

Primary Care Plan Update 2017

[Mount Sinai PPS] [November 28, 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, PPS are asked to provide a series of brief (250 words or less per question) updates to questions under each fundamental in their 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 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 PPS convenience based on figures available to the DSRIP team. The Department requests that PPS review these fields for accuracy and make revisions where necessary. The completed template is **due September 29, 2017** to Timothy Lalowski of the DSRIP Team at timothy.lalowski@health.ny.gov.

Index

Primary Care Plan Overall Strategic Updates.....	1
Fundamental 1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs	2
Fundamental 2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?.....	5
Fundamental 3: What is the PPS’ strategy for how primary care will play a central role in an integrated delivery system?	8
Fundamental 4: What is the PPS’ strategy to enable primary care to participate effectively in value-based payments?	11
Fundamental 5: How does your PPS’ funds flow support your Primary Care strategies?	14
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)?	15
GLOSSARY OF TERMS.....	18

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.

Between January and March 2017, the PPS leadership re-evaluated the clinical strategy to focus efforts around priority clinical initiatives for the remainder of DSRIP across the entire PPS network. As a result of this, the PPS has pivoted to the following focus areas:

- Continuation of the pilot community care hub focused on care transition planning between acute and post-acute care settings
- Increasing Health Home enrollment as the key care coordination approach, especially in primary care settings, to ensure high-risk and eligible patients are receiving critical care management services throughout the PPS network
- Focus clinical improvement efforts on: disease management, behavioral health Integration, increasing access to care, and social determinants of health screening
- Improve SNF to ED communication for patients in long-term post-acute care
- Engage primary care providers in gap closure activities and initiatives

The PPS has begun collaborations with several primary care providers in the network to implement these initiatives through a phased approach and will continue to do so for the rest of DY3.

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:

PPS' over-arching approaches to expand primary care capacity include:

1. The PPS is encouraging the primary care providers to increase their collaboration with local Health Homes to increase care management services, which is expected to result in increased primary care access to those in need. The six health home leads in the PPS are beginning to train all PCP practices in the PPS, educating them on health home screening and policies, with the goal of increasing overall enrollment. Partners are required to report the number of health home enrollments to the PPS to measure progress.
2. The PPS is also working with primary care providers on implementing strategies to increase access to care, which include options to increase after-hours, engage with urgent care centers, and potentially increase staffing. In August and September, partners developed implementation strategies with PPS input based on these options and are implementing those strategies from October through March. The PPS is providing both funding and technical assistance.
3. Through the community care hub, the PPS has launched a Community Paramedicine initiative that seeks to reduce unnecessary emergency visits through increased collaboration and real-time consultation with patients' primary care providers.

In order to facilitate these strategies, the PPS is also providing financial incentives through performance contracts to support these efforts. Since these initiatives are rolling out in phases, the phase 1 partners primarily include PCPs from Mount Sinai Health System and Brooklyn Hospital Center's primary care practices and four Federally Qualified Health Centers

b. Describe the PPS' challenges with addressing primary care capacity needs:

Fully understanding the PPS's primary care network and their needs has been a challenge. While the PPS has taken steps to survey and better understand provider needs, many have different challenges, based on their size, services, geography, and other factors. The PPS faces challenges in determining the best way to allow each organization to take strategic steps they feel are best suited to meet their patients' unique needs.

Collection of data to support access to care strategies, a theme across all PPS efforts, continues to be a challenge. Understanding utilization patterns, appointment status, no-show patterns, and other key attributes for access to care have been difficult to gather across the entire network.

