Primary Care Plan Update 2017

Finger Lakes PPS

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.

FLPPS' strategic vision to enact an overarching Primary Care Strategy to achieve the Triple Aim by:

- Defining and identifying opportunities to increase primary care capacity
- Building a strong PCMH infrastructure to support population health transformation
- Utilizing technology to close gaps in coverage while improving access and capacity

Over time, the PPS has had an opportunity to take stock of the challenges surfacing across the FLPPS Network, realizing it shared several challenges with region's existing, mature, regional IPAs/ACOs. The existing IPAs/ACOs, affiliated with the major health systems in the region, employ or contract with the majority of primary care providers in the region. In addition, FLPPS has begun to engage with a newly forming IPA, the Finger Lakes IPA (FLIPA), which is comprised of four FQHCs and other community clinical providers, who serve the FLPPS 13-county region. The PPS estimates between 60,000 – 70,000 managed Medicaid members will be attributed to this new IPA across all MCOs. FLPPS will be partnering with FLIPA to support development of infrastructure to align with DSRIP goals in serving their attributed members in a VBP environment.

With the formation of FLIPA, the FLPPS primary care network has almost 100% affiliation with an IPA/ACO. As a result, FLPPS began considering a collaboration with these IPA networks, with a focus on scaling efforts while using the entities to design, deploy and measure targeted initiatives that raise the capacity and efficacy of the PPS Network's primary care services. With these networks, the PPS will look to build on existing PCMH/ enhanced primary care practice transformation efforts already underway through DSRIP projects, as well as explore the possibility of deploying rapid pilot programs that support the integration of behavioral health in primary care.

Though the basic tenets of the initial FLPPS Primary Care Plan strategy are not changing, the PPS is looking to augment its efforts by engaging regional IPAs/ACOs, and defining the roles they might play so that initiatives yield results that are more effective. In short, FLPPS will benefit greatly by aligning the PPS with the evolving organizational construct of the broader PPS Network, in view of the VBP roadmap and sustainability vis-a-vis the FLPPS IPA/ACO Strategy (page 1).

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:

FLPPS has made progress in addressing primary care capacity and needs. Eleven of the 13 FLPPS counties are HPSAs. Primary care capacity has expanded with additional providers in the five Naturally Occurring Care Networks (NOCN), to increase Saturday and extended hours. Additional provider as follows: Monroe NOCN - 10 providers; Western NOCN - 4 providers; Finger Lakes NOCN - 3 providers; Southern NOCN - 3 providers; Southeastern NOCN - 9 providers.

The PPS has developed targeted interventions and innovations: 1) FLPPS supported a pilot project in DY2 that focused on children's access measures and outcome data was used to target practices. FLPPS offered financial resources and created a learning collaborative platform to assist practices in process improvement for outreach to families. Although barriers were identified, PCP access was not a regularly identified barrier. While this did not dispute the PCP shortage existing in the region, it did demonstrate many other barriers at the family-level need to be addressed before actual availability presents as an issue. 2) High utilization in Chemung County was addressed through a successful MAX project at Arnot Health, partnering with Health Homes, behavioral health services and primary care. 3) Innovation in team-based care redesign occurred at Jordan Health. 4) Finger Lakes Community Health extensively used telehealth to improve quality and grow their capacity by 10% in the Finger Lakes NOCN.

PCMH/APC growth is addressed in Fundamental 2. The FLPPS Care Management Workgroup, comprised of providers, IPAs, MCOs and Health Homes, developed a Health Home pilot to reduce a care manager's case load, enabling Health Home care managers to work with patients to strengthen connections with primary care and behavioral health, thereby supporting providers and improving outcomes.

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

Building an understanding of the FLPPS primary care network to reflect a true picture of capacity has been a challenge. FLPPS is comprised of 600 Partner organizations, including four health systems and four FQHCs across a 13-county region. Obtaining Provider NPI data by site, with an accurate count of FTEs, and maintaining this database with additions and departures, has been a larger task then originally scoped.

Delays in CRFP funding has also posed a challenge. There has been limited funding for Partners' capital expansion projects due to the CRFP delays. Plans for 2017/2018 capital expansion are in place for several major partners, including Rochester Regional Health's Northeast Health Center expansion, Clifton Spring's Medical Village, and UR Medicine's expansion of Highland Family Medicine and Strong Internal Medicine. Finger Lakes Community Health will expand in Bath, and Jordan Health's plans include expansion in Monroe county.

