Primary Care Plan Update 2017

The New York and Presbyterian Hospital 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.

The NewYork-Presbyterian Performing Provider System (NYP PPS) has made significant progress in DSRIP Year 2 on the implementation of its primary care plan which involves both institutional and community-based providers. During this time period, the PPS made a significant structural strategic "pivot" from focusing on the ten Domain 2, 3, and 4 projects to focusing on natural groupings of providers and patient populations to help drive change, especially in the outpatient environment. The PPS reorganized into six Population Lines: (1) NewYork-Presbyterian Hospital (NYPH) Adult Medicine, (2) NYPH Pediatrics, (3) NYPH Sexual Health, (4) Community Provider Quality Improvement, (5) CBO/Social Determinants, and (6) Transitions/High Utilizers. This reorganization has allowed the PPS to have a deeper, more targeted, impact on providers' practice patterns and services.

During this period, the PPS was able to submit NCQA 2014 Level 3 applications for nine NYPH-based primary care practices (all later achieved accreditation) and to further applications from the PPS's four independent community providers. All providers are on-track to achieve certification in DY3.

The PPS has also made advances in co-locating primary care into behavioral health settings, and behavioral health providers into primary care settings. This work will continue into DY3.

Throughout DY2, the PPS dedicated 37% of its $9.7 million in expenditures to support primary care practices.

Fundamental 1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.

- PPS' over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)
- How is the PPS working with community-based Primary Care Practitioners (PCPs), as well as institution-based PCPs?

a. Describe the PPS' progress in addressing primary care capacity and needs from April 1, 2016 to March 31, 2017. Include efforts to extend hours and increase access to primary care services:

The PPS continues to focus on improving population health across Washington Heights and Inwood, the South Bronx, and Manhattan through the pursuit of (1) PCMH Level 3 accreditation and (2) the integration of behavioral health services into the PCMH.

For the pursuit of PCMH – there have been 6 Hospital-based primary care practices, two FQHC sites, and two community provider practices that either submitted applications or achieved PCMH certification in DY2. As part of the PCMH accreditation process the practices have focused on (1) open access, (2) leveraging team-based care, and (3) after-hours access. The Hospital-based practices are also exploring options to leverage telemedicine in order to improve access for low-acuity patients by reducing the need for patients to come to the physical practice.

The PPS has also worked on pushing forward the integration and/or access to behavioral health services. During DY2, the PPS successfully implemented primary care services at a NYS Psychiatric Institute outpatient clinic as well as made successful connections between an independent community provider and an outpatient behavioral health provider to ensure the community provider's patients received the necessary care. The Hospital-based clinics also embedded additional behavioral health resources focused on substance use and depression-related care during DY2. These expansions of service have enabled patients to access a broader array of primary care and behavioral services in a more integrated manner.

The PPS will continue to expand its focus on access in DY3, as this is a major driver of the access and screening P4P metrics.

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

The PPS has encountered a number of issues throughout DY2 while addressing primary care capacity needs. These have included:

1. Stress on independent community practices to achieve 2014 Level-3 PCMH Status – these practices do not often have the back office and/or IS resources required to implement the processes or put together the materials to meet the NCQA requirements.
2. Regulatory and reimbursement limitations on BH integration – the PPS is focused on integrating substance use and depression care management into its hospital-based clinics, but there have been a number of uncertainties around reimbursement and regulatory requirements that have slowed the expansion of this integrated access.
3. Recruitment of experienced staff – the PPS has made efforts to expand primary care and primary care-based services through the addition of advanced practitioners (i.e. NPs); however, the PPS has been challenged in recruiting providers experienced working with comorbid populations. This has resulted in the PPS needing to invest in additional provider time to provide the aprropirte level of clinical oversight.
4. Sustainability of access investments – the PPS is committed to working to expand access to primary care, as this is a major driver of P4P metrics and population health improvement; however, there have been financial challenges in supporting after hours and weekend coverage. Due to lower volumes, the practices cannot always identify a sustainable revenue stream to cover the staff needed for extended hours.

The PPS will continue to work with NYS, HANYS, GNYHA, and other organizations to address the structural issues outlined above.

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?

