Primary Care Plan Update 2017

Montefiore Hudson Valley 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.

N/A - MHVC remains committed to the 5 key strategies identified for expanding primary care. They include:

1. **Implementing PCMH Standards across the Network**
2. **Utilizing CRFP Funding to Expand Primary Care and Behavioral Health Services**
3. **Deploying Medical Village Projects at 7 Hospital Sites**
4. **Incentivizing access through Reimbursement Models**
5. **Integrating Urgent Care in the IDS Continuum**

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:

Within our original Primary Care Plan submission, MHVC articulated five strategies with regard to primary care expansion. Below is an update on each strategy to expand access.

Implementing PCMH Standards across the Network - MHVC is currently supporting 42 practices undergoing PCMH transformation. Each practice has a commitment to expand primary care hours as part of transformation.

Utilizing CRFP Funding to Expand Primary Care and Behavioral Health Services- MHVC partners were awarded $87.9m dollars by NYS. CRFP recipients are actively engaged with NYS on developing contracts. Each project includes expanded access as a component of the project.

Deploying Medical Village Projects at 7 Hospital Sites – to date, MHVC has facilitated the creation of strategic plans for five of our seven medical village sites.

Integrating Urgent Care in the IDS Continuum- Montefiore has developed a relationship with City MD and is working to develop clinical pathways for treating patients and ensuring meaningful connection back to Primary Care.

Incentivizing access through re-imbursement models – MHVC is committed to continuing to evaluate how access may be incentivized in future contracts.

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

MHVC experienced challenges engaging community practices in PCMH Transformation due to limitations in resources, inadequate infrastructure and competing priorities e.g. other programmatic initiatives.

This challenge was mitigated in a number of ways:

-Deployment of dedicated resource, Director of Practice Transformation to establish Leadership buy-in
-One on one coaching, provided through MHVCs contracted PCMH vendor, PCDC
-Ongoing engagement with Provider Relations & Performance Improvement Specialists to align requirements with opportunities for additional support from MHVC e.g. Trainings, Learning Symposiums, Linkages to Network Partners.

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?

Challenge:

This challenge did not result in any strategic changes to Fundamental 1. MHVC remains committed to the strategies outlined in the Primary Care Plan submitted in 2016.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
As articulated in our original submission, MHVC has utilized data collected during our Network Assessments to tier our Network based on level of readiness (defined by provider's current infrastructure, EMR, PCMH status and RHIO connectivity) and to frame our approach to engaging with community-based primary care providers. The tiering of our Network has allowed us to create custom contracts for partners, incentivizing the most appropriate process measures based on their level of readiness. For example, for PCPs without PCMH, their contract focus was attaining PCMH. For those practices that had achieved PCMH, contracted requirements were to track/manage cohorts of patients. MHVC has utilized engagement with Hospital leadership to understand practice patterns, prioritize community based practices for engagement and leverage economies of scale in engagement and onboarding. We have continued to work with PCDC to support community-based providers in practice transformation. Additionally MHVC has connected practices with NY State funded Advance Primary Care (APC) resources as appropriate. MHVC has continued to leverage both Provider Relations and Performance Specialists to engage with community based practices within our Network.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	518

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:	485
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	157
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	6

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:

MHVC contracted with PCDC to support our PCMH Transformation. To date, MHVC has engaged 42 practices through our PCDC contract. Supporting activities have included:

1. Training/Webinars: in consultation with PCDC, MHVC provided a series of four educational Practice Transformation webinars.
- Introduction to PCMH
- High Risk Group Designation (aligned with HH at Risk Project)
- Care Management
- Care Coordination

2. One-On-One Coaching:
Each practice was designated a Practice Facilitator to guide them in meeting PCMH requirements, including assistance implementing PCMH-compliant clinical and operational activities, documenting the necessary evidence of PCMH-related activities, navigating and tracking the application and submission process, and developing sustainable work plans.

3. Alignment with MHVC DSRIP Project requirements: MHVC has utilized our contracting structure to incentive appropriate adoption of people, process & technology in support of practice PCMH attainment while recognizing and aligning this work with project specific deliverables.

4. MHVC has been supportive of APC initiative, and committed to educating and linking practices to alternative State supported programs.

