

Primary Care Plan Update 2017

Central New York Care Collaborative

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.

The Primary Care Plan submitted to the NYS DOH in 2016 underwent revision which included an action plan to actualize the strategic plans of the PPS. These changes included: 1) implementing a primary care provider recruitment plan, 2) implementing a plan for expanding primary care medical student and resident clinical rotations and opportunities, 3) revising the funds flow policy to enhance incentives for primary care provider DSRIP participation, 4) assessing and enhancing capacity for health professions mentoring and shadowing and finally, 5) hiring of a Chief Medical Officer.

Our PPS includes 11 hospitals systems and over one hundred other partner organizations that compete for a limited pool of healthcare provider candidates. The PPS has changed its strategic efforts to financially assist partners in sharing the cost of recruitment and insure that partners do not “steal” each other’s providers but rather collaborate to make the community more attractive to outside professionals seeking to relocate. The PPS has engaged with the state’s medical schools and regional colleges to enhance and increase opportunities for training and mentoring within our community.

The PPS has revised its funds flow policy to provide incentives for primary care providers to participate in DSRIP projects, receive monies upfront to facilitate implementation of strategies that enable participation and finally reward them for collaborative improvement of outcomes. Primary care providers were front and center in the revisions of the funds flow policy.

Finally, the addition of a CMO has facilitated clinical oversight of PPS efforts as well as engagement and recruitment of primary care providers.

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:

The CNYCC developed a Primary Care Plan which aimed to address primary care capacity, performance and needs. This required development of an action plan which focused primarily on addressing the shortage of primary care providers in CNY. The action plan has been implemented and is being successfully executed on time, budget and goal. Half the goals have been fully completed at the halfway point. These include: selection of a workforce recruitment agency and promotion of the cost-sharing program for recruitment costs, promotion and collaboration in expansion of medical student clinical rotations and residency programs and finally, revision of funds flow policies with the active participation of primary care physicians.

In addition to addressing the workforce challenge in expanding primary care capacity, the PPS is strategically engaged in assisting partners to increase productivity, improving operations and care delivery. This is done through webinars, newsletters, learning collaboratives aimed at improving more efficient care, improving patient scheduling, improved population health management and team based healthcare delivery. Engagement of partners in the population health management platform has begun. The process involves coaching work flow changes which will improve primary access through efficiencies once implemented. The PPS is working with partners to expand their primary care physical capacity including opening new sites, promoting the mobile crisis stabilization unit within the region and expanding hours and access to primary care services via urgent care centers. With assistance from the PPS, three partners have been successful in attaining infrastructure development grants totaling approximately \$74 million to expand physical capacity.

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

One of the challenges encountered by the PPS in addressing primary care capacity is the institutional barriers to agility in change implementation. Sixty percent of our primary care providers are employed by partner institutions, namely, hospitals. Whereas changes in a single site private primary care practice can be expedited, changes in hospital based clinics must proceed via institutional change processes which slow change implementation. Hospital based clinics, however, often have access to capital which is not readily available to private physician practices. This lack of financial resources to implement technology changes and capacity solutions presents a significant barrier in the community based private practice sector for improved efficiencies, access, performance and capacity.

While primary care providers can often be persuaded of the need and value of change, the hurdle of adoption of a uniform standard for new processes is often time consuming and difficult. This is true of both private practice as well as hospital clinics where providers are accustomed to across network policy changes being imposed.

Finally, engagement of community based physicians in healthcare reform and innovation endeavors is a challenge as engagement requires setting aside time from an already busy schedule as well as representing a loss of revenue given time away from rendering clinical services to patients.

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?

Initial strategies aimed at addressing capacity, performance and primary care needs required revision at the mid-point assessment so as to develop a firm and actionable plan which addressed these needs. The Funds Flow policies required revision to better incentivize primary care practices to engage in the DSRIP initiative. Physicians were incentivized to participate in the decision-making processes via compensation for their time and effort. Engagement of a Chief Medical Officer has created a collaborative relationship between the PPS and providers through personal engagement of the CMO with providers.

Evidence-based strategies for workforce development have been developed which include reaching out earlier students and individuals who might have an interest in health careers. This has included reaching out to non-partner organizations in our communities to better understand the efforts being made by institutions of higher learning as well as hospitals to foment and advance interest in the health professions.