The PPS has not made any significant changes to its primary care plan since its submission in 2016. The PPS continues to pursue (1) connection to HIE tools, (2) expanded access to behavioral health services, (3) expansion of hours, (4) collaboration with non-primary care providers, (5) implementation of open access as part of PCMH recognition, and (6) expansion of hours to a FQHC-supported mobile medical unit.

In DY2, the PPS also launched a collaboration with the Advocate Community Providers (ACP) PPS to embed their care coordination staff in NewYork-Presbyterian Hospital to ensure patients were connected back to their primary care practices. This program went live in DY3.

Throughout DY3, the PPS will continue to implement and expand upon the strategies outlined above.

To alleviate the challenges in recruiting experienced primary care providers (NPs), the PPS has conducted significant outreach to NP training programs/colleges, to collaborating primary care organizations, and to local and national professional networks to post and distribute potential job postings. The PPS has also recruited within inpatient and emergency department settings for Nurse Practitioners (or those in training programs) who have experience in the clinical speciality (pediatrics, medicine, etc.), and would have a shorter learning curve.

To alleviate challenges in primary care access, the PPS continues to augment primary care staffing with care coordination-like staff (RN Care Managers, Community Health Workers, Peers, etc.) to ensure that the providers can focus on patients' medical concerns.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
The PPS engaged community-based providers in a number of ways throughout DY2, including: 1. Consulting support for PCMH application – the PPS has funded access to Primary Care Development Corporation to support the community providers in the development of the processes and application materials to meet the NCQA Level 3 criteria. 2. Dedicated project manager – the PPS has dedicated a 1 FTE project manager to work with its four independent community providers and four FQHC partners. This manager has worked on efforts related to (1) PCMH application, (2) improving communication with Hospital-based services, and (3) connectivity and partnerships with non-medical services, such as behavioral health from across the PPS. 3. Access to cross-PPS technology – throughout DY2, the PPS started the rollout of a web-based community resource directory (Healthify) and Healthix (RHIO) to all of its primary care collaborators. This process continues as the practices are ready to connect with the RHIO. 4. Engagement in governance committees and workgroups – the community providers have been engaged in the PPS's governance committees (Executive, Clinical/IT Operations, and Finance) as well as workgroups focused on reducing preventable ED visits across the PPS. The four independent community physicians have also participated in quarterly discussions on collective improvement efforts. 5. Support for IT development - the PPS has also made CRFP funds available to support the independent community providers to develop the necessary IS tools to meet NCQA requirements. These funds were allocated in DY2, but will be distributed in DY3.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	77

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:	348
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	1
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	0

Fundamental 2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?

- What are your PPS plans for working with Primary Care at the practice level, and how are you supporting practices to successfully achieve PCMH or APC recognition? (Resources could include collaboration, accreditation, incentives, training and staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.)
- How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

The PPS has supported its primary care practices to achieve NCQA PCMH 2014 Level 3 milestones through three strategies:

1. Hospital-based primary care practices – the NewYork-Presbyterian Hospital has a team dedicated to supporting its 14 primary care practices to achieve PCMH status. This team is been working on developing the necessary processes and infrastructure to meet NCQA requirements since 2015. Applications were submitted in DY3.

2. Independent Community Providers – the PPS has made Primary Care Development Corporation consulting support available to help the four community providers meet the NCQA requirements. The PPS has also made CRFP funds available to these providers to meet the IT-related requirements.

3. Federally Qualified Health Centers – the PPS has regular check-ins with these providers. However, many of these practices were either already Level 3 certified or significantly finished their applications at the beginning of DY2 .

The PPS continues to support education and training through partnerships to provide trainings on care coordination and population health. The PPS engages and informs providers through committee meetings, Town halls, and email blasts. The PPS also works closely with NYC DOHMH (PCIP/REACH) to make statewide practice transformation resources available where needed.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

The PPS has encountered a number of challenges related to achievement of NCQA and/or ACP requirements, including:

1. Competing priorities and additional work required to achieve PCMH requirements – the primary care practices (hospital- and community-based) are the epicenter of a number of transformation efforts, including PCMH, VBP arrangements, DSRIP, Meaningful Use, etc. There is significant manpower needed to be successful in each of these initiatives.

2. Recruitment challenges – there have been challenges recruiting and identifying experienced providers to expand access to primary care and behavioral health.