PCP workforce recruitment remains a consistent challenge for the PPS. Nationwide, there continues to be a shortage of PCPs coming out of residency. Rochester and the rural Finger Lakes Region struggle with recruiting PCPs, as the majority of residents prefer to work in larger cities, putting the FLPPS 13-county region at a disadvantage. Also, large hospital systems in the FLPPS region have existing recruiting efforts and resources. Efforts by the PPS to maximize resources and not duplicate effort has been difficult as health systems conducting recruitment activities cannot share details of their recruitement strategies due to anti-trust laws and competing interests. Some rural practices are connected to the larger health systems, while many are not.

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?

Data collection for DY3 includes collection of NPI data, including closer collaboration with the IPAs/ACOs to collect such data, which will give the PPS a currect picture of PCPs in its region. Based on that data, more details can be learned of areas within the FLPPS 13-county region that should have a priority focus. In addition, connecting this data with outcome measures regarding PCP access will be conducted to identify areas of overlap. FLPPS has realigned resources to expedite the completion of understanding the FLPPS primary care network.

In the initial Primary Care Plan submitted, FLPPS initially articulated plans for a regional office for provider (PCP) recruitment with a focus on rural practices and FQHCs. Implementation for operationalizing a regional office of physician recruitment has been met with significant challenges, many of which were anticipated by the PPS. As referenced on page 1, the FLPPS IPA/ACO Strategy (page 1) has refocused FLPPS in the process of outlining a regional office of provider (PCP) optimization as recruitment solely, may not address primary care shortages. FLPPS intends to serve as a resource for recruitment supporting all three IPAs, including connections to advisement on foreign visa issues for foreign PCPs entering the US or foreign born medical students, as one innovative solution to HPSA challenges. The focus will be on increasing the number of PCPs in the FLPPS 13-county region, in tandem with increasing PAs and NPs to maximize the utilization of PCPs.

FLPPS also continues to work with the DOH on the completion of CRFP funding.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
FLPPS has taken steps to engage and support community-based primary care providers, focusing on PCMH assistance. Two dedicated NCQA-certified content PCMH experts worked mostly with community-based providers, assisting them on their path to accreditation, focusing on smaller, more rural practices. Services have included gap assessment, individual practice training and coaching, and application review and submission for PCMH 2014. FLPPS also provided support to community-based practices on an individualized basis through a partner relations team. Projects 2biii (ED Care Triage), 2biv (Care Transitions) and 3ai (Integration of Primary Care and Behavioral Health) engaged community-based providers. The FLPPS team provided assistance to the community-based providers on project implementation, and Partner Portal access for reporting and comprehension of metric requirements for contracting. In addition, onsite visits by FLPPS staff to these community-based providers, provided focused and individualized support, and reinforcement of IT trainings and webinars. Customized orientations and trainings were provided, as requested by the community-based providers, on a fairly regular basis due to staff turnover. Collaboration with the Health Home Network of Upstate NY (HHUNY) to provide informative sessions for local community-based practices regarding Health Homes for adults and children was also initiated. The FLPPS IPA/ACO Strategy (page 1) will allow FLPPS to leverage the existing IPA/ACO relationships with community-based primary care providers in supporting their DSRIP efforts.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	213

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:	933
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	552
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	20

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:

FLPPS PCMH infrastructure grew to achieve 96% of the Project 2ai (IDS) provider speed and scale target, as of 3/31/17 - one year ahead of target. This achievement included 552 providers in 111 sites reaching 2014 PCMH Level 3 accreditation. FLPPS is actively working with practices towards the 9/30/17 submission date.

FLPPS employed two NCQA PCMH Certified Content Experts, whose role was to provide consultative support to organizations with internal PCMH teams, and provide hands-on coaching and training support to small practices. Some larger organizations engaged outside consultants for support, and FLPPS frequently collaborated with the consultants to move NCQA application work forward.

FLPPS provided Meaningful Use (MU) assistance in audit and MU attestation, which the PPS continues to provide to Medicaid-based participants in the program today.

FLPPS met regularly with the local technical assistance (TA) vendor regarding practice transformation network (PTN) and APC, to ensure that practices were appropriately enrolled in these programs, and that there was no duplication of services between FLPPS and the vendor.