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:

Due to varying levels of readiness for transformation, Primary Care Practices face different challenges.

1.) Information Technology (IT) - Most physicians are not familiar with the capabilities of their existing EMR systems, which hampers their ability to document and capture needed information and run the necessary reports for submission. Most of the practices have limited IT resources and must deal with their EMR vendors directly to make any needed system changes. MHVC has enlisted the support of an HIT consultant and IT project specialist that work with practices to understand and guide their unique capacity and capability issues.

2.) Engagement - The physicians and staff often have trouble seeing the value of PCMH recognition. The staff is not consistently prepared for their weekly coaching calls, which contributes to extending a 6 month engagement plan to nine months long. It is also difficult for the staff to attend trainings. MHVC has encouraged the assignment of a Physician Champion to spearhead efforts and make the necessary decisions to manage priorities.

3.) Resources - The front line staff members juggle multiple competing priorities. The addition of other roles and responsibilities takes time away from patient care. Therefore, dedicating the time to gather all necessary documentation and create the necessary polices has been difficult and often a lower priority. MHVC, through our Workforce team, has created a comprehensive DSRIP training module targeted towards front line staff. It has been well received by the Network

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?

No strategic changes have been made to Fundamental 2. MHVC will continue to deploy resources to support transformation, and utilize our contract structure to incentivize the incremental change across the PPS Network.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
The strategy MHVC has found to be most effective includes: - Engagement: MHVC interacts with our practices through multiple levels of engagement. 1.) Vendor support: Each practice receives technical assistance from PCDC via coaching calls and computer/online assistance. 2.) On Site visits: MHVC's Provider Relations team meets with our partners at a minimum of once a month to provide necessary support. MHVC also assists in providing training, educational resources and workflow optimization. 3.) Leadership support: MHVC met with Senior Leadership to obtain feedback, troubleshoot/brainstorm challenges, and align strategic goals with DSRIP goals.

e. Additional Questions:

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

Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:	141
Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:	282

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	994

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:

Building upon the early collaborative process mapping, which defined the roles of primary care providers and other stakeholders in the care continuum, MHVC has facilitated trainings and data collection activities during DSRIP Year 2 to further define the role and connections to other stakeholder types. Please see examples below.

1. Community Linkage Survey - To better understand what existing relationships existed with secondary and tertiary providers MHVC developed and disseminated a Community Linkage Survey, which required contracted Organizations to provide data on existing linkages for secondary and tertiary services within their communities. MHVC is currently evaluating the data collected and will utilize the repository to make connections between contracted and non-contracted providers to fill gaps and guide Network Expansion activities.

2. Health Home Education – MHVC facilitated process mapping sessions with Primary Care Providers and the Regional Health Homes to collaboratively develop a one page referral work flow for referral to Health Homes services, and for adoption into clinical workflow. Additionally MHVC co-developed with the lead Health Homes, a supplemental webinar for distribution to Primary Care Practices within the Network.

3. Connections to CBOs- Through engagement with partners we learned that many clinical providers did not screen for social determinants of health. MHVC, guided by our Clinical Quality Committee, defined standard elements of social determinants of health screening. Adoption of the screening into practice workflow was included as a contractual deliverable for all partners.

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:

As outlined in our original submission, many DSRIP provider requirements live in the primary care space. Competing priorities in the Primary Care Domain with regard to Project Implementation and transformation continue to be a challenge. MHVC has continued to right size the expectations of Primary Care Providers by focusing on activities/interventions that impact multiple domains, e.g. focusing HH at risk care management on patients with chronic conditions such as diabetes and asthma that are the focus population of other projects.

As discussed previously, the introduction of tiered contracting has allowed MHVC to right size the contractual expectations of primary care providers currently undergoing PCMH transformation, recognizing the large resource investment in the transformation process.

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?

MHVC remains committed to the strategies outlined in our primary care plan, will continue our work to refine the roles of different stakeholders in the IDS, and to further the connection to broader networks of care including community based organizations, mental health providers and post-acute care.

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

MHVC has incentivized HIT adoption through our contract structure.