3. Information technology resources/limitations – There is also a fixed bandwidth to address the IT changes needed for PCMH, Meaningful Use, and Healthix connectivity. Many providers work with outsourced IT staff or fixed numbers of IT staff to meet their many, competing demands.

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

There have been no strategic changes to this fundamental.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
The PPS has found direct technical assistance/consulting support has been most effective/valuable to support PCMH transformation. Those providers who have received direct support from the NYPH-based PCMH team and/or Primary Care Development Corporation have been able to focus on their internal transformation efforts, rather than worry about completing the application. Given that community-based, independent primary care practices are often limited in the provider time that can be committed to transformation efforts (rather than revenue-generating efforts), this direct support has been extremely valuable.

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:	6
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:	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	329

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:

The NYP PPS is committed to developing an integrated delivery system that is based on a strong primary care foundation. To achieve this goal, the PPS supported a number of initiatives throughout DY2, including:
1.Connection to Healthix RHIO – the PPS continues to support its primary care members in connecting to the RHIO, including financial support, workflow support, and on-boarding guidance.
2.Connection to Community Resource Directory – the PPS started the rollout of the Healthify community resource directory to its providers in DY2. This tools enables providers to easily search for and identify social service providers in their patients' communities.
3.Embedding Navigators in Emergency Departments – the PPS has embedded Navigators in all NYPH EDs; these staff work to connect patients to existing and/or new primary care providers. The Navigators also work to ensure patients keep their appointments following discharge from the ED.
4.Improved Communication with Hospital/ED – the PPS continues to focus on efforts to improve post-discharge communication with community primary care providers. This includes development efforts to put CCDs into Healthix and developing manual workflows around the Patient Navigators' referral to community providers.
5.Collaboration with ACP PPS – the PPS started a collaboration with the Advocate Community Providers PPS to embed their care coordinators into NYPH facilities in Washington Heights and Inwood. This program will go live in DY3. The PPS has also engaged primary care providers in governance committees, ad-hoc workgroups, and project leadership positions.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in implementing an integrated delivery system with Primary Care playing a central role:

The PPS has faced a number of challenges in implementing an integrated delivery system, including:

1. Competing priorities and additional work required to achieve PCMH requirements – the primary care practices (hospital- and community-based) are the epicenter of a number of transformation efforts, including PCMH, VBP arrangements, DSRIP, Meaningful Use, etc. There is significant manpower needed to be successful in each of these initiatives.
2. Access to specialty care – As these transformation efforts are implemented and greater connectivity is established, the need for increased access to specialty care (behavioral and medical) has become increasingly apparent. These transformation efforts have created increased demand for already-limited specialty services.
3. Differences in practice size/structure – the primary care practices across the PPS are significantly different in their size and structure. This presents a challenge in rolling out cross-provider solutions (i.e. Health Home access, and connectivity with specialty providers).

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

The PPS is going to continue to individually tailor its support (financial, technical assistance, project management, etc.) to meet the wide-variety of providers within the network. This will mean a focus on (1) tailored educational efforts, (2) dedicated support for cross-PPS IS platform rollout, and (3) additional financial support for primary care practices. The PPS recognizes that primary care is the foundational driver of transformation and improved population health and will continue to make targeted investments in this area to ensure sustainable success.

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:

The PPS has connected its community providers with the NYC DOHMH REACH team to support the efforts related to meeting Meaningful Use. For the NYPH-based practices, the Hospital has dedicated IS resources to meet these requirements.

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):

The PPS has made CRFP funds and dedicated project management support available to all PPS network members to become fully integrated members of the Healthix RHIO. This process continues to unfold as providers are ready, as the RHIO's integration team has capacity, and as the providers respective EHR vendors can complete the necessary work.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	17 practices

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	10 providers, N/A %
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	8 providers, N/A%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	2 providers/practices, N/A

Fundamental 4: What is the PPS' strategy to enable primary care to participate effectively in value-based payments?