FLPPS also partnered with UR Medicine for a Practice Transformation training grant engaged in two rural groups in practices in the towns of Hornell and Warsaw.

The FLPPS IPA/ACO Strategy (page 1) will allow FLPPS to leverage the existing IPA/ACO relationships with community-based primary care providers in supporting PCMH efforts.

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:

PCMH challenges the PPS faced were generally with the smaller and more rural practices. Due to the challenges related to the NYS definition for Safety Net, many of these practices were not eligible for adequate DSRIP dollars to do the work required. This work required internal resources, as well as EHR enhancements. FLPPS focused its resources on assisting these particular practices.

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?

FLPPS leveraged its large Partners and IPAs to use their resources to support PCMH. This approach aligns with the FLPPS IPA/ACO Strategy (page 1), to assign more resources to the IPA to outreach smaller providers and engage non-contracted attested community providers.

FLPPS continues to collaborate with Common Ground Health (formerly FLHSA) on APC for community Partners that are not contracted with FLPPS.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
FLPPS has found that having flexible, dedicated, in-house resources to focus practices on PCMH has been the most effective and successful endeavors in supporting PCMH transformation. The largest benefit of this strategy is the ability to integrate PCMH into the bigger picture of Delivery System reform, by assisting the practices on electronic health record (EHR) optimization and quality improvement. FLPPS worked with internal DSRIP teams and PCMH resources of large organizations to ensure that those practices are covered; this approach has also enabled FLPPS to reach its goal.

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:	0
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:	374

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	933

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:

FLPPS strategy for how primary care plays a central role in an integrated delivery system is grounded by strong representation of primary care providers in its governance structure, as noted on page 11.

Successful implementation of projects helped support PCP linkage with Project 2biv (Care Transitions) providing a 30-day care plan to community PCPs with real time notification and using care management to complete follow-up services. Project 2biii (ED Care Triage) ensured that EDs are connected to community PCPs for follow-up appointments upon discharge. Care managers for Project 2bvi (Transitional Housing) provided ongoing follow up for a 90-day period to ensure the individual has stabilized in the community.

FLPPS Social Determinants of Health (SDH) Strategy involved a concerted effort to engage vital CBOs to support primary care providers in population health, focusing on 1) Mapping all CBOs in the catchment area and creating a digital directory, 2) Creating an inventory of all SDH screening tools being used in clinical and non-clinical settings to understand data that is currently being collected, and 3) Actively working with the RHIO to expand "Direct" technology to all FLPPS CBOs, so that referrals can be made through secure digital communications as a "Phase 1" approach, while building out a more robust IT Infrastructure that will include a Care Coordination Platform to exchange information between clinical and non-clinical settings; In addition, a MAX Series, completed in the Elmira area, actively built and standardized approaches for the hospital, PCPs and CBOs to coordinate care of its most high-risk patients.

Cultural competency and health literacy progress for DY2 includes the completion of a cultural competency and health literacy readiness evaluation for 30 organizations providing primary care within the PPS, with support and training to occur in DY3.

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 large geographic area with varying care settings poses a challenge. The FLPPS 13 counties differ vastly, from urban to rural, with transportation issues facing many of our patients. Designing a "one size fits all" solution is a very challenging task when dealing with resource differences between smaller rural hospital and larger health systems.

Connecting rural community PCPs with specialty services is a challenge because of the competitive nature of the two major health systems.

The care management complexity that exists in serving our Medicaid patients was exemplified by the challenges that the Health Home care manager faces in serving as the "quarterback" of the patient's care. The FLPPS Care Management Workgroup identified many barriers that exist with the current Health Home structure, such as large caseloads. The ability of Health Homes to effectively ensure patients have their required follow-up after hospitalization, as well as a connection to social services, varies widely. Integrating this resource optimally with the PCPs office and PCMH care manager is a challenge. Efforts within the PPS to overcome these barriers is a major focus of DY3.

The vision of primary care playing a central role in an IDS requires effective clinical integration. The PPS has had an aggressive approach for Partners to increase adoption of core RHIO services. Challenges are many in the future strategy to develop standard electronic formats for important care documents, such as care plans and discharge summaries, that are seamlessly shared, in order to make the PPS vision a reality.

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?

