

# Primary Care Plan Update 2017

## Community Partners of Western New York

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](mailto: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.*

No overall strategic changes have been made to the primary care plan for the PPS, Community Partners of Western New York (CPWNY).

Focused efforts continued within two major sets of physician teams, organized through the Catholic Medical Partners (CMP) and the Chautauqua County Health Network (CCHN). The PPS continues its work with partner teams who have existing trust and contract relationships with their members. The PPS works closely with the Catholic Health System (CHS) and its hospital-run primary care practices as identified in its initial Primary Care Plan submitted in 2016. No external vendor support is supplied to primary care practices.

PPS has addressed provider categorization issues in its network management with use of the New York State Department of Health modifications of the provider tracking tools, such as the PIT replacement tool.

**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:*

CHS achieved designation of three of its hospital-run primary care health centers as National Health Service Corps sites. These include Neighborhood Health Center in Niagara County, St. Vincent Health Center, and Mercy Comprehensive Care Center (MCCC), both in Erie County.

In calendar year 2016, CHS recruited 6 primary care physicians, 5 primary care graduate medical education (GME) residents, and 26 mid-level providers. Of the practices retaining these physicians, 2 are community based. The other 4 are in underserved communities with high volume Medicaid volume. MCCC was recently awarded a "Doctors Across New York" \$100,000 grant to secure and retain a primary care physician who began practice in August 2016. In certain instances, incentives (sign-on and relocation) are also offered to recruit physicians into those underserved areas.

CCHN has utilized a Facebook group named Chautauqua County Medical Student Community to promote shadowing and loan repayment opportunities.

In addition, CCHN has been working to build relationships with local medical students through semiannual mixers, where medical students and local physicians can get together and network. CCHN coordinates MECO and DECO externships that are promoted to local M1, M2, D1 and D2 students. These externships provide a 6-week shadowing experience with local health care providers that allows students to gain experience while building local relationships. Students receive a stipend following the completion of the externship. Four homegrown physicians started practicing and one Family Practice physician was recruited back in DY3.

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

In community based practices, PCP providers with solo/small practice may have challenges covering operating expenses to track and manage value based/risk sharing arrangements with MCOs. These arrangements call for more advanced data technology and workflow changes to support population health management. Solo practices also may be challenged by managing the different quality measures and process improvement efforts which vary by MCO relationship.

CPWNY's largest PCP providers are hospital-based, and there are no federally qualified health centers in the network. Changes to the physical plant or changes to scope of service require review and/or changes to hospital certificate of need. A good example is a planned PPS effort to add Behavioral Health Services in the hospital based primary care centers. Department of Health review of floor plans and entrances and exits postpone the implementation of programs that support primary care providers' effort to address the needs of its patient populations.

Regarding addressing low acuity visits to the emergency room (ED) by our attributed population, the PPS continues efforts to facilitate communication between the ED and primary care. Coordinating appointments between the emergency department and the primary care centers was challenged by software changes to the Crimson suite of services originally noted in the 2016 Primary Care Plan. A portion of the software was de-commissioned by Crimson, and the PPS team successfully replaced the tool with another communication process and workflow enhancement.

*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?*

For the network managed by CCHN, additional resources have been added to the team to facilitate successful completion and recognition of PCMH standards. While most providers had familiarity with many population health measures, a different focus was placed on educating practices and setting up new reports to track patient engagement around expanded use of behavioral health screening tools and self-reporting of cardiovascular health measures.

Additionally, as part of DY3 contracts, CCHN plans to implement some portions of the Crimson software suite to support workflow enhancements and monitoring primary care related performance metrics.

Regular weekly meetings between the PPS's ED triage project team (for project 2biii) are occurring that help facilitate communication between the patient navigators employed by the PPS and the primary care centers. These regular meetings help address potential communication concerns, process improvement issues, plus barriers and successes.

To mitigate challenges in operating expenses and quality measure management in solo practices, both CCHN and CMP focus efforts on ensuring the practices understand the importance of improvements in their quality scores and understanding the changing managed care payment models. Work is focused on identifying areas for improvement that improve quality and are related to practice payments. Areas for improvements usually include annual wellness visits or annual physicals as these offer the opportunities for the practice to address gaps in care. In addition with the partial capitation model these visits are excluded from the capitation payment. Other areas for improvement would include measures with health plan incentives such as A1C testing, fall risk screening or depression screening.