In addition to recruiting efforts, an action plan to expand capacity by increasing access for medical students to our hospitals and ambulatory care offices and residency training capacity for resident physicians has been implemented.

The PPS hired a Chief Medical Officer who has focused on efforts to engage community based physicians in governance and committees as well as education of the physician community in regards to funding sources for technology, VBP and Population Health Management transformation.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:

The PPS has engaged community-based primary care providers through a variety of efforts. First, since implementation of the Primary Care Plan in 2016, the PPS has hired a Chief Medical Officer who has placed a critical role in engaging physicians in the DSRIP Project.

Second, the PPS has carried out numerous educational initiatives for both hospital and community based primary care providers via its newsletters, webinars, hospital medical staff meetings, county and district medical society meetings as well as small group practice educational sessions on topics including but not limited to smoking cessation, CVD and hypertension management, palliative care pain and symptom management, and advance care planning. These have garnered the interest of community PCPs to engage in the clinical governance committee and its other subcommittees including clinical quality reporting committees and the Funds Flow Revision workgroup. Two thirds of the clinical committees' members are community based providers. Activities have included work on the development of the new funds flow policies, their associated performance and outcomes measures, transition to VBP and population health practice. The robust community primary care provider engagement has helped to develop performance activities and incentives which promote DSRIP goal outcomes, transition to VBP, the practice of population health and attainment of PCMH level 3 certification.

Third, through the RPAC, EPAC and learning collaboratives, community based providers have been engaged in the development of standards that work for integrating the many community practices which do not have the standardized processes implemented across hospital integrated primary care practices.

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| <i>Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:</i> | 176 |
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e. Additional Information

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| <i>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:</i> | 447 |
| <i>Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:</i> | 68 |
| <i>Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:</i> | 26 |

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:

In the past year, the number of practitioners recognized as NCQA PCMH 2014 Level 3 has increased from 22 to 68, tripling the number of practitioners meeting patient-centered milestones. Within the next few days, we anticipate 85% of our primary care practice sites will attain level 3 PCMH certification status. This was achieved through its global initiatives in PCMH transformation.

The PPS has used its learning collaboratives and webinar platform to educate providers on the PCMH model and the level 3 certification process. This has included education in change management and rapid cycle improvement as well as NCQA standards and healthcare delivery transformation.

The PPS has provided funding and education for IT tools necessary to comply with requirements and practice assessment education on preparedness for certification requirements. Amongst these tools is a work plan tool which helps PCPs meeting recognition requirements. Financial incentives were provided for partners to implement the planning tool as well as hire a CNYCC recommended vendor for PCMH support.

Finally, CNYCC has employed a PCMH Certified Content Expert (PCMH CCE) to assist practices in transformation to patient-centered medical homes. CNYCC has implemented strategies to support CNYCC partners in achieving PCMH transformation. This has been at the PPS-wide level as well as with larger partners groups and smaller practice cohort consultation. This has included assistance with baseline assessments, gap analyses, best practices and logistics of the application process.

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:

One of the main challenges our PPS has encountered in working with primary care practices to meet NCQA PCMH Level 3 or APC milestones has been the lack of provider awareness of the PCMH or APC models of care delivery and/or a sense of urgency in moving towards meeting these healthcare reform targets. Uneven amounts of focus on population health management and quality improvement has been evident in current state assessments of across practices. The shift to a patient-centered care approach has meant a shift in culture for most organizations and practices. Training opportunities in patient-centered fundamentals have been limited.

Another barrier has been a lack of resources in primary care settings for practices to meet the standards. While early on funds were available for engagement of PCMH consultants from a variety of sources, they were both insufficient for many practices as well as underutilized by others resulting in a slow adoption of the PCMH or APC recognition process. Additionally, the ease with which primary care providers could access funds or assistance were often viewed as burdensome, warranting funding strategies and assistance that could be perceived as "hassle-free" and user-friendly.

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?

The challenges identified in addressing Fundamental 2 highlighted the need for strategic changes in the PCP plan.