Telehealth continues to be a growing part of the FLPPS Primary Care Plan, as it provides an opportunity to connect patients and overcome geographic barriers to specialists. Finger Lakes Community Health, an FQHC in the PPS, is a benchmark for providing a variety of telehealth services throughout their nine rural health centers, overcoming social determinants of health, lack of trust, and language differences, while improving access and resource utilization.

FLPPS will augment its efforts by engaging regional IPAs and ACOs, through the FLPPS IPA/ACO Strategy (page 1), for connection to tertiary services, as well as improving communication and connectivity.

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 an IT survey that FLPPS conducted in late 2015 (redistributed in July 2017), all FLPPS contracted primary care practices have adopted EHRs and most have achieved Meaningful Use Stage 2 certification. To assist practices in achieving the objectives of Meaningful Use Stage 2, we have enabled and encouraged the exchange of clinical information via our local QE (Rochester RHIO). This assistance has included the funding of EHR vendor and PCP End-User integration with the QE for the bi-directional communication of clinical information using standard exchange mediums such as CCDA (HL7 Messaging) for the coordination of care and population health management. This process has been managed and governed through FLPPS contracting metrics and the Integrated Delivery System (IDS) Plan that all contracted Partners have adopted and committed to.

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 encourage and enable the adoption of RHIO services, FLPPS developed an IDS Plan for each PPS contracted Partner. This plan details the requirements of each Partner to adopt RHIO Core Services (DIRECT, MyResults, Alerts & Patient Query Portal) as well as Contribute, which is the integration of EHR systems that allow clinical providers to bi-directionally exchange patient information. Each plan is tailored to each Partner based on their care setting. For primary care practices, they must adopt all services mentioned above. To support this effort, FLPPS has contracted with the Rochester RHIO to bring on additional staff and resources to expedite the onboarding of all FLPPS Partners by 3/31/18. FLPPS has also taken on the cost of EHR vendor integration with the RHIO for systems that have the highest adoption in the PPS Network. The status of the adoption of RHIO services covered in the IDS Plan is monitored on a weekly basis and adoption is supported via FLPPS's bi-annual contract reporting periods.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	933

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	29%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	67%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	33%

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 Value-Based Payment (VBP) Needs Assessment revealed that only 20% of FLPPS Partners currently participate in VBP arrangements. However, the cohort of providers that do participate in VBP arrangements accounts for most of the attributed lives in the PPS. On a whole, because of the significant concentration of attributed lives to providers who are employed by one of the major health systems in the PPS, many providers who are affiliated either through employment or through an IPA with these organizations are receiving support in their transition to VBP. However, the Needs Assessment revealed that providers who are not affiliated or employed with a major health system have not experienced the same level of readiness and preparedness for VBP. The varying degrees of VBP readiness on the part of providers in the PPS has heavily influenced the development of FLPPS VBP Implementation Plan. Refer to the VBP Implementation Plan document for further details regarding the results of the Needs Assessment.

The FLPPS IPA/ACO Strategy (page 1) will work to align VBP readiness initiatives of the PPS with those of the IPAs and ACOs.

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 VBP needs assessment, providers revealed that their largest barriers to enable successful transition to VBP, are financial resources, workforce resources, MCO communication and data analytics support. On average, Partners indicated that, on a scale of 1 to 5, with 1 being the least prepared, and 5 being the most prepared, they felt their level of preparedness and readiness for VBP is a 3.

Three-quarters of respondents reported that their organizations utilize certified electronic health/medical records, while approximately one-third use clinical decision support, and less than one-fifth use telemedicine technology for patient care. Sixty-seven percent of respondents reported their organizations receive information from a RHIO, but only thirty-five percent currently send information to a RHIO.

Successful VBP practices typically include care coordination with support services, and integrate mental health and substance use services for their patients. Most respondents indicated that they offered care coordination or management for their patients, with around a third providing it onsite only, ten percent leveraging it externally, and forty percent leveraging it externally in combination with onsite services.

The perceived barriers and challenges as identified by providers in the VBP Needs Assessment has heavily influenced the development of FLPPS VBP Implementation Plan. Refer to the VBP Implementation Plan document for further details regarding the results of the Needs Assessment.

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?

Referencing the FLPPS IPA/ACO Strategy (page 1), FLPPS will use the strategic partnerships with the IPAs/ACOs to increase provider readiness for VBP contracting. This approach will identify gaps in readiness and steps that can be taken to prepare providers for VBP, throughout the FLPPS 13-county region.