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

Health Connections out-going patient call center at Catholic Health System continues its efforts to referral patients to community based providers.

Targeted communication to network continues, including weekly email updates to CMP practices which include training opportunities, regulatory alerts, and progress on key initiatives.

Teams at CMP and CCHN continue work to evaluate the Advanced Primary Care (APC) model as a performance improvement and patient centered approach to care. Community providers have taken advantage of the expertise at CMP and CCHN to better understand this model and evaluate it for implementation at practices. One practice in Chautauqua County has decided to pursue the APC model under the direction of CCHN.

<i>Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:</i>	525
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**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) as of March 31, 2017:</i>	642
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<i>Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:</i>	181
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<i>Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:</i>	3
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## 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:*

CMP and CCHN primary care practices are linked to technical and administrative support for the pursuit of the PCMH and APC model (Chautauqua county only). The Clinical Transformation (CT), Care Management and Care Management advisor teams at CCHN and CMP provide this expertise. Specialized staff is deployed from Buffalo, NY and Jamestown, NY and meets on-site and is available as needed for consult to practice staff. They also focus on process improvement.

Additionally, the CT assist in NCQA application submission and tracking all providers who comply with the PCMH and/or APC model. This strategy is identical to the strategy reported in the PPS 2016 Primary Care Plan. Driven by a practice level toolkit (i.e. sample policies and templates) CT and practice level teams develop an individual work plan. These work plans help ensure practice achievement of PCMH 2014 Level 3 recognition. Over the course of the year 24 practices successfully submitted and received Level 3 recognition with another 17 practices in process. There has been no external vendor support contracted for this work with partners.

CCHN certified three staff as Practice Facilitators through Millard Fillmore College. CCHN was awarded an "APC PT TA" contract in November and continues to work with New York State DOH and other contractors to clarify provider eligibility and develop a crosswalk between PCMH and APC to help providers decide their options to meet practice transformation milestones.

Requirements review for primary care providers to access workflow enhancement tool(s) continues. Through CCHN and CMP teams, primary care providers have opportunities for shared learning in critical workflow enhancement tools and tracking systems. Examples include, tools to support behavioral health and substance abuse screening and intervention tools, EHR workflows to support tobacco cessation programs, and also the Crimson suite of population health management tools.

*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:*

Single physician providers with small practices remain challenged with adopting either PCMH or APC models. PPS and CMP leadership team advocates to its physician members to consider strategic collaborations to help providers achieve the types of staffing and infrastructure improvement required for implementation of these models. The clinical integration plan for CMP also includes substantial incentives for adopting PCMH.

CMP and CCHN understand elements of the PCMH or APC that can be adopted to support improved patient health and support practice level financial performance. The PPS has prioritized its efforts working with its member practices and the majority of its resources are placed on those practices best positioned for success with NCQA recognition milestones.

If a practice cannot comply with recognition or is not deemed an ideal candidate for PCMH or APC, the PPS makes efforts to share best practice in workflow improvement and population health regardless of the commitment of that practice to apply for formal recognition. For example, a small physician practice can still benefit from patient registries developed as part of its work with its independent practice association for follow-up on wellness visits and targeted care coordination activities.

*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 in PPS approach to fundamental 2. The PPS team remains committed to training and support of all primary care practices regardless of their ability to achieve PCMH or APC recognition.

As cited in the 2015 Primary Care Plan, the PPS team work with CMP and CCHN to review their clinical integration programs annually to align with the goals of DSRIP. For example, in DY2 the PPS added training and support for clinical integration efforts related to primary care sites supporting specialty service. An example would be addition of palliative care education and programs within their practices.

For practices that are not able to meet the PCMH standards quality improvement efforts are focused on a several areas, especially those with high impact, such as annual wellness visits or annual physicals. Using a rapid cycle improvement/PDSA (plan, do, study, act cycle) methodology, practices adopt incremental change that affords them the opportunities to address gaps in care with regular success and staff buy-in. Additionally, focusing on ensuring patients regularly see their primary care physician helps build the relationship with the practice with the goal of reducing ED/urgent care usage. Other areas for improvement for practices choosing not to seek PCMH recognition include measures with health plan (managed care) incentives such as A1C testing, fall risk screening or depression screening.