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

Key changes include:

- The pilot Community Paramedicine program within the community care hub.
- Focusing access and capacity efforts outside of the hub model. The PPS has established one community care hub which will serve as a pilot for future hubs. While this pilot continues, the PPS has engaged providers outside the hub to participate in access to care initiatives, as well.
- Partners with large numbers of PCPs have submitted plans to expand access to care, either by extending hours, increasing staff, or partnering with other organizations with extended hours, like urgent care centers. They will be implementing those unique strategies from October through March. The PPS is assessing partners' performance and challenges and will provide technical and financial assistance to meet identified challenges.
- The PPS has launched a data gathering strategy to utilize near real-time data to support decision making and improve performance by identifying opportunities where PCPs can implement efforts that will help them close care gaps. The effort started with a limited selection of data elements and is being expanded to include the elements required to calculate all priority performance measures. Once the data is gathered, the PPS will analyze and share the results with partners to support their process improvement efforts.

d. Describe what the PPS has done to engage community-based primary care providers:

Outside of the primary care network established through the Mount Sinai Health System and The Brooklyn Hospital Center, all remaining PCPs in the PPS belong to community based providers. The community-based primary care providers account for approximately 40% of PCPs in the network, making them important partners in ensuring the success of the PPS's clinical goals. The PPS is actively collaborating and engaging PCPs in the community for the initiatives listed in the sections above. In the initial phases, four of the largest FQHCs in the PPS network are heavily engaged for access to care initiatives, with the intention to extend these efforts to all FQHCs and other community based providers within the network in DY3. The remaining PCPs are in community-based practices within two IPAs, which are now implementing strategies to expand access to care as well as implement depression screening protocols and improve antidepressant medication management.

Most of these FQHC and IPA partners are engaged through the PPS's governing committees, workgroups, and one-to-one meetings with the PPS. Since the PCPs are an integral part to the success of the PPS, they are heavily involved in activities around disease management, care management, Behavioral Health integration, and increasing access to care. The PPS is also incentivizing Social Determinants of Health Screening to increase integration between PCPs and CBOs.

Number of Engaged Primary Care Practitioners in Community-Based Practices

4 FQHCs (Institute for Family Health, Community Healthcare Network, William F. Ryan Center, Settlement Health)

e. Additional Information

<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):</i>	1751 (Speed and Scale requirements)
<i>Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized currently:</i>	780 (as of June 2017)
<i>Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition:</i>	n/a

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. Describe the PPS' progress in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

The PPS recognized the importance of moving the primary care provider network towards PCMH early on and conducted assessments to better understand internal initiatives providers have for achieving PCMH or APC milestones. Many of the PPS providers are already actively working on strategies to meet these requirements so the PPS has chosen to support these initiatives through our performance contracts. Partners receive incentive funds for specific activities, such as sharing meaningful use data through RHIOs, increasing collaboration between behavioral and primary care providers, increasing access, and providing care management services for their patients in need.

b. Describe the PPS' challenges in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

The PPS has learned that different providers are at different stages of their transformation efforts, making it challenging to create a unified approach or set of supporting services the PPS can deploy to all providers.

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

While the PPS continues to support and incentivize initiatives that are similar to PCMH and ACP requirements, including flowing funds to organizations so they receive financial support, the PPS is no longer engaging a practice transformation vendor and pursuing patient-facing technological solutions. The technical challenge of bringing all practices in the PPS up to PCMH 2014 Level 3 with the modest funds provided in the metrics associated with them pushed the PPS to focus on achieving critical Pay for Performance measures. However, the PPS plans to continue efforts around increasing data sharing, RHIO connectivity, and improving EMR workflows for efficiency and data capture.

In review and approval by the Project 2.a.i. workgroup, Practice Transformation Cross-Functional Workgroup, and PPS Board of Managers, the PPS has determined that it will not require primary care partners to pursue PCMH recognition if it is not in the best interest of the practice and their strategies. This decision was based on extensive PPS current state PCMH maturity as well as quantitative and qualitative analyses of PCMH's clinical impact and coupled with the PPS' six largest attribution partners already being PCMH 2014 Level 3 recognized.