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:

FLPPS, as a NewCo, is a non-contracting entity. Nevertheless, FLPPS has actively attempted to work with MCOs, recognizing DSRIP as the road to VBP. FLPPS has MCO participation in the Clinical Quality Committee, Care Management Workgroup and Population Health Workgroup. These groups review clinical initiatives to improve clinical outcomes, and ultimately achieve the Triple Aim. Moving forward, as part of the FLPPS VBP Implementation Plan, FLPPS will support providers by aligning with the IPAs/ACOs in the progress towards VBP, as part of the FLPPS IPA/ACO Strategy (page 1).

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):

As stated in the submitted FLPPS CBO Engagement Strategy, FLPPS continues to work directly with CBOs (89 contracted Partners) to understand their role in a VBP environment, and the importance of connecting clinical and non-clinical providers, specifically in a primary care setting. Although the PPS did not specifically target support for primary care providers to reach level 2 and 3 VBP arrangements to address social determinants of health during this time, FLPPS' strong focus on social determinants of health and building CBO infrastructure, as per the FLPPS CBO Engagement Strategy, will be an enabler for providers to reach these arrangements in the future.

In addition, FLPPS PCMH support that includes quality improvements such as measuring clinical quality performance and referral tracking and follow-up are building infrastructure within the PCP practices for the VBP roadmap that would enable providers to reach these arrangements in the future. FLPPS is also working to identify key CBOs that can help providers achieve their desired clinical outcomes for these arrangements.

Progress with Project 2di (Patient Navigation), will assist providers as well. FLPPS created a community navigator program that links non-utilizers and Uninsured to primary care. These community navigators secure appointments with primary care and assist individuals in obtaining insurance. As part of this project, FLPPS created a Toolkit for CBOs to establish MOUs and BAAs with clinical providers, as well as case studies and work flow of best practices to assist with navigation of non-utilizers and low utilizers.

In addition, a MAX series, completed in the Elmira area, actively built and standardized approaches connecting clinical and non-clinical providers, to coordinate care of its most high-risk patients.

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: FLPPS provided technical assistance to the Finger Lakes IPA (FLIPA) partnership.

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:

It is important to note that approximately 77% of the PPS primary care providers are affiliated with the four major health systems. FLPPS flows funds at the parent health system level, and does not have the stratification of funds flow at the primary care level.*

FLPPS flows funds to all Partners for achievement of DSRIP activities, encompassing patient engagement, project milestone and task achievement, organizational workstream participation (CC/HL, Workforce), RHIO and IDS integration, PCMH achievement, and building processes to track and report on clinical outcomes. The funds flow to all Partners, including PCPs, takes place through a scheduled contracting and reporting cycle, which is conducted every six months. The bi-annual funds flow cycle will continue for Partners who successfully complete DSRIP activities. In addition to the traditional contracting cycle, FLPPS has funding opportunities available through the Innovation Fund and Pilot Programs. The Innovation Fund is a program designed to flow funds to Partners for activities which move the clinical outcomes and are not specifically address in the projects. The Pilot Programs are designed by the FLPPS Clinical Team, FLPPS Clinical Quality Committee and FLPPS Population Health Workgroup, and the goal is to flow funds to Partners for short-term pilot initiatives that will provide FLPPS with information to better design future clinical care initiatives.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$47,455,292.43	**100%**
Primary Care Provider	Unable to answer	Unable to answer
Hospital-Ambulatory Care	$29,404,560,30*	62%
Federally Qualified Health Centers (FQHCs)	$4,749,501.40	10%
Primary Care Practitioners	$1,373,585.90	3%
PMO Spending to support Primary Care	$1,170,000.00	2.5%

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?

FLPPS flows funds model was amended in DY2 in several ways to flow funds to Partners who are significantly influencing project milestones and clinical outcomes. FLPPS funds flow formula includes an index score to reflect the provider's impact on Project Milestones. Additionally, the FLPPS funds flow formula includes an index score for the provider's impact on clinical outcomes. The PCPs have significant impact on both Project Milestones and Clinical Outcomes. Additionally, moving forward with Phase III of FLPPS funds flow strategy, a primary goal of the strategy is to flow funds to providers whose performance achieves clinical outcome targets. FLPPS, in transition to VBP, will incorporate a risk-bearing element in the PPS-Provider contracts in Phase III funds flow. FLPPS funds flow strategy will continue to emphasize flow of funds to those Providers who are significantly impacting DSRIP outcomes.