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

The PPS, through its relationship with CMP and CCHN, uses centralized clinical, technical, and administrative expertise to support the change management and workflow changes needed to achieve the recognition. The focus is one on one support on-site. Teams whose sole job is to stay abreast of the NCQA rules plus understand the changes in New York State adoption of APC models, help providers wade through the shifts regulations. Both CMP and CCHN bring peers together to share changes in practice management. Shared learning and process improvement initiatives remain at the top of the agenda for these collaboration discussions.

Additionally, a centralized data team that can negotiate on data sharing with Managed Care Organizations, and also distill that data through a common population health model helps create operating efficiencies for the practice and also aides in shared learned across the network.

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 as of March 31, 2017:</i>	0
<i>Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:</i>	0

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*

597

*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:*

Communication between the hospital in-patient (IP) and ED teams and the primary care teams is a critical component to supporting patient usage of the primary care system. To achieve this, the PPS took the following actions: Solicited support from leadership and staff at high volume Medicaid CHS PCP clinics. Developed a standard primary care electronic scheduling template and tested it with clinic and PPS staff. PPS sponsored patient navigation staff obtained access to PCP clinic scheduling to create seamless access to appointments. Patient Navigators embedded in the ED and Health Connection call center staff successfully scheduled patients in PCP clinics. Daily surveillance occurs at primary care practices, who use their EHR to pull discharge rosters from the hospitals to follow-up with patients who have had an IP or ED stay.

CMP has an established interdisciplinary team, called care management advisors, to support practice level care managers. The team shares best practice in addressing social determinates of health and linkages to non-medical services for patient support. Common workflows are shared with primary care for addressing the needs of high risk patients. Additionally, CMP offers practices centralized social work support to overcome barriers to care related to social determinates of health.

In DY3, CCHN plans to build out its centralized team for care coordination support to the primary care network and is hiring at minimum 1 full team employee to address the need for technical and professional support to its practices.

*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:*

Achieving common care coordination workflows related data collection was met with a challenge due to software changes to the Crimson suite of services originally noted in the 2016 Primary Care Plan. A portion of the software was de-commissioned by Crimson, and the PPS team successfully replaced the tool with enhanced communication processes and workflow tools. For example, care management templates are used in the EHR and there are periodic audits of the use of these templates. Additionally, CMP offers incentives via its clinical integration program to follow care transition protocols.

Claims data received from MCOs for populations managed under contract is inconsistent in format and content, which create challenges in implementing targeted population health management programs. For example, identification of patients who may or may not have been seen by their primary care provider within the last year. Or, the identification of patients who meet high risk profiles and make need additional follow-up by the primary care team.

Behavioral health partners face challenges with effective communication with primary care. Care transition documentation and processes require improvement. Improvements to the behavioral health provider hand-off to primary care providers are part of the PPSs performance program in DY3.

*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?*

No strategic shifts have been made in addressing fundamental 3.

CMP continues to provide centralized care management advisors to the primary care partners in Erie and Niagara County. It continues to explore process enhancements which support the timeliness of transition of care information across provider types.

CCHN is committed to the Collective Impact Model for its CBOs and provider partners in Chautauqua County.

Work at both CMP and CCHN continues with the Crimson suite of tools with efforts focused on the Population Health Analytics tool that combines claims data with EMR data.

*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 clinical transformation (CT) teams at both CMP and CCHN work with PCP practices individually on-site and via web-based training to improved shared understanding of the changes to meaningful use standards. CMP and CCHN have modified their training programs to adapt to MACRA regulations and to help practices understand their requirements on complying with MACRA.

Additionally, most CCHN and CMP participating providers are also involved with the Medicare Shared Savings Program and will receive credit for 2 of 3 domains in the Quality Payment Programs (QPP). That leaves the third domain, the Advancing Care Information domain, which is roughly equivalent to Meaningful Use Stage 2.

Both CMP and CCHN continue to assist PPS providers in maintaining their meaningful use status. This will ensure that Medicare Providers will receive maximum credit under the QPP, as well as helping Medicaid Provider's earn New York State Meaningful Use payments as long as possible.