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

The PPS is currently encouraging partners to engage and share data with the local RHIO, Healthix, to increase visibility of a patient across the continuum of care. First, the PPS incentivized partners through contract metrics to enter into agreements with Healthix and then implement connections, providing technical advice and brokering relationships where necessary. However, partners have discovered that low consent rates are hampering data sharing, so the PPS is now incentivizing partners to improve their consent rates. The PPS is also working closely with Healthix to increase transparency around consent rates and other activities to support successful collaboration between partners and Healthix.

e. Additional Questions:

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

<i>Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS:</i>	n/a
<i>Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors:</i>	n/a

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

1318

a. 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:

The PPS has a few initiatives that support integration of primary care:

- Improving specialty care access to primary care providers in the community care hub pilot, potentially through an eConsult service
- Incentivizing social determinants of health screening, including providing resources that help providers connect patients to social services organizations. The PPS rolled out NowPow to partners with the most PCPs over the Summer of 2017. 5 partners are live on NowPow with 14 more in progress. Between October and March, most partners have a contract metric to develop a social determinants of health screening program for their patients.
- Supporting increased collaboration between primary and behavioral health care in managing patients with ongoing depression management. The PPS is currently analyzing data to understand current best practices in depression care management that will inform strategies with partners in DY4.

The PPS is currently developing approaches, vendor relationships, and designing incentives to support these initiatives in collaboration with their primary care partners.

b. Describe the PPS' challenges in implementing an integrated delivery system with Primary Care playing a central role:

The central challenge continues to be data gathering and managing consent across the various Primary Care Partners. The PPS has encountered many obstacles to capturing data, making it more difficult to assess how patients are receiving care and formulate appropriate strategies for implementing an integrated delivery system. Balancing data security requirements and technology capabilities has made it difficult to quickly make meaningful data available to partners. Additionally, consent rules limit accessibility of patient-specific clinical data to providers as they begin to integrate across different practices.

A secondary issue is balancing provider's internal strategies with those of the PPS. While the PPS is continuing to roll out efforts through the community care hub and other initiatives, it realizes that not all partners are able to resource appropriately and in a timely manner to engage in these efforts due to funding and technical limitations. To respond, the PPS has worked with partners to provide increased up-front funding as well as technical assistance.

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

The PPS has developed strategies to improve data sharing and analysis in the PPS. It is currently implementing a data gathering strategy, which started in Summer 2017 with 37 data elements from 20 partners and has now expanded to 30 partners and up to 120 data elements. The PPS will analyze the data elements and the resulting performance measure data will be shared with partners to inform decision making, determine resource allocation, and develop targeted strategies.

Data sharing between partners has been hampered by limited Healthix patient consent. To understand the challenge in more detail, the PPS is working with Healthix to develop partner-level consent reports, identifying what percentage of their patients have a consent decision on file. In the meantime, the PPS is incentivizing its partners to implement protocols to increase the proportion of patients with consent on file.

d. Describe what the PPS has done to assist primary care practices with implementing EHRs and reaching Meaningful Use Stage 2:

The PPS has performed assessments to understand the status of EHR connectivity across the primary care network, which have shown that most providers are already in process of implementing EHRs or have completed that effort. As a result, the PPS has focused much of its efforts on supporting partners in optimizing the EHR workflows to increase data capture. The PPS has also incentivized primary care providers to capture and share Meaningful Use Level 2 data with Healthix and continues to support this initiative.

e. 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):

The PPS has provided incentive payments through performance contracts to all Partners for establishing Healthix connections for data exchange. Partners are engaged in this effort through phases such as establishing ADT feeds and sharing Meaningful Use Level 2 data elements.

Number of Primary Care Practitioners connected to RHIO/QE:

1,270 safety net PCPs (as of June 2017)

f. Additional Information

<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance:</i>	~25% within PPS Board of Managers and Clinical Quality Committee
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based:</i>	2 hospital-based facilities (Mt. Sinai, The Brooklyn Hospital)
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based:</i>	4 FQHCs (Settlement Health, Institute for Family Health, Community Healthcare Network, Ryan Center)

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. Describe the PPS' progress towards VBP Readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan:

Within the Financial Sustainability plan, VBP milestones 5 and 6 were submitted to DOH as a plan to address the needs identified in the PPS' VBP Needs Assessment (VNA) and a partner engagement schedule for VBP education, training, and support. Based on the most recent VNA, the PPS has developed a three-tiered approach based on the top barriers to VBP implementation. Focus areas include:

(1) Education: Educational sessions on VBP reform, with sessions specifically tailored to PCPs, CBOs, and Behavioral Health providers. The PPS has planned a schedule that begins in January 2018. As part of a coordinated effort for provider education and engagement, the PPS is working with the Greater New York Hospital Association (GNYHA) to develop and implement a curricula and VBP workshop series.