Educational

First, the PPS implemented a strategic plan to educate providers on the basics of the PCMH model, the certification process and the preparation for engagement. The PPS and its consultants conducted webinars and assisted partners on the PCMH model, the process for certification and selecting an EMR vendor. The PPS-wide educational strategy was reinforced through the smaller group efforts such as the facilitation of regularly scheduled user group meetings for primary care practices that utilize the most popular ambulatory EMR platform across our region. It promoted the exchange of ideas and best practices for PCMH and DSRIP project requirements.

Technical support and training

Because of the diversity of EHR/HIE amongst our providers, the PPS provided broad tools and support allowing the funding strategy to assist providers select the vendor more suitable for their practice needs. The PPS through its CCE, IT Staff and project managers provided customized educational/technical assistance to smaller community practices. Additionally, the PPS provided partners with tools such as model RFPs, sample project plans and requirement matrixes.

Financial

The PPS provided funding and incentives for partners to assess their clinical practice and technology readiness for engagement. The PPS engaged primary care providers in designing the best performance metrics aligned with the appropriate financial incentives capable of moving practices swiftly into PCMH level 3 certification.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?

The PPS is poised to have 85% of its primary care practice sites PCMH level three certified in December 2017. The PPS has employed four strategies, all of which it has found vital to the success of PCMH transformation in primary care practices:

Education and training

In 2016, CNYCC staff and consulting resources conducted webinars to assist partners with their efforts to select an Electronic Medical Record Vendor. Discussion topics included project structure, RFP/RFI, and other essential technical/operational functions to consider when choosing an EMR. Additionally, template that were developed by CNYCC were reviewed and made accessible to the PPS partners, including an RFP, sample project plan and req matrix.

Financial support

The PPS provided funding for as detailed more explicitly in other areas of this plan which provided funding incentives for EHRs as well as to meet the standards necessary for successful PCMC level 3 accreditation.

User group engagement

CNYCC staff also facilitate regularly scheduled user group meeting for primary care practices that utilize the Medent EMR, which is the most prominent ambulatory EMR vendor in use across the CNYCC partnership. The primary objective of this user group was to provide a forum for CNYCC Partners using Medent to come together, share experiences, and learn how to use MEDENT to meet PCMH and DSRIP project requirements.

CCE support

As noted elsewhere in this report, the CCE and staff provided more tailored assistance particularly to community based practices in meeting transformation goals.

e. Additional Questions:

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

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| <i>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:</i> | 0 |
| <i>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:</i> | 202 |

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

447

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:

In 2016, CNYCC implemented a Primary Care Plan which laid out the strategy for evolving as an IDS with Primary Care playing a central role. In that plan, the integrated delivery system included health partners throughout the continuum of primary care as well as linkages to secondary and tertiary care. The strategy included the PPS serving as the facilitator for adoption of the PCMH/APC model across primary care practices using a healthcare informatics platform consisting of PHM platform (IBM Watson), EHRs, the RHIO, and our 11 DSRIP projects. The PPS has engaged and continued to engage primary care providers from both institutional and community practices in the clinical governance process as well as the PPS's working committees and clinical quality reporting committees. The PPS was successful in engaging both institutionally and community-based primary care providers in the fund flow revision process which allowed them to develop metrics driven by primary care and which encourage and incentivize engagement with secondary and tertiary service partners.

The PPS has established the operational infrastructure for the 11 Clinical Governance Committee's Clinical Quality Reporting Subcommittees with a strong weighting towards primary care provider engagement. With the guidance of primary care physicians, outcomes and performance metrics have been developed and adopted with the engagement of secondary and tertiary services partners. Primary care providers have been engaged in the Population Health Management platform implementation strategy development and implementation effort. Finally, they have successfully engaged with the RHIO to enable connectivity which provides for meaningful engagement with the full continuum of care partners in the PPS.

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 PPS has encountered several challenges which have affected implementation of its strategies for primary care playing a central role in its integrated delivery system. First and foremost has been the challenge of recruiting primary care providers to engage in governance. Both community and institutional primary care providers report being pressed for time and being unable to engage in governance within the PPS. Most of the primary care engagement has been by providers employed by large partner organizations. With this population of providers, the challenge is eliciting willing and enthusiastic engagement. With community providers, the challenge is primarily the loss of revenue represented by taking time to participate in PPS governance.