As of DSRIP Year 2, 98% of Primary Care Practices within our contracted Network were reported to be on a Stage 2 Meaningful Use EHR. Those practices that were not yet on an appropriate EHR were incentivized within their most recent contract, which included the following contract deliverable:

"Adopt and implement a Stage 2 Meaningful Use certified E.H.R. For sites without PCP services, adopt and implement a stage 2 Meaningful Use certified E.H.R. or equivalent E.H.R. with the following functions: ability to extract clinical data in a CCDA format, secure messaging, referral via direct address, clinical decision support, clinical summaries, patient list or registry support, connectivity capabilities with HIE and external registry submission."

To support partners in achieving HIT contractual deliverables, MHVC has engaged an IT Consultant. The IT consultant supports the refinement of the MHVC IT Roadmap and is available to consult with partners to provide guidance.

Our IT Project Specialist and Partner Relations Specialists are in constant contact with partners to provide support on deliverables, discuss barriers and make connections to appropriate expertise within the MHVC team. These staff members meet with our IT Consultant bi-weekly to review partner progression with HIT deliverables via a dashboard.

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):

MHVC utilized a combination of strategies to assist Primary Care Practices in connecting to the Regional QE: Cross PPS Collaboration and network training, incentiving adoption in contract structure, and consulting support.

- Cross PPS Collaboration & Network Training:

To support RHIO adoption MHVC collaborated with the Regional QE and neighboring PPS's to prioritize RHIO adoption across shared partners. This work was facilitated through monthly calls where data was shared regarding partner connection type and IT readiness. Additionally MHVC co- facilitated educational sessions (2 in person and 3 via webinar for contracted partners).

- Contract Structure - MHVC has incentivized RHIO adoption though our contract structure:

During DSRIP Year 2 Contracted partners were incentivized to complete the most appropriate incremental change with regard to current QE Connectivity.

- Those who had not yet executed a QE Participating (PAR) were incentivized to execute the PAR
- Those who had a PAR in place were incentivized to train staff on clinical viewer and consent protocols
- The most mature partners were incentivized to establish bi-directional connectivity and track discharge alerts.

- Consulting Support:

In addition to serving as a technical subject matter expert (SME) for Network partners, our IT consultant leverages relationships with EHR vendors to identify opportunities of scale for QE connectivity for Network partners utilizing the same EHR.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	595

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	668 (67%)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	476 (71%)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	192 (29%)

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:

MHVC continues to work diligently with its network to bring providers at varying levels of VBP readiness into a position to take advantage of future VBP arrangements. Although many of the challenges outlined in the original Primary Care Plan persist, MHVC has also worked on improvements and mitigations to address these challenges.

Network Alignment: Provider silos are a consistent barrier, but one that MHVC has done a great deal to break down, particularly through the integrated implementation of DSRIP projects and regional meetings that have brought providers closer together and shown the opportunity for coordination. MHVC also conducted detailed process mapping sessions to allow partners to collaboratively construct a care continuum for patients.

Financial/Cultural Readiness: Provider VBP readiness varies across the network. Through MHVC Financial Sustainability and VBP Needs Assessment surveys, MHVC has learned a great deal about the needs and knowledge base of the network and created an actionable strategy to address them. MHVC's DSRIP contracting is a VBP-style outcomes based model. Additionally the evolution of the Montefiore Hudson Valley IPA has continued to be a resource for engaged MHVC network partners on workstreams like shared services and contracting.

Workforce: Partners have described the need for non-licensed care coordinators including patient navigators, community health workers, peer support, and referral coordinators; behavioral health and substance abuse counselors; and licensed depression and nursing care managers; important for a VBP future state. MHVC is deploying training to address the identified care management needs.

Behavioral Health: MHVC, working with our other local PPSs, have developed extensive BH and BH Crisis service resources throughout the Hudson Valley

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

MHVC, working with its extensive and innovative network, is well positioned to continue to move towards Value Based Payment (VBP) arrangements. The Montefiore Health System (MHS) has been on the forefront of VBP arrangements for more than two decades and has become a national leader in the drive for value over volume. MHVC has leveraged the extensive knowledge base of our Care Management Organization (CMO) and their strong MCO relationships to lay a groundwork for a VBP future in Westchester and the Hudson Valley.