*e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices to connect to Regional Health Information Organizations (RHIO)/Qualified Entities (QE) and the State Health Information Network of New York (SHIN-NY):*

To help assist provider participation in the local RHIO (HEALTHeLINK or HeL), CPWNY utilizes the CMP Clinical Transformation, CCHN Clinical Transformation and HeL team. Both networks strongly recommend partners sign HeL participation agreements.

CMP supplies practices with clinical transformation staff trained to assist primary care practices in the transition to a population health management model of care. Part of the team's outreach includes urging practices to participate in the RHIO and why data exchange is essential to improved care and better health outcomes.

CCHN's Clinical Transformation Coordinators hold monthly Learning Community meetings, to which PCPs and their representatives are invited. RHIO and data exchange education, and the patient consenting process, is included in this outreach effort. Additionally, HeL participates on CCHN's HIT Committee, which promotes signing on to the RHIO and more robust usage.

HeL has, since its beginning, implemented the community-wide consent model. Given the community-wide patient consent model, HeL's strategy, with input by the PPS staff, identifies the primary care providers (PCP) and other first-line care providers or care coordinators that are likely to engage with the Medicaid patients. This strategy includes education on consenting at all the Emergency Rooms in the PPS network plus leveraging the clinical transformation staff at CMP and CCHN to facilitate engagement between PCP offices and HeL. HeL staff provide practices on-going education and direction on consent collection.

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

582

f. Additional Information

<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:</i>	10 (16%)
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:</i>	1 (1.6%)
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:</i>	10 (16%)

#### 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 needs assessment conducted by the PPS helped identify initiatives to further the transition of primary care providers to VBP arrangements. The PPS has, and continues to provide, VBP education and updates at project advisory committee meetings. Additionally, it provides educational and training materials on the CPWNY website and links to New York State VBP materials (i.e. VBP University).

The PPS has large number of primary care providers who participate in VBP arrangements through Independent Practice Associations (IPAs) whom are members of the PPS. CPWNY continues to support these providers as some make the transition from upside only risk arrangements to arrangements that assume downside risk. The PPS builds infrastructure and analytical support in order for PCPs to measure their own progress on quality and financial metrics. Support like this becomes especially important as the providers utilize reporting tools to understand what metrics are most impactful while being able to measure them in real-time. Efficient is required when combining data from provider electronic health record and claims data provided by MCOs. Primary care providers are successful in a VBP environment when they recognize the value they provide within the VBP arrangement and can measure it.

CPWNY works with small independent primary care providers to adapt to the changing reimbursement environment through education and engagement of specialty work groups, allowing providers to communicate with colleagues regarding their issues and concerns. Some of these practices may ultimately elect to join the existing IPAs and participate in their VBP arrangements.

##### *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 most challenging, but also the most rewarding part of working toward VBP readiness among primary care providers, is transitioning the small independent practices with no current affiliations to VBP. Both building data analytics that have a high level of integrity, or initiation of a collaboration with behavioral health (BH) and community based organizations (CBOs) are examples of the PPS work.

The PPS encourages collaboration among small independent providers to either come together or collaborate with an IPA that can provide the necessary support to be successful in a VBP environment. As reimbursement models continue to transition, it will be very difficult for independent providers to exist.

Another challenge the ability to produce real time data with a high level of integrity. The PPS has gone through infrastructure implementation that is very time-consuming and resource intensive to produce reporting that providers can utilize to make decisions regarding cost and quality. This will be very important for all providers because if there is no confidence in the data and analytics there will be a low level of success. The PPS has invested in building this infrastructure and the work continues today.

Collaboration among primary care providers with BH and CBOs will enable the providers to seek services beyond the capabilities of the primary care provider and address social determinants of health. The PPS is working with both BH and CBOs on projects that bring these services to the beneficiaries through primary care.

*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?*

The PPS has not had to make any material changes to the strategy outlined in fundamental 4 of the primary care plan.

The IPAs that are part of the PPS will continue to lead the transition from fee for service to value based payment. VBP arrangements with Medicaid providers have expanded during DY2 and now include more Medicaid beneficiaries. The PPS continues to move resources forward in improving the data and analytic tools available to the primary care providers. Work will continue with collaboration amongst behavioral health providers, community based organizations and primary care providers to provide the services necessary to be successful in a VBP environment.