- How will key issues for shifting to Value-Based Payment (VBP) be managed? (e.g. technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals and emergency departments (EDs), creating transition plans, addressing workforce needs and integrating behavioral health)

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards VBP Readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan:

The PPS completed a VBP readiness assessment in DY2, as required by the New York State Department of Health. This assessment identified a number of areas of support needed by both primary care, behavioral health, and CBO providers, including: (1) VBP overview education, (2) support with analytics, (3) support with performance measurement and transformation required to be successful in VPB arrangements.
The PPS (in collaboration with NYS DOH and GNYHA collaborative efforts) will be working on education around:

1. Defining VBP – providing definition of key terms and concepts
2. NYS VBP Roadmap – overview of NYS DOH VBP efforts
3. VBP Contracting 101 – overview of contracting for VBP and differences from current contracting vehicles
4. Data and IT – introducing role of data and how to optimize IT for VBP
5. Performance Measurement – introducing how performance measurement can drive VBP success
6. Delivery system transformation – outlining the role of care models and delivery system transformation

These modules and resources will be developed throughout DY3.

Throughout DY2, the PPS also initiated a number of conversations with Medicaid MCOs to discuss how they could collaborate to drive improvement at the overlapping contracting providers.

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

The PPS faced a number challenges in working toward VBP readiness among primary care providers:

1. Aligning cross-payor contracting and performance improvement efforts – each PPS primary care provider is participating in a variety of payor- and contract-driven initiatives (MSSPs, quality contracts, etc.). Medicaid is just one component of their overall payor strategy, and may not receive the immediate attention required to be successful in DSRIP.
2. Aligning PPS efforts with Medicaid MCO efforts – the PPS and Medicaid MCOs have a number of P4P metrics in common; however, the proprietary nature of the MCO-provider relationship has limited the ability to align improvement efforts.
3. Granting access to actionable performance data – the PPS is limited in its ability to grant access to its performance data to its downstream primary care providers (this is changing in DY3). Medicaid MCOs are also limited in their ability to share performance data with the PPS lead. This limits the ability to collaborate on VBP readiness.

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?

There have been no strategic changes to this fundamental. The PPS will continue to develop and evaluate its strategy as education efforts are launched in DY3.

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:

The PPS has provided a number of educational opportunities and conversations around the DSRIP-required pay-for-performance metrics throughout DY2. These conversations have included the opportunity to discuss these metrics in the context of providers' current contracting strategy/requirements.
The PPS has also had a number of conversations w/ Medicaid MCOs about opportunities to align quality improvement efforts for the shared providers.

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):
The PPS continues to engage its Tier 1 CBO collaborators in workflow and contractual arrangements that would support the Level 2 and Level 3 VBP contract requirements. This includes contracting for Community Health Worker and Peer services through CBOs to serve the PPS's attributed patient population. The PPS also submitted an application to the CMMI Accountable Health Communities grant (and was later awarded) – this program will allow the PPS to develop contractual and IS-enabled relationships between primary care providers and CBOs throughout DY3.

f. Additional Questions

Is the PPS planning to form a contracting entity (e.g. ACO Certificate of Authority)? ☐Yes ☐No ☒N/A

…If yes, has it been granted? ☐Yes ☐No

Has the PPS provided technical assistance to primary care partners planning to form a contracting entity (e.g. ACO or IPA)? ☐Yes ☒No

…If yes, describe: Click or tap here to enter text.

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

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

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

The PPS had a number of mechanisms to flow funds to primary care providers throughout DY2, including:
1.Direct investment in resources (FTEs, IT, etc.) – the PPS invested in a large number of FTE and IS resources to support primary care practices throughout DY2 to meet the requirements of the 10 PPS-selected projects.
2.In-kind investment in PCMH Application – the PPS invested in a dedicated team to support the Hospital-based primary care practices to achieve NCQA 2014 Level 3 requirements.
3.Dedicated PCMH Consulting support – the PPS contracted with Primary Care Development Corporation to support independent community physicians in meeting NCQA requirements. (While services were delivered in DSRIP Year 2, vendor was not paid until DSRIP Year 3.)
4.Direct investment in primary care leadership – the PPS provides funding support for a number of primary care providers to serve as the dedicated leaders of project and quality improvement efforts across the PPS.
5.Funding for IT development and RHIO connectivity – the PPS made CRFP funding available for independent community physicians to perform the necessary IS development to meet NCQA requirements. The PPS is also financially supporting all PPS members to connect to the Healthix RHIO.
The funds flow below is for funds distributed during DY2. This does not include CRFP dollars or those funds related to in-kind support to Hospital-based ambulatory care or any costs related to the rollout of the Healthix RHIO connectivity. The funds for dedicated PCMH support were released in DY3 and are not reflected below.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$11,041,548.08	**100%**
Primary Care Provider	$3,575,889	32.4%
Hospital-Ambulatory Care	$3,575,889	100%
Federally Qualified Health Centers (FQHCs)	0	0
Primary Care Practitioners	0	0
PMO Spending to support Primary Care	0	0

