors on December 12, 2017 outlining a $10,000,000 investment into VBP. The program is structured through a PMPM model whereby an organization receives a base rate depending on the level of the VBP arrangements. Level 2 VBP arrangements have a higher base rate than Level 1 VBP arrangements. To that base rate, modifiers are added for the quantity of Tier 1 CBO Relationships (defined as contracts for Social Determinant of Health interventions), the percentage of that organization's Medicaid revenue in VBP (thresholds at 50% and 90%), and lastly there is an add-on for alignment with CCN's Pay-For-Performance DSRIP measures. The maximum PMPM is $7.00 and the minimum is $2.50. Partner Organizations are required to submit a limited data set as an attestation for participation in the VBP arrangement with the MCO. In this way, the PPS will be able to track MCO dollars in VBP, partner participation, as well as risk appetite.

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:

In the period from April 1, 2016 to March 31, 2017, CCN has provided education to support Primary Care Providers to engage MCOs for VBP contracting. CCN is, again, fortunate to have the bulk of the PCPs in our network are part of larger health systems, and those organizations regularly engage MCOs. For the independent providers, most of whom are in our North RPU, an IPA in Tompkins County – Cayuga Area Plan/Preferred – regularly engages MCOs. Finally, we have also begun to provide direct incentives through our Innovation Program and plan to provide additional direct incentives through a VBP Support Incentive Plan. In Summer of 2017, the VBP Incentive Support Program had been developed as a framework through which to incent partners across the PPS to enter into VBP arrangements with MCOs. After thorough reviews by the CCN VBP Sub-Committee and the CCN Finance Committee, a program is being presented to the CCN Board of Directors on December 12, 2017 outlining a $10,000,000 investment into VBP. The program is structured through a PMPM model whereby an organization receives a base rate depending on the level of the VBP arrangements. Level 2 VBP arrangements have a higher base rate than Level 1 VBP arrangements. To that base rate, modifiers are added for the quantity of Tier 1 CBO Relationships (defined as contracts for Social Determinant of Health interventions), the percentage of that organization's Medicaid revenue in VBP (thresholds at 50% and 90%), and lastly there is an add-on for alignment with CCN's Pay-For-Performance DSRIP measures. The maximum PMPM is $7.00 and the minimum is $2.50. Partner Organizations are required to submit a limited data set as an attestation for participation in the VBP arrangement with the MCO. In this way, the PPS will be able to track MCO dollars in VBP, partner participation, as well as risk appetite.

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):

From April 1, 2016 to 31, 2017 CCN had no PCPs in level 2 or level 3 VBP arrangements, focusing instead on engaging Teir 1 CBOs as a PPS through our Navigation and PAM programs, and providing a matchmaking role in identifying gaps in care where CBOs can support PCPs on their DSRIP metrics. In Summer of 2017, the VBP Incentive Support Program had been developed as a framework through which to incent partners across the PPS to enter into VBP arrangements with MCOs. After thorough reviews by the CCN VBP Sub-Committee and the CCN Finance Committee, a program is being presented to the CCN Board of Directors on December 12, 2017 outlining a $10,000,000 investment into VBP. The program is structured through a PMPM model whereby an organization receives a base rate depending on the level of the VBP arrangements. Level 2 VBP arrangements have a higher base rate than Level 1 VBP arrangements. To that base rate, modifiers are added for the quantity of Tier 1 CBO Relationships (defined as contracts for Social Determinant of Health interventions), the percentage of that organization's Medicaid revenue in VBP (thresholds at 50% and 90%), and lastly there is an add-on for alignment with CCN's Pay-For-Performance DSRIP measures. The maximum PMPM is $7.00 and the minimum is $2.50. Partner Organizations are required to submit a limited data set as an attestation for participation in the VBP arrangement with the MCO. In this way, the PPS will be able to track MCO dollars in VBP, partner participation, as well as risk appetite.

Additionally, the next phase of contracting with CCN and its partner organizations will have built-in monetary incentives for partnerships between health systems and CBOs. There will also be separate contracts for building the integrated delivery system, but those details have not yet been finalized.

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:

PCPs can earn funds through the PPS by participating in several of our projects. We provide $20k to PCP sites previously at Level 3 2011 PCMH standards if they can get to Level 3 2014 standards, and $40k if they previously had no PCMH certification. Participation in 3ai (Integration of Behavioral Health & Primary Care) is supported through fee-for-service payments for behavioral health screenings and $50k incentives for integration at each site. 3bi (Cardiovascular Disease Management) participation is supported through a PMPM payment for managing a panel of cardiovascular disease patients, and 3gi (Palliative Care) participation is supported through a PMPM payment for management of a panel of Palliative Care Patients. 4bii participation is supported by payments for COPD screenings and related COPD management activities. For each of these projects, PCPs are able to select from a panel of metrics those which they would like to improve upon, and will be rewarded based on both their individual performance as well as the performance of the PPS (70/30 split for DT3).