A second challenge has been the financial barriers associated with IT transformation, especially for community-based primary care providers, which delay implementation of the strategies. This has included both the costs of acquisition of IT which facilitates the engagement and integration with the rest of the partners in the continuum of care. It includes the costs for consultant services to help them with EHR implementation, new workflow processes related to technology as well as population health focused clinical practice, and finally PCMH/APC recognition.

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?

The PPS has made these strategic changes to Fundamental 3 as originally addressed in 2016:

Engaging PCPs in IDS governance

The PPS has successfully encouraged institutional partners to prompt primary care engagement by highlighting the importance of institutional representation in the process. Similarly, community-based primary care providers have been prompted to participate by highlighting their need to define and drive strategies which work for community providers and not simply institutional partners.

The Chief Medical Officer's local background and primary care experience has helped garner buy-in for physician driven IDS governance. This has in turn aided in their recruitment for participation in the governance process. The CMO, CCE and other project managers have aided in customizing solutions for project engagement, PCMH certification and VBP/PHM adoption such that the PPS has been very successful in recruiting community based physicians into the governance process.

Financial strategies for overcoming IT transformation barriers

CNYCC has committed a very significant amount of funding in both operational costs and partner funds flow to overcome IT financial barriers to attaining an IDS. Most notably is the acquisition and implementation of the IBM Watson Health Population Health Management (PHM) infrastructure. The vendor licensing and integration costs associated with this project have been accounted for within CNYCC's operating budget and are provided to the PPS partners at no cost. CNYCC also distributed ~\$6M (~\$175,000/partner), upfront, to cover partner costs associated with the integration of these technologies. Additional funding incentives are also in place to support partner costs associated with training and platform adoption.

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:

Based on feedback from the State, CNYCC has worked to ensure that PPS partners' Electronic Medical Records are capable of meeting Meaningful Use Stage 2 requirements, using surveys, project plans and RHIO support. CNYCC has also worked to connect our partners to existing Regional Extension Centers (RECs), as well as to educate them on available incentives.

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):

To Collaborate on RHIO Related DSRIP activities, CNYCC, HealtheConnections and other regional PPSs have collaborated to create a centralized tracking mechanism for required RHIO Participation. The PPSs use this repository to feed information to the RHIO. The RHIO utilizes this information to inform its engagement with PPS partners and to ensure that they are implementing necessary and relevant RHIO services.

In addition CNYCC works with the RHIO to provide list of partners who are incentivized to participate in additional RHIO services through CNYCC's funds flow program. Approximately \$900,000 in RHIO incentives were distributed to PCP and other PPS partners as part of our year one funds flow policies to encourage the signing of RHIO participation agreements, as well as documentation of organizational consent management workflows. An additional \$440,000 worth of incentives targeting the adoption of RHIO alerting services have also been included in CNYCC's most recent funds flow policies.

As part of the initial PPS planning efforts, CNYCC established a process to identify partner organizations that were eligible for RHIO participation, as well as RHIO services. Following is a summary of current utilization for applicable partner organizations.

- RHIO participation agreements: 95% adoption rate
- Patient Lookup: 95% adoption rate
- Direct Messaging Services: 58% adoption rate
- Data Sharing: 68% adoption rate
- Alerts: 52% adoption rate

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

447

f. Additional Information

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| <i>Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:</i> | 48, 10.7% |
| <i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:</i> | 16, 3.6% |
| <i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:</i> | 32, 7.1% |

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:

As outlined in our VBP Support Implementation Plan, CNYCC has continued with the development and implementation of performance and care management toolsets that will enable our partners to manage the risk associated with taking on the additional financial and clinical accountability associated with VBP contracting. Additionally, CNYCC's PHM Executive Steering Committee developed a scope of work and selected a vendor of choice to assist the PPS with an in-depth VBP Readiness assessment to both inform the partner network and help identify value-added services that CNYCC could develop to further support VBP readiness and execution across our region.