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 of 8/28/17, 52 primary care sites are reporting to FLPPS that they are integrated or co-located with behavioral health services, which is an increase of five sites since the initial FLPPS Primary Care Plan submission on 8/31/16. These sites consist of a mix of Article 28 facilities, FQHCs, and private practice sites. Four Model 2 sites are currently moving towards full project implementation. FLPPS has identified four sites (not included in the 52) that have expressed an interest and are taking the initial steps necessary to implement Model 3 (IMPACT), with an additional two sites completing the model.

FLPPS has undergone many project-related exercises, such as conducting a current state analysis, identifying barriers and risks, development of an outreach strategy for Partners who have yet to fully engage, and providing additional incentives for Partners to co-locate and report on patient engagement. Despite these efforts, FLPPS did not meet its DY2 patient engagement targets for Project 3ai, and is at risk for not meeting its patient engagement targets for DY3 and beyond.

As described in the 8/31/16 submission, FLPPS convened a series of Behavioral Health Workforce Workgroup sessions with the goal of identifying innovative solutions to mitigate project risks. Exploring the use of telehealth for behavioral health services, particularly in primary care, was identified as a top priority. As a first step, the PPS has developed a business case summary on the capacity and potential for FLPPS to support implementation of a telebehavioral health services program for Partners participating in Project 3ai.

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

Challenges, other than regulatory, consist primarily of behavioral health workforce shortages in the FLPPS 13-county region. FLPPS is tasked with implementing Medicaid Redesign via DSRIP initiatives in these counties. Many of these counties are in rural and HPSA areas. As noted in the prior submission, FLPPS mental health and substance use providers serve an above average number of attributed lives compared to other PPSs. FLPPS has mapped out its Model 1 sites, and were not surprised to find that, except for Monroe County, counties with the highest levels of Medicaid enrollees residing in mental health provider HPSA regions had the fewest or no integrated primary care sites. These regions include Allegany, Orleans, and Wyoming counties.

As documented in a Background Paper for the Regulatory Modernization Initiative, Work Group for Integrated Primary Care and Behavioral Health (8/17/17), "licenses…billing methodologies, and oversight processes cause a burdensome, confusing, and inflexible maze through which providers must navigate to offer integrated services." FLPPS concurs with the sentiment of the Workgroup statement, recognizing the complex challenges, including multi-layer workforce challenges that need to be met if the PPS is to be successful in achieving integration of behavioral health and primary care 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:

Regulatory issues remain the most significant challenge in the FLPPS region within the Project 3ai framework. For example, sharing space between an FQHC and a separate provider, under the current regulations, would serve to continue to promote stigma when one seeks care for behavioral health within this framework. The inability for a social worker to provide and bill for behavioral health services within an Article 28 clinic (unless the patient is with-child or under the age of 18) severely constricts the widespread adoption of behavioral health services provision in primary care. Disallowing Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, and other licensed behavioral health provider types to provide and bill for services in the Article 28 environment also limits integration uptake.

As FLPPS futher develops the implementation strategy, the PPS has discovered that the regulatory framework that exists for telepsych and telesuds (i.e. telebehavioral health), is just as complex and restricting as the in-person regulations for integrating behavioral health and primary care.

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?

Integration of behavioral health and primary care is strategically aligning with the FLPPS IPA/ACO Strategy (page 1) as well, including the potential for FLPPS to provide support for the development of a telebehavioral health program for Partners participating in Project 3ai. FLPPS is also promoting the implementation of Model 3 (IMPACT), and participation in the NYS Collaborative Care Learning Network. Preliminary results from these outreach efforts have resulted in four additional sites that plan to implement the IMPACT model.

As a potential solution to the PPS' behavioral health workforce shortage, particularly in rural areas (i.e. Orleans, Allegany, Wyoming counties), FLPPS has examined the option of implementing a telebehavioral health program to support primary care practices.

FLPPS will be participating the DOH/OMH/OASAS/OPWDD regulatory modernization initiatives addressing the regulatory challenges.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	59	7	52
Model 2	4	2	2
Model 3 IMPACT	6	4	2

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:

UR Medicine has held two trainings on integration of primary care and behavioral health, and a full-day symposium on behavioral health integration. Many of the training topics above are included in these and other Partner-led trainings.

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