*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:*

As stated in the 2016 Primary Care plan, a large majority of the PPS's PCPs are members of local Independent Practice Associations (IPAs). In Erie/Niagara County they are members of CMP IPA, and in Chautauqua County are members of Chautauqua Integrated Delivery System IPA, managed by CCHN. Both IPAs engage with local Managed Care Organizations (MCOs) around initiatives supporting the Triple Aim, including VBP contracts.

The IPAs collaborate with primary care members, developing Clinical Integration plans with a commitment to enhancing the quality of care. Both IPAs' governance structures hold strong Primary Care representation. The IPAs work with MCOs, creating consistent plans across multiple payer arrangements, for their primary care practices to follow. Leadership at the IPAs collaborates with CPWNY PPS to be accordant with DSRIP goals and metrics.

CMP holds risk-based contracts with most local payers across commercial and Medicare populations, and is a Track 3 ACO under the Medicare Shared Savings Program. CMP has a level 2 VBP arrangement for the Medicaid population with one of its largest local MCOs, Independent Health. CMP is working towards developing level 1 VBP agreements with Fidelis Care, YourCare, United Healthcare, and Amerigroup for the Medicaid Population. CMP has aligned its quality goals for these VBP arrangements with CPWNYs.

Chautauqua Integrated Delivery System holds risk based contracts with some local payers and is an ACO under a CMS Shared Savings program. CPWNY supports ongoing education to Chautauqua Integrated Delivery System and assists them in achieving VBP arrangements for their Medicaid covered lives.

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):

Generally speaking, pursuit of the PCMH recognition addresses transitions to CBOs to mitigate social determinates of health. Initiatives that specifically address this within our partner provider networks include:

- Requirements for updated referral contact lists and agreements
- Population health management systems that track patients across various modes of care with shared understanding of patient non-medical challenges
- Care management team education and shared provider training on mitigating social determinates of health through referrals and partnerships with CBOs

The provider support teams (such as Care Management and Clinical Transformation) at CMP and CCHN are preparing practices for 2017 PCMH standards. Shared learning is planned in DY3 about the PCMH program's stronger emphasis on CBO collaboration to mitigate social determinates of health. CMP plans in DY3 to have standard practice-level templates for screening for social determinates of health.

CCHN is serving as the county co-lead with Chautauqua Workforce Investment Board for the New York State DOH CBO grant and during DY3, 36 organizations were identified to recruit to participate in webinar trainings on topics such as: DSRIP 101, health information exchange, value based payment concepts, contracting needs, and performance measurement. Trainings were expected continue through DY4. This project is expected to prepare smaller CBOs to engage with the local integrated delivery system(s) and participate in value-based payment and contracting.

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:

CPWNY distributes provider engagement payments to primary care practices and practitioners based on each partner's project participation status, patient attribution for performance, and the PPS overall performance in Pay for Performance and Pay for Reporting metrics. Provider engagement payments are aligned with detailed clinical integration plans which support DSRIP outcomes such as RHIO connectivity, behavioral health screening and access, blood pressure monitoring, clinical quality as well as specialty service metrics (e.g. cardiac, endocrinology and OB/GYN metrics). Providers are measured on their performance and rewarded for performing at a high level. Funds are paid to practices which serve the Medicaid population, including hospital based article 28 freestanding sites providing primary care services as well as privately run primary care practices. The PPS has no FQHCs participating in its network.

In addition, clinical transformation specialists, social workers and care management advisors at CMP and clinical transformation staff at CCHN are supported by DSRIP funds. The team supports primary care practices in building infrastructure to support PCMH recognition, workflow enhancement, and clinical quality outcomes improvement. CPWNY also offers performance analytics support, technical support, training in cultural competency, health literacy and rapid cycle evaluation to all providers in the network, including PCPs.

<i>b. Funds Flow</i>	<i>Total Dollars Through DY2Q4</i>	<i>Percentage of Total Funds Flowed</i>
Total Funds Distributed	\$10,148,895.65	<b>100%</b>
Primary Care Provider	\$2,468,225	18.78
Hospital-Ambulatory Care	\$0	0%
Federally Qualified Health Centers (FQHCs)	\$0	0%
Primary Care Practitioners	\$2,468,225	18.78
PMO Spending to support Primary Care	\$107,573	.82%



*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?*

There has been no strategic changes to the funds flow model to support the Primary Care Plan.