(2) Analytics: As part of the ongoing clinical implementation and IT strategy, the PPS continues to advance its capabilities in delivering information and analytics to partners through partner-specific performance dashboards and tracking on health home enrollment from both health care providers and CBOs.

(3) Care Coordination: Care coordination and integration through increased Health Home enrollment, including Health Home training for PCPs, behavioral health providers, and CBOs. Over Summer 2017, the PPS incentivized partners to develop and implement protocols and procedures to ensure patients are screened for health home eligibility and referred for enrollment. Starting in October, Health Home leads are being paired with PPS partners to educate providers on health home screening, eligibility, and services. The education sessions will continue through the remainder of DSRIP.

The PPS continues to utilize performance-based incentive contracts to encourage PPS partners to implement strategies, processes, and workflow changes that will better position them for VBP arrangements

b. Describe the PPS' challenges in working towards VBP Readiness among the PPS' primary care providers:

Notable VBP barriers include VBP education, post-acute care integration, and analytics. Related to VBP education, the PPS expects to conduct educational sessions around VBP reform. The above proposed three tiered strategies were designed to address these critical areas of needs.

Additionally, balancing the partner-based strategies and business priorities with the State's vision for VBP adoption has been an important consideration for the PPS, recognizing that partners have many competing priorities and a range of maturity related to VBP readiness. The PPS has sought to find a balance in defining contractual metrics and expectations, so that providers can integrate strategies and recommendations within their own business plans at a feasible rate that supports their respective vision and objectives.

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

With the VNA completed and partner engagement schedule developed, the PPS will engage FHQCs and primary care partners in VBP education, readiness, and support. Education will take place over three sessions between 2018 and 2019 and will include material on the role PCPs play in VBP arrangements, specific types of VBP arrangements that may be beneficial for PCPs, capabilities necessary for success in VBP arrangements, partnership models for VBP contracting, and a frank assessment of the benefits and barriers to VBP for PCPs. The first of these sessions will be held in February 2018.

d. Describe what the PPS has done to support Primary Care providers engage Managed Care Organizations (MCOs) for VBP contracting:

The PPS continues to engage and coordinate with MCOs as part of the EPP and EIP metrics implementation activities, which directly tie to partner performance-based incentive contracts. Through these contracts, partners are incentivized to implement clinical strategies to improve key performance measures on which they will likely be measured if they chose to engage in a VBP contract with MCOs. As these strategies are implemented from October through March and then through the remainder of DSRIP, the PPS expects that partners will be in a more advantageous position to pursue VBP arrangements. Through these contracts and subsequent funds flows, the PPS is aligning PPS and partner efforts towards meaningful VBP readiness as defined by DOH and MCOs. PPS clinical and finance leadership continues open conversations with MCOs about opportunities for alignment and ensuring proposed PPS strategies are in line with MCO expectations for VBP success.

e. Describe what the PPS has done to support Primary Care providers in levels 2 & 3 VBP arrangements to address social determinants of health and engage Tier 1 Community-Based Organizations (CBOs):

The PPS will be releasing a Social Determinants of Health screening tool to acute care facilities and FQHC partners within the Upper West Side community care hub (Hub) model. The screening tool can be completed by care managers or social workers to identify key needs of the patient and documented into the EHR. Partners will also be able to use a web-based directory tool offered by the PPS to refer patients with social determinants of health needs to community-based organizations.

These tools combined with the enhanced centralized analytics and provider performance dashboards will assist providers in better understanding and addressing patient needs through integrated care plans. Provider dashboards enable partners to understand how they are performing against key performance metrics, which would be important under level 2 and 3 VBP arrangements, providing critical experience as providers learn to align patient care strategies with VBP quality and outcome metrics.

f. Additional Questions

Is the PPS planning to form a contracting entity (e.g. ACO Certificate of Authority)? Yes No **X 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 **X No**

...If yes, describe: [Click or tap here to enter text.](#)

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

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

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

The PPS releases performance-based contracts during each DSRIP Year, which contain clinical process, quality and outcome-associated metrics for which partners receive incentive dollars based on demonstrated performance. The PPS has established a process to design metrics that are tightly aligned with the clinical strategies associated with VBP readiness and population health. Initiatives and activities shared in this document are incentivized through these performance contracts. Since Primary Care Providers are critical in driving much of the PPSs success with clinical improvement strategies, they receive metrics that can be achieved to ensure they are able to maximize their draw down.