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

Through the Value-Based Readiness Assessment (VBRA) process conducted on CNYCC's behalf by ECG Management Consulting, a number of challenges were identified specific to primary care providers. For hospital-based clinics, lack of experience in VBP, payor contracts that are nearly exclusively fee-for-service, minimal participation in established ACOs or CINs, limited readiness for risk, insufficient resources and full patient panels, limited care management staff, variable utilization of the RHIO, slim operating margins, heavy reliance on manual processes for data analysis, reporting, and measurement, productivity-based compensation structures, and underdeveloped physician training and educational infrastructure were identified as current-state gaps.

For federally qualified health centers, limited engagement from payors in support of moving into value-based contracts, a nascent and therefore inexperienced IPA, lack of medical and behavioral health documentation integration, and challenges with largely manual communication with external healthcare organizations related to patient care transitions that has negatively impacted care coordination were identified as current-state gaps. Community-based primary care providers experienced similar challenges but at a more acute level. Most practices are single site entities with little if any organizing structure which might serve as a means for collective education and preparation.

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?

Between July and September 2017, CNYCC conducted in-depth value-based readiness assessments with more than 20 partner organizations that offer primary care (PC) services, including FQHCs, health systems, a medical group, and post-acute/long-term care providers. The interviews revealed that more than 90% of interviewed organizations that provide PC are engaging in innovative care delivery models via DSRIP, PCMH, commercial ACOs (e.g., Excellus ACQA), and/or MSSP ACOs. As a result, most PCPs have experience with quality and performance measurement and reporting.

That said, reimbursement remains largely FFS. While approximately half of PC organizations are engaging in P4P and/or shared savings arrangements (VBP Levels 0 and/or 1), few interviewed providers assume downside risk (VBP Level 2). Some lack the financial reserves, and most lack the ability to effectively manage care in a PC setting due to:

- Limited PC, behavioral health (BH), and care management (CM)/care coordination (CC) resources—a result of workforce shortages, recruitment challenges, and financial constraints;
- Lack of business analytics tools to understand performance (quality, utilization, and/or costs);
- Fragmented, labor-intensive care transitions due to poor electronic information exchange; and/or
- Autonomous PCP culture, limiting enterprise-wide integration and protocol and policy adoption.

To address the identified gaps, CNYCC is undergoing strategic planning to determine the feasibility of offering centralized navigation/CC, CM, and BH support. Simultaneously, CNYCC is preparing to deploy the IBM Watson population health management product suite. Finally, CNYCC has outlined specific, operational education sessions for PCPs in the “Partner Engagement Schedule” submitted in July 2017.

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:

During DY2, CNYCC has supported primary care providers in engaging with MCOs in several ways. During CNYCC's annual meeting in November 2016, CNYCC invited a speaker from United Healthcare to present to our partner network regarding their planned approach to rolling out value-based contracts. Subsequently, CNYCC facilitated connecting partners that contacted us following that presentation with UnitedHealthcare.

Additionally, through CNYCC's role in the VBP-QIP program with two facility-plan partnerships, CNYCC has supported facilities, both hospitals with primary care clinics, in accomplishing necessary steps in the process to receive VBP-QIP funds and to enter into VBP Level 1 agreements with their partnered plans.

On the topic of quality, CNYCC has invited MCOs to present during our Outpatient Learning Collaboratives attended by primary care and outpatient behavioral health providers. During those Learning Collaboratives, the MCOs shared information with the present primary care providers regarding their quality and outcomes priorities and the initiatives underway by the MCOs to work with primary care providers to improve identified measures.

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):

CNYCC is unaware of any partners in Level 2 or 3 VBP arrangements at the time of this report. To engage CBOs, CNYCC sponsors PPS-wide Learning Collaboratives to focus upon cross-setting communication between the health sector and human/social service agencies. With IPRO, CNYCC co-sponsors local Care Transition Coalitions which have fostered partnerships between human/social service agencies and health care providers to reduce readmissions. Additionally, CNYCC is a strategic partner of the Human Services Leadership Council, a member organization of over 60 human/social service agencies in Central New York and has presented at HSLC member meetings to engage community-based organizations.