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$8,916,401.39	**100%**
Primary Care Provider	$2,670,570	30%
Hospital-Ambulatory Care	$2,101,250	24%
Federally Qualified Health Centers (FQHCs)	$299,910	3%
Primary Care Practitioners	$269,410	3%
PMO Spending to support Primary Care	$202,060	2%

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?

The PPS has shifted to more payments for performance and less fee-for-service, thereby aligning with the upcoming shift from fee-for-service to fee-for value (VBP). We are also anticipating a $10 million incentive across the PPS to entice participation in VBP arrangements to begin in January 2018.

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):

As 3ai has moved forward, CCN has needed to support integration efforts from a number of different angles, including innovative pilot programs and workforce. With the initial primary care plan, CCN's strategy revolved largely around leveraging the MAX project and the pilot program at Lourdes Robinson Street Primary Care that embedded a behavioral health consultant at the practice, standardized PHQ-9 screenings, and implemented a brief intervention model which saw success in improving patient-provider engagement. Since this plan was submitted, CCN has progressed toward integration by developing a workflow to translate the successes of this MAX project to other practices and by increasing the amount by which CCN subsidizes PHQ-9 screenings across the entire network for primary care providers. CCN has also funded a new Video Teleconferencing for Behavior Health Patients program at Lourdes which will train MSWs in web-based, evidence-based problem solving therapy shown to be especially effective in rural populations like those found across much of CCN.

In an effort to promote behavioral health co-location across the PPS for our contracted partners, CCN has also designed a workforce recruitment initiative that prioritizes the recruitment of behavioral health professionals. 8 sites have already put co-location in place, and 9 more are in process, however, in several cases CCN's partners have met with difficulty meeting co-location requirements due to a behavioral health workforce shortage, and so in addition to this recruitment initiative, CCN has also leveraged its own professional networks and website to attract much needed professionals to these partners.

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

The hardest challenge in integrating Primary Care and Behavioral Health and for CCN has been the workforce shortage because it prevents willing partners from being able to adequately staff for co-location. This, in turn, increases burden on primary care providers who now, having incorporated early intervention screenings into their patient workflows, lack the on-site resources necessary to redirect patients based on their newly acquired information.

Besides issues with staffing, CCN has also seen its partners struggle with licensure optimization when it comes to behavioral health integration. Because behavioral health integration both increases the amount of coordination needed in the clinical setting and complicates the billing situation both for the primary care provider and for the behavioral health professional, ensuring that everyone on the patient's care team is working as efficiently as possible becomes absolutely critical. Though as more EMR systems come online and with the new workforce recruitment initiative, as more care coordinators take their places in primary care practices licensure maximization is getting better but remains a key challenge network-wide.

Workforce has developed a two-phase recruitment strategy to bring high needs position into the PPS. Partner organizations will have an opportunity to work with a CCN – chosen recruitment firm to assist their own recruitment efforts. Partner organizations will also be able to apply for a financial subsidy that will help to alleviate some of the burden in recruitment fees. CCN's two-phase recruitment approach will begin with phase one recruiting of behavioral health workers due to their pervasive shortage, as identified via the Gap Analysis and Future Workforce State. The process of partners applying for financial subsidy began on Nov 1st with the release of an RFA. Phase One Recruitment is slated to start the beginning of January and the program will run until June 30th, 2018. Phase Two Recruitment of PCPs and RNs will commence a couple of months into 2018 and will likely also run for a 6- month period. Upon completion of both phases of the recruitment program, the results will be analyzed and a determination will be made as to whether or not to run additional rounds of recruitment.

CCN has also implemented a recruitment campaign via LinkedIn. Behavioral Health recruitment started on 9/12/2017 and resulted in 1556 impressions for a total of 21 clicks to our partner organizations' HR website. We will continue to monitor and evaluate this recruitment campaign. We will be rotating the recruitment among the four categories of workforce shortages which were identified in the Gap Analysis: Primary Care, Licensed Behavioral Health Specialists, Nursing and Care Coordinators.

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

The complexity of primary care and behavioral health integration has been made even more challenging by inconsistent and confusing regulations that have hampered the ability for behavioral health professionals to move into the roles that an integrated delivery system needs them to fill. Two key issues have surfaced over the course of DSRIP: (1) Confusion over licensure requirements and billing rules for behavioral health workers who "float" between different practices, and (2) burdensome requirements for telepsychiatry practicing that excludes non-medication prescribing behavioral health professionals from engaging patients and limits the flexibility behavioral health professionals have in terms of what locations they can offer telepsychiatric counseling from.

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?

The development of a robust workforce recruitment strategy represents the most significant strategic change since the previous Primary Care Plan. In addition CCN has worked to develop a process that translates the learnings from the MAX projects to the rest of the PPS, filling in a crucial gap that existed in the earlier plan.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	88	42	8
Model 2	10	4	4
Model 3 IMPACT	N/A	N/A	N/A

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): Columbia Suicide Severity Rating Scale Senior Counselor
☐ Other Substance Use screening (please specify): Click or tap here to enter text.
☒ Other

Describe:

Crisis Stabilization Clinical Guideline Training

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