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

The PPS's Finance Committee is currently enhancing its funds flow model to support continued performance improvement across the network. The PPS aims to have this model developed by the end of DY3Q3 for implementation by the end of DY3Q4. The model will include:

1. Innovation fund – RFP process to support PPS member proposals to drive key performance metrics (prospective)
2. Health Home incentive fund – dedicated funds to compensate Health Home providers in meeting quality goals (retrospective)
3. P4P Metric improvement – dedicated funds to compensate PPS providers in meeting quality goals (retrospective)
4. PPS engagement – funds to compensate PPS members for participating in PPS workgroups/committees and surveys (retrospective)

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):

In addition to those efforts related to 3AI Model 2, the PPS is working to integrate depression care managers (LCSWs) and substance use treatment support into the Hospital-based primary care practices. The PPS is also working to establish connections/relationships between its community providers and established mental health providers in the community. While these services are not fully co-located, they will result in new access to mental health services for patients.

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

The PPS continues to face the following challenges in integrating primary care and behavioral health services:

1. Space – practices do not currently have the needed physical capacity to add new providers.

2. Reimbursement challenges – The PPS continues to develop new, integrated care models, but there are challenges in understanding and implementing the necessary billing processes to ensure sustainability of new programs.

3. Recruitment – the PPS has been challenged in recruiting experienced providers who are ready/able to treat comorbid populations.

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

The PPS faces several issues specific to regulatory limitations for this project. The PPS is in the process of evaluating the regulations for partners at Article 31 sites to integrate with Article 28 providers. The regulations require specific space needs that may require capital costs (DSRIP funding is not able to be used for capital costs). In addition to capital needs, the PPS is evaluating the billing regulations for having integrated care including what licensure types are billable for which populations and the dynamics to ensure that the providers are both reimbursed at 100% for services rendered.

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

The PPS is currently in the process of developing a number of new initiatives to support the integration of behavioral health services:

1. Development of a NYPH opioid epidemic reponse – the Hospital, including the DSRIP leadership, is currently assessing the resources and collaborations needed to ensure an appropriate and effective response to the opioid epidemic. This response will include primary care-embedded and community-based supports.

2. Development of a PPS Substance Use Consortium – the PPS launched a new consortium of substance use providers in DY3. This group is focused on developing collective programming, pursuing State and Federal network funding opportunities, and developing an integrated continuum of services for the community to access.

3. Engagement of non-PPS behavioral health providers – the PPS started outreach in DY3 to behavioral health providers not currently in the network. The PPS continues to seek to expand its community-based resources in order to ensure primary care practices have access to the necessary services for their patients.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	0	N/A	N/A
Model 2	4	1	3
Model 3 IMPACT	0	N/A	N/A

f. Please check all trainings that the PPS provides directly, or supports partners in delivering, to Primary Care Providers for Behavioral Health Integration within DSRIP projects from April 1, 2016 to March 31, 2017:

☒Alcohol Use screening
☒ Billing for Integrated Care
☒ Collaborative Care for Depression, i.e. IMPACT model
☒ Depression screening
☒ EHR Integration
☒ Health Homes
☐ Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
☐ Mental Health First Aid
☐ Outcomes Measurement
☒ Patient Consent and Privacy regulations specific to Behavioral Health populations
☐ Person-Centered Care
☐ Peer Services
☒ Population Health
☐ PSYCKES
☒ Quality Improvement Processes
☐ Regulatory Issues
☒ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
☐ Serious Mental Illness
☒ Tobacco Cessation
☐ Trauma Informed Care
☐ Other Mental Health screening (please specify): Click or tap here to enter text.
☐ Other Substance Use screening (please specify): Click or tap here to enter text.
☐ Other

Describe:

Click or tap here to enter text.

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