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: CNYCC arranged for in-depth Value-Based Readiness Assessments for a cohort of partner organizations including several primary care providers. One group of primary care providers recently formed an IPA and the results of the assessment was shared with the IPA to assist them in addressing their current-state gaps. Additionally, as described in Fundamental 4 in our 2016 Primary Care Plan, the regional Population Health Management (PHM) system that CNYCC is making available to partners is a significant form of technical assistance available for all partners, including primary care, that are planning to form contracting entities.

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:

Through DY2 Q4, hospital-operated primary care clinics, federally qualified health centers, and other independent primary care practices received approximately \$4 million (18.45%) of CNYCC's overall payments to partners, representing one of the highest-earning categories of partner organizations. Under CNYCC's DY1 & DY2 funds flow model, primary care received payments for many activities including but not limited to signing participation agreements with the RHIO and demonstrating a process for capturing RHIO consents, for PCMH/APC planning, for planning and implementing Model 1 of the Primary Care/Behavioral Health Integration (3ai), Cardiovascular Disease Management (3bi), and Palliative Care PCMH Integration (3gi) Projects, for staff to receive required training, and for reporting engaged patients.

CNYCC's redesigned funds flow model, further described below, increases the share of total funding allocated to non-hospital-operated primary care such as federally qualified health centers and independent primary care practices to over \$7.3M, or 20% of the total funding planned for distribution under the model. Funding allocated for hospital-operated primary care activities is not separated under our funds flow model from the funding allocated to hospital health systems (\$12.2M or 43% of the total). CNYCC does not issue payments to the primary care practitioner employees of our partner organizations directly, and thus will continue to report no direct primary care practitioner payments as all funding is directed to the contracted hospital health system, federally qualified health centers, or independent group partner organization.

| <i>b. Funds Flow</i> | <i>Total Dollars Through DY2Q4</i> | <i>Percentage of Total Funds Flowed</i> |
|--|------------------------------------|---|
| Total Funds Distributed | \$21,560,947.58 | 100% |
| Primary Care Provider | \$3,977,777.53 | 18.45% |
| Hospital-Ambulatory Care | \$1,806,169.33 | 8.38% |
| Federally Qualified Health Centers (FQHCs) | \$1,754,687.09 | 8.14% |
| Primary Care Practitioners | \$416,921.11 | 1.93% |
| PMO Spending to support Primary Care | \$112,800.00 | 0.52% |

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?

In fall 2016, CNYCC's Board of Directors recognized a need to redesign the PPS's funds flow model. Although the DY1 & DY2 model achieved many DSRIP project milestones and patient and provider targets, there was a need accelerate the flow of funds to partner organizations to seed transformation and to align the funds flow model with the DSRIP Program's overall shift to improving outcomes. CNYCC began work to redesign our model with consulting support from COPE Health Solutions and the input of a multi-disciplinary workgroup composed of partner organizations, physicians, and a MCO representative. With COPE's assistance, the workgroup defined the activities partner organizations will be paid to complete in the upcoming year and determined the relative impact of different partner service types upon achievement of the PPS's defined performance measurement targets.

Given the scope of this effort and the time required, the Board approved a short-term payment to partner organizations to bridge the gap between our DY1/DY2 model and the beginning of the redesigned model. The "Bridge" payment opportunity provided all partner organizations, including primary care, payment in exchange for completing a number of activities such as required DSRIP workforce reporting, the 2017 required financial health assessment, CNYCC's VBP readiness assessment, and validating their provider NPIs and other DSRIP contact information. Partners with the greatest volume of Medicaid patient data, including many primary care providers, were eligible for a sign-on payment to offset the start-up costs of sharing data with CNYCC's population health management (PHM) system.

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):

CNYCC is progressing towards integration through various efforts. CNYCC continues to educate partners in regards to relevant regulatory thresholds and the requirements for fully integrated licensure.

A significant element of our strategy has been focused on establishing connections between partner organizations through a one-on-one approach. These efforts by the PPS have been vital for partner organizations that do not have the capacity or funding to hire a position to provide the complimentary service to achieve integration in their location. Through these relationship building efforts, CNYCC is bringing together potentially complementary partners to generate creative sustainable partnerships.