PPS PMO staff and its network partners regularly evaluate their funds flow model to support DSRIP goals and metrics. The PPS governance model supports revisiting budget and funds flow models for adaptability and support of programmatic goals. For example, funds may be shifting to effect priority performance outcomes metrics as performance is measured through DSRIP calendar.

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):*

CPWNY supports several models integrating Primary Care and Behavioral Health:

Model 1. Since September 2016, the PPS supports counsellors at a hospital-based primary care clinic and at four primary care office settings. Referred patients complete an initial assessment for services, with supportive on-site counselling if needed. For those needing additional support, a "warm handoff" to a behavioral health organization is completed. Patients referred to outside services are reported to have higher show rates, are better prepared and educated on what to expect from counseling, and are be more motivated for treatment. Providers value having more information on their patients and trusted resources to support their needs.

Model 2. CPWNY supports startup expenses for a behavioral health organization to establish a fully integrated site, expected to open September 2017. This partnership is led by a behavioral health organization, contracting with primary care providers. The center provides individual, family, and group counseling services, as well as health monitoring. Medication-assisted therapy for both mental health and addiction is also available.

Two behavioral health organizations established mobile mental health units to serve clients who are unable to obtain treatment in a traditional outpatient behavioral health treatment setting. Teams typically consist of a consulting prescriber, a nurse, and licensed counselors.

*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 lack of integrated EMR systems and the inability to share meaningful data continues to be a challenge to connecting primary care and behavioral health services. Although the PPS has made strides to physically co-locate services, the systems that support the organizations do not interface. Conversion to the same platform is costly. CPWNY continues to advocate with the local RHIO (HealthLink or HeL) and with behavioral health and primary care providers to enhance data sharing options.

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

CPWNY encounters barriers related to co-locating Article 28 and Article 31 facilities. Over the past two years, CPWNY facilitated conversations between its largest health system and a private behavioral health organization to formalize a co-located Article 28 and 31 arrangement for two high-Medicaid volume hospital-based clinics. A project plan and budget were developed. Floor plans were reviewed and approved by the DOH, and a formal application to CMS is pending. The OMH application was recently rejected, needing additional construction of a dividing wall. The PPS has encountered ambiguous and sometimes conflicting direction on how to proceed within rigid regulations.

CPWNY was approached by primary care practices in rural areas who have an interest in piloting telepsychology consults in the primary care setting. Due to a shortage of behavioral health providers in the region, a virtual approach is appealing to covering an area more effectively. The main challenges are insufficient reimbursement and low volume of patients at individual practices to support a telemedicine initiative. Alternatives, such as sharing resources across multiple PCP offices and providing DSRIP funding to test models, are being explored.

Performance payments are part of the CPWNY performance improvement efforts in partnership with behavioral health providers. Included in that payment are incentives to improve communication with primary care. HeL provides access to services such as Mirth Mail (secure messaging) which helps support improved communication across various modes of care. Performance improvement programs like this help CPWNY encourage both HeL and Behavioral Health providers to share data and use critical communication functions that support continuity of care.

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

CCHN is developing a performance plan for Chautauqua practices. Screening for Depression and Follow-up Plan was added as a performance metric for DY3. Initial work with practices include establishing registries, educating practices on how to measure performance, interventions. Medication management is also a priority measure for DY3.

<i>e. Model</i>	<i>Number of Sites Planned</i>	<i>Number In Progress</i>	<i>Number Complete</i>
Model 1	9	2	7
Model 2	1	0	1
Model 3 IMPACT	0	0	0

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

- Alcohol Use screening
- Billing for Integrated Care
- Collaborative Care for Depression, i.e. IMPACT model
- Depression screening
- EHR Integration
- Health Homes
- Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
- Mental Health First Aid
- Outcomes Measurement
- Patient Consent and Privacy regulations specific to Behavioral Health populations
- Person-Centered Care
- Peer Services
- Population Health
- PSYCKES
- Quality Improvement Processes
- Regulatory Issues
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Serious Mental Illness
- Tobacco Cessation
- Trauma Informed Care
- Other Mental Health screening (please specify): Pediatric Anxiety Screening: GAD-7 Scale
- Other Substance Use screening (please specify): [Click or tap here to enter text.](#)
- Other

Describe:

VBP (Value Based Payment) education in accordance with the VBP education strategy and related plan

## 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