MHVC is a key player in the standing up and launch of the Hudson Valley Integrated Provider Association (HVIPA) as a vehicle for VBP participation. The HVIPA launched in December 2015, and the formal governance structure has been engaged in regular meetings and network recruitment since that time. MHVC will utilize the knowledge from the Value Based Needs Assessment to further strengthen and refine the HVIPA for the unique needs of our network.

Additionally, analysis of MHVCs VBP Needs Assessment Survey showed clear VBP areas of need as well as areas of interest for the network. These included VBP 101, Quality and Performance, Analytics/Data Management, Contracting, and Practice Transformation. The survey was created with significant input from MHVC's Finance Subcommittee and 100% of eligible contracted partners completed the survey. MHVC's VBP Support Implementation plan is built around these areas and MHVC has already begun training to meet the goals of the strategy and the network.

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?

MHVC has largely followed the strategies, mitigations and planning outlined in the 2016 Primary Care Plan. MHVC has continued to leverage the VBP expertise of the Montefiore Health System and in particular the creation and evolution of the Montefiore Hudson Valley IPA. MHVC has also continued to build and mature its VBP training and education strategy to meet the unique needs of our region.

MHVC has also utilized the state's Value Based Payment Quality Improvement Program (VBPQIP) to help key partners gain VBP experience and expertise, while transitioning those lessons and relationships to others in the network. In particular, the project has focused hospitals on key areas of process and performance that also require close collaboration with their primary care providers. The program has required MHVC to engage in MCO contract negotiation and relationship building which will benefit the entire network as it moves towards broader VBP relationships.

Additionally, MHVCs funds flow methodology has evolved to mirror the VBP experience with providers being held responsible for process as well as outcome related measures. See Fundamental 5 for more information. At the same time, MHVC has instituted performance management and "gaps in care" reporting data for network partners to help them prioritize workflows and reach patients with critical interventions.

Finally, MHVC's workforce team provided partners with an online communication and engagement toolkit that includes templates for providers to use with their staff when implementing change.

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:

MHVC has partnered closely with the Montefiore Hudson Valley IPA (HVIPA) as it grows its network and its contract relationships. The IPA has entered into several MCO relationships which already incorporate many MHVC network partners, including those with primary care services. MHVC primary care partners are involved in HVIPA governance which will ensure the integration of the MHVC network and the IPA in the out years of DSRIP.

Additionally, MHVC has utilized the state's Value Based Payment Quality Improvement Program (VBPQIP) to bring key MHVC providers into relationships with area Managed Care Organizations (MCOs). The program has evolved from one that encouraged providers to put VBP style processes in place to one that now actively rewards providers for performance. The program is hospital focused, but requires those hospitals to engage with their contracted and employed providers, including primary care providers, in their required goals.

Finally, MHVC continues to bring providers and MCOs together to complete certain DSRIP specific milestones related to behavioral health, asthma and other services. These meetings and growing relationships serve as building blocks for future engagement.

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):

Through engagement with partners we learned that many clinical providers did not screen for social determinants of health as they lacked a standard assessment tool as well as knowledge of what resources were available in their community to meet patients' needs. MHVC, guided by our Clinical Quality Committee defined standard elements of social determinants of health screening for adoption by all clinical partners. To support providers without an existing tool an assessment tool was provided that could be adopted into providers' workflow. For providers with an existing tool, it could continue to be used, if it met the minimum requirements. To ensure that providers had access to a comprehensive resource list for their community, MHVC disseminated an Excel based resource repository created by IPRO.

MHVC used our contract structure to ensure wide adoption of the screening, creating a contract deliverable related to adoption of the screening into Primary Care Providers workflow. To better understand what existing relationships existed with secondary and tertiary providers, MHVC developed and disseminated a Community Linkage Survey. This survey, also a contract deliverable required partners to provide data on existing linkages for secondary and tertiary services. MHVC is currently evaluating the data collected. Partner Relations will utilize the repository to make connections between contracted and non-contracted providers to fill gaps and guide Network Expansion activities. This data is especially useful in identifying Tier 1 CBOs.

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: Primary Care providers have been a critical partner in the formation and maturation of the Hudson Valley IPA. This includes TA from Montefiore regarding clinical practices as well as contracting process.

