



## DOH REVIEW AND EXECUTIVE SUMMARY OF PRIMARY CARE PLAN DECEMBER, 2016

### PPS NAME: MILLENNIUM CARE COLLABORATIVE

Millennium covers Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties with an attribution of 252,737 Medicaid members. All counties except Erie are primary care HPSAs; many areas in and around Buffalo are primary care and/or MH HPSAs.

Overall Assessment: The plan includes many ideas that appear they would be successful, yet without baseline data on capacity analysis and HPSA clarity or workforce needed to support gaps in care, there may be significant primary care plan areas that will be challenging.

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

- Using community needs assessment and other anecdotal data sources, Millennium has developed a three-pronged approach to expanding current capacity:
  - Increase efficiency of primary care practice partners by infusing Patient-Centered Medical Home (PCMH) principles of team-based care and population health
  - Capitalize on opportunities to educate high school students, medical students, and residents about primary care as an attractive career option
  - Support organizations with strong recruitment efforts aligned with University at Buffalo Medical School to encourage students to choose primary care
- The plan uses six Practice Transformation Staff (PTS) who track primary care site transformation activities including PCMH 2014 Level 3 status. Also engaging high schools and med school residency programs to increase awareness about primary care as a career goal; not clear about nursing or peer navigation career needs or options.
- Plan briefly acknowledges a shortage of PCP and how PCPs need to take on greater role in integrated care, capacity has not been quantifiably measured, estimated or explained.
- Millennium Care Collaborative states that internal resources can assist 30 practices of 45 to achieve 2014 PCMH Level 3; strategy for remaining 15 unclear.

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

- Consultant conducted PCMH, IT and DSRIP project readiness and prepared report of areas of focus, EMR interoperability and clinician rosters.
- 2014 PCMH Level 3 toolbox has been developed and six Practice Transformation Staff (PTS) hired who work with assigned PCPs to track project management, training, coaching, and reinforcing cultural change. Unclear on current PCMH status.
- The PTS will support training primary care sites on population health, team based care, care coordination and care transitions offered in different venues including onsite, online and webinars and possibly CME.
- Implementing sustainable population health strategies including proactive patient engagement activities prior to office visits is not clearly described nor is a timeline for PCMH milestones. The PPS' Best Practices Workgroup includes representation of local

physicians helping identify Standards of Care for project deliverables and best channels to deliver information.

- Plan to raise awareness about Loan forgiveness via the HRSA award at UB Medical School, the General Scholar's program and the Primary Connections Program.

**FUNDAMENTAL #3: What is the PPS's strategy for how primary care will play a central role in an integrated delivery system?**

- Changed partner strategy from project to relationship management within an integrated delivery system model including strategic development in PCMH standardized care coordination protocols, maximized use of EMR technology/robust connection to HEALTHeLINK RHIO and Millennium's population health software, and education to other partners to support better communication with primary care practices.
- Population Health solution will also create scorecards to merge workflows and data and rolled out via the PTS, on-site training and online learning system.
- Maximize health homes engagements via monthly meetings with health plans and CPWNY PPS. Where possible centralize processes of referrals, communication and education.
- There are 8 Primary Care Physicians are on the Physician Steering Committee, 2 PCPs on Board of Managers, 3 PCPs on PACs and 2 PCPs on Clinical QC.

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

- VBP questionnaire was distributed to all partners including PCPs; results will lead to plans for each organization, timelines and gaps and mitigation strategies.
- While VBP descriptions specific to primary care are not clear, there are website resources on VBP and the Physician Steering Committee is unofficial workgroup for VBP and recommended financial models to help predict future state revenues.
- Use of the population health software in December 2016 is expected to help integrate clinical data from partners of Medicaid members and support VBP budgeting and risk management.

**FUNDAMENTAL #5: How does your PPS's funds flow support your Primary Care strategies?**

- Through the use of Master Services Agreement, funds are bucketed by provider category and then by % of Medicaid patients. More are directed to Safety Net primary care partners (but not clearly explained). Primary care practices can receive support from PTS or work independently to earn funds. Dollars paid to date to PC sites not included.

**FUNDAMENTAL #6: How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?**

- PC assessments found that many sites already have Model 1 BH into Primary Care integration but need to further improve access to BH services. Strategy to provide education to PCPs on how to better manage patients with BH within internal practices through agreed upon standards of care, workflows, consent issues within integrated service models, and funds flow to support this integration in the BH MSA.
- SBIRT training offered for practices seeking to expand SUD services. PCP education to increase confidence in prescribing psychotropic medication, patient screening, and care coordination vs lengthy wait for external psychiatrist outpatient appointment. Partnering with psychiatrist in developing a collaborative care model.