As partners work together towards integration, CNYCC is catalyzing the design and implementation strategy process critical for operationalizing the colocation of services through facilitated meetings. These meetings further serve to highlight best practices as well as barriers and obstacles partners are facing. Through these meetings, partners are able to assist one another and generate solutions to barriers that each may be facing. This working meetings also facilitate connection of early adopters to practices struggling towards implementation.

CNYCC has been facilitating OMH and OASAS presentations to PPS partners as well as bringing together State agencies and resources with partners. These presentations and connections have been invaluable to partner integration. Finally, the Funds Flow revisions further incentivize integration.

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

CNYCC has faced several challenges with integration. Competing challenges in healthcare reform have slowed the contracting and implementation efforts for many partner organizations. Understanding the State requirements for integration and meeting the challenges of such integration within a diverse and complex market has been a significant challenge for many partners. The vetting process, selection and implementation of IT systems and other workflow processes have added to these challenges especially as these require consideration for the needs of collaborating partners who require agile tools and processes to meet other needs as well.

Another challenge facing partners is staff turnover. The limitations in human resources within our region means that our partners who are engaging in such integration often do not have the capacity to employ two individuals with the same project building skills or knowledge. Thus, loss of project integration personnel often means the integration process comes to a halt while a new resource is trained and brought up to speed on integration efforts. Momentum is lost when finding a replacement takes months.

In addition to the staff turnover within these organizations, hiring and/or finding staff that could fill the colocation vacancies has posed a large challenge. There is a significant shortage of certified providers to fulfill project requirements (i.e. Psychiatrists, Psychiatric Nurse Practitioners, Licensed Clinical Social Workers, etc). Due to this shortage, partners cannot integrate into their practices as there are no providers to deliver the requisite services.

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

CNYCC has attempted to address several regulatory challenges related to primary care/behavioral health integration. These include challenges related to regulations on billing for services rendered and hours of service.

Primary Care Practices are facing a significant challenge due to their lack of ability to bill for social work services. Entities that are choosing to integrate services through the addition of direct hire staff are finding they cannot bill for services their staff member provides. This has served as a significant barrier as Primary Care Practices eager to hire such staff find themselves unable to bill appropriately for the services they seek to render.

Another regulation which poses a challenge is the eight hour per week staffing requirement for a Primary Care Provider that is co-located within a Behavioral Health site. Due to the shortage of Primary Care Physicians, this eight hour requirement still serves as a barrier, as many providers are booked to capacity within their current practice.

Lastly, the licensure process in which to co-locate services via partnership with a licensed Mental Health clinic/provider requires an application for a satellite site. This process requires permission from the County, a certificate of need, and a separate application to OMH. This regulatory challenge is daunting for practices that are attempting to co-locate services as they must jump through these hoops before services can be rendered.

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?

In order to keep this project moving forward and to adequately fund true integration, CNYCC has taken steps to address the financial challenges of integration through its recent funds flow revision process. The PPS has sought to provide financial support through the establishment of outcomes and performance metrics which operationalize the goals of integration and rewards partners implementing the necessary steps for integration.

Partner organizations have worked collaboratively to establish metrics which financially incentivize outcomes measures which align with integration goals. Monies are advanced to partners to assist with the financial challenges of integration while leaving additional monies on the table to insure successful completion and financial reward along the continuum of integration.

The PPS participates in the RMI- BHPC workgroup of the RMI Regulatory Modernization Initiative- as part of its effort towards facilitating knowledge transfer and problem solving for integration challenges.

Additionally, the PPS has begun to collaborate with institutions of higher education to develop new degree programs for the emerging new healthcare team roles including those in BH.

Finally, the PPS implemented changes to its workforce strategy which helps partners in the recruitment of providers of primary care and behavioral health services by sharing the financial cost of recruitment.

| <i>e. Model</i> | <i>Number of Sites Planned</i> | <i>Number In Progress</i> | <i>Number Complete</i> |
|-----------------|--------------------------------|---------------------------|------------------------|
| Model 1 | 81 | 42 | 39 |
| Model 2 | 24 | 5 | 4 |
| Model 3 IMPACT | 0 | 0 | 0 |

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): [Click or tap here to enter text.](#)
- Other Substance Use screening (please specify): [Click or tap here to enter text.](#)
- Other

Describe:

GAD-7 and CAGE Screening tools

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