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:

MHVC is committed to a funds flow model that is a careful steward of state and federal dollars, and distributes funds in a thoughtful, fair, and equitable manner. At the same time this model recognizes critical MHVC partners, and supports the development of an Integrated Delivery System infrastructure to ensure a financially stable future for MHVC partners in the Hudson Valley. The funds flow process is highly iterative and will continue to be revised as DSRIP and the MHVC network matures.

As stated in the 2016 plan submission, primary care continues to be supported by several funding streams, including:

Project Implementation and Administration: these fund services to PCPs including the build of care management, PCMH implementation and centralized evidence based practice.

Partner Payments: the main budget category supportive of PCPs. Providers are paid directly for meeting process and performance goals. Partner contracts emphasize PCP attribution as a key factor in funds allocation and as a primary point of contact in the care continuum.

Other: PCPs will also be supported via MHVC's Innovation Fund and Revenue Loss funding. Innovation funds will seek to partner PCPs and other types of providers in collaborative practice transformation projects. Revenue Loss funds will go to hospitals in the name of creating best practices that keep care in the community when possible.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$31,227,423	**100%**
Primary Care Provider	$3,693,247	13%
Hospital-Ambulatory Care	$1,157,236	4%
Federally Qualified Health Centers (FQHCs)	$1,427,235	5%
Primary Care Practitioners	$1,108,776	4%
PMO Spending to support Primary Care	$4,698,970	15%

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?

MHVC has continued to evolve its funds flow methodology. Phase II contracting included a big step forward in ensuring that MHVC is properly valuing the role of each provider in its funds flow. In Phase II contracting, engagement of partners making up 90% of the attribution was still a key driver of network partner selection. Most importantly, in the Phase II funds flow framework, partner dollar eligibility was driven in part by a stakeholder group's role in impacting key clinical outcomes. This focus, which was recommended by the MHVC Clinical Quality Committee resulted in PCPs being weighted the highest of all other stakeholder types.

The evolved structure of contracting will now have 75% of funds earned via successful completion of Project Milestones and 25% of funds earned via the network's ability to successfully meet clinical outcomes set and measured by New York State. This relationship closely mirrors the experience of a VBP arrangement or IPA partnership in which a provider has responsibility, and potential upside based on achieving outcome measures.

Since inception, MHVC has flowed $8,851,377 to partners as part of Phase II contracting.

In future rounds, outcomes and performance will continue to take on a greater role in driving funds to the network, including use of partner specific outcome data and impact.

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):

Partners participating in Project 3ai have shown significant movement towards BH integration as demonstrated by the results of a tool, the UHF Behavioral Health (BH) Integration Readiness Assessment. Primary care partners piloted the Assessment to determine their readiness along the PC/BH Integration Continuum early in DY2 and the findings were presented as a case study in a UHF publication. In a reassessment in fall 2017, partners showed marked improvement along the Integration Continuum with "integration" scores ranging from 22 – 53 (Mean = 36), whereas in 2016 scores ranged from 18 – 40 (Mean = 24). This increasing integration is a result of education and technical assistance provided to PC and BH partners provided via the MHVC BH Learning Collaborative. Many providers have reached 2014 Level 3 PCMH with assistance from MHVC funded experts. As a result, we are on target to meet our PCMH PCP commitments for this project, with 1144 PCPs anticipated to reach 2014 Level 3 PCMH by the 3/31/18 deadline. Evidence-based guidelines, including measurement informed care, medication management and screening have been a focus of the BH Learning Collaborative. As part of the MHVC contractual deliverables, partner sites have been required to provide monthly status reports on the numbers of patients screened for depression using the PHQ 2/9 in primary care. Targeted technical assistance has been provided based on these results. This has led to the increased patient engagement as illustrated by the higher numbers of patients screened. Most sites are beginning to use screening results to inform patient care, including initial treatment planning and ongoing measurement-informed care. Case finding and screening, the addition of care managers at a number of sites, and use of patient tracking systems (e.g., Registry or EMR) for information monitoring and exchange among providers has helped to move sites along the Integration Continuum.

- It is our expectation that the committed 94 Primary Care sites will have successfully completed the project requirements by 3/31/18. The committed 26 behavioral health sites are focusing on "whole person health" to incorporate medical screenings into their workflow and we expect that sites will be able to document this work in their EHRs by the project completion date. In the last two quarters of the project there will be much education and training centered on SBIRT and substance use. This support and all technical assistance including webinars, on-site coaching and full day conferences, will continue through and beyond the Project completion date of 3/31/18 to ensure superior patient care.