<i>b. Funds Flow</i>	<i>Total Dollars Through DY3Q1</i>	<i>Percentage of Total Funds Flowed</i>
Total Funds Distributed	\$28,991,707	100%
Primary Care Provider	\$12,216,185	42%
Hospital-Ambulatory Care	\$2,040,237	17%
Federally Qualified Health Centers (FQHCs)	\$8,958,971	73%
Primary Care Practitioners	\$1,216,977	10%
PMO Spending to support Primary Care	\$3,763,345	13%

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

The PPS has updated its funds flow methodology in the past six months to increase its emphasis on primary care providers. About 80% of Mount Sinai PPS's attribution to primary care providers fall within the PPS's two hospital health systems and four largest FQHCs. Beginning in April 2017 at the start of DY3, the PPS engaged these six partners to focus on undertaking improving care for patients with behavioral health, diabetes, and cardiovascular diseases in the primary care setting and through DY3 Q1, \$8M was delivered to those key partners.

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. 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):

The PPS's behavioral and primary care integration efforts to date have focused on:

- Developing guidance documents on integrated care teams, care protocols, screening and warm handoffs, care engagement, shared EHR templates and tracking, monitoring and case review, SBIRT, billing, medication guidelines, and therapeutic modalities.
- Developing trainings that will be made available to partners for depression screening and follow-up as well as depression medication management and adherence. Training opportunities will be available for partner's staff participating, such as Problem Solving Therapy.
- PPS is actively collecting depression screening data from partners for clinical improvement initiatives that impact screening follow-up rates and depression medication adherence. It is also working with Substance Use Disorder and PCP SMEs to develop a list of harm reduction and internal PPS referral resources, as well as a cheat sheet of questions based on the OASAS LOCADTR to assist primary care providers in making referrals to the appropriate level of care.

Through these efforts, approximately 25 Primary Care and Behavioral Health sites have implemented some form of integrated care to date.

b. Describe the PPS' challenges to integrating Primary Care and Behavioral Health (not including regulatory issues):

The PPS continues to advocate for our Model 2 partners who face barriers in integrating care at Mental Health and Substance Use sites. Some challenges include credentialing primary care providers, executing contracts for primary care with the Managed Care Organizations, and billing issues which prevent expansion and sustainability of primary care services. The PPS has also identified workforce challenges, particularly the availability of psychiatrists and bilingual social workers to embed within primary care settings.

c. Describe the PPS' challenges to integrating Primary Care and Behavioral Health specific to regulatory issues:

Our PPS partners have not identified regulatory issues outside of the issues mentioned above.

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

The project workgroup has completed and disseminated the Best Practices Manual described in the plan submitted in 2016. The current focus of integrated care efforts has been on the clinical depression screening and anti-depression medication initiation and continuation performance measures. The PPS has developed recommended guidelines and workflows, and has contracted with PPS partners doing integrated care to work on improving their performance on these measures. As mentioned above, we continue to develop trainings for engaging patients in integrated care settings in depression management (both therapeutic and medical) and in making appropriate referrals for substance use services.

<i>e. Model</i>	<i>Number of Sites Planned</i>	<i>Number In Progress</i>	<i>Number Complete</i>
Model 1	14	3	11
Model 2	17	11	6
Model 3 IMPACT	8	0	8

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:

- 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:

Problem Solving Therapy, Interpersonal Psychotherapy, Anti-Depression Medication Management

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 defined by PPS in the MAPP DSRIP PPS Network Tool filtered to Practitioner- Primary Care Provider (PCP) accounting for PPS-defined Provider Category alterations.

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