- Additional educational support/technical assistance/onsite coaching:
-Free Access to U of Washington BHI Registry and technical assistance provided that facilitates measurement-informed care and reporting
-MHVC BHI Listserv facilitates sharing ideas, materials, conferences, trainings, with the opportunity for feedback from colleagues

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

Barriers in the Hudson Valley include:

1. Limited availability of appropriate BH referral sources, e.g. psychiatrists, etc.
2. Lack of resources to perform regular measurement-informed care follow-up.
3. Partner confusion with model definitions: Organizations felt locked into specific model not in sync with changing clinic culture or personnel challenges.
4. Site Level Reporting: Intent to use contracting structure to hold organizations responsible for site level outcomes reporting. This data would inform coaching activities. Several large partners resistant to reporting monthly site level data. We have been meeting with their senior leadership.
5. Access to Front Line Staff teams: Our BHI Collaborative coaching team met with leadership to gain access to front line teams where coaching is most vital.
6. UW Registry Uptake challenges: 5 organizations have registry accounts, with 1 regularly using the system. Challenges for increasing registry uptake include: Existing patient data cannot be automatically uploaded onto the platform, requiring manually entry. Requires double documentation (in EMR and registry). Our current contracting metrics do not require the registry use.
7. Meeting CCMP Pilot Billing Requirements: As of 3/31/2017 several MHVC partner sites participating in State collaborative care funding pilot (CCMP) not able to meet criteria to enable billing. One site having difficulty recruiting patients for IMPACT model and is considering leaving pilot.
8. Regional Substance Use Treatment access is limited: ED data identified SU as major driver of ED visits and admissions. Limited access to appropriate SU treatment referrals and patients often discharged to inappropriate levels of care. Patient preference often not considered.

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

-Same day billing restriction which hurts integration (PCP visit and BH visit on same day)

-Lack of regulatory clarity on telehealth/video visits (i.e. requirement of point to point clinical locations for billing)

-Lack of adequate reimbursement for nurse driven care performed in OMH and OASAS certified sites

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?

- MHVC has dramatically increased the number of partner organizations engaged in on-site coaching and has provided it to front line staff, including physicians, social workers, nurses, and case managers. This comprehensive coaching will be ongoing and should continue to positively impact outcomes. MHVC incentives partner organizations via a P4P model. This model focuses on Behavioral Health outcomes and incentivizes partner organizations based on delivery of performance results.
- Partners have been reluctant to use the University of Washington Registry due to the issue of "double documentation." To address this, we have assisted one partner in integrating its EMR with the Registry. Based on this partner's experience, MHVC will provide guidance to other partners wishing to do the same. To date, 17 sites have signed on to use the Registry and MHVC provides initial training and on-going assistance.
- Telehealth is one of MHVC's strategies to improve access to BH providers and we are working on a variety of projects to promote its use among Partners. First, the Telehealth Strategic Planning Group identified BH as a priority area for Telehealth at Montefiore. A Learning Collaborative webinar devoted to technology featured a partner who has incorporated BH Telehealth into their primary care site. Additionally, we shared the State's recent guidance which would allow MCO's to provide payment for Telehealth services outside of a medical facility.
- MHVC is supporting partners to advance SBIRT use via in-person and webinar training and distribution of materials. Substance use will be a focus of the upcoming full-day Learning Collaborative Session. Two trainings are being offered to certify providers and allow them to bill for SBIRT and more are planned for 2018. Site-level coaching is also provided. We have identified that access to SU services at the appropriate levels of care are a barrier and are working with SU inpatient and outpatient treatment providers to streamline the referral process. This will guide improved referral processes from PCPs. We are also supporting MTM to facilitate "same day" access initiatives for up to 7 Substance Use treatment provider partners across the region (at multiple SU treatment sites).

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	88	88	0

Model 2	26	26	0
Model 3 IMPACT	6	6	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:

University of Washington Registry; Integrating Psychotropic Meds into Collaborative Care; Whole Health in Behavioral Health.

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