



DSRIP Primary Care Plan

PPS Name: Albany Medical Center Hospital

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

- PPS’s 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 PCPs, as well as institution-based PCPs?

Primary care is a critical component to the success of DSRIP. In New York State, about 15% of adults lack a regular primary care provider. The proportion is similar for the Capital Region, with some slight variation at the county level. The emergency department is a major source of care for Medicaid beneficiaries as well as for the uninsured and therefore there is a greater need for access to primary care services within this demographic. There are a total of almost 60,000 Potentially Preventable ED Visits within the AMCH PPS. A consumer survey of Medicaid enrollees showed that 29% of respondents used the emergency room as their usual place to receive healthcare services as it was the most convenient for them at the time of needing care. Of those who used the ED as their primary source for care, 59% used it three or more times in the year prior. Medicaid primary care visits are lower than the NYS average in 4 out of 5 counties in the AMCH PPS Region.

The **PPS Network Analysis** included the following information for the AMCH PPS PCPs:

Data provided by DOH:

- Total PCPs in PPS: 495
- Total # PCPS participating in multiple PPS: 319 (64.4%)
- % PCP/ Extenders offering after-hours care: 27.7%
- Average total care hours: 36 hours
- % PCPs accepting new Medicaid members: 87.9%*
- Total PCPs at sites with PCMH 2011 Level 2: 4
- Total PCPs at sites with PCMH 2011 Level 3: 109
- Total PCPs at sites with PCMH 2014 Level 2: 0
- Total PCPs at sites with PCMH 2014 Level 3: 2

**Note:* Based on the feedback from our participating partners, the % of PCPs accepting new Medicaid members as listed above is not an accurate reflection of the current state. Significant numbers of new Medicaid patients face delays in finding a PCP who is able to accept new Medicaid members within a reasonable time period. In 2015, a PPS wide survey that was conducted to assess access to primary care services showed that the average third next available appointment for new adult patients among our key safety-net practices was 24 days, ranging from 4 to 38 days. This demonstrates disconnect between the data from the Provider Network Data System (PNDS) and the reality faced by our Medicaid beneficiaries.



Current state assessment: Medical Practice Types

As part of the current state assessment of PPS practitioner capacity, AMCH PPS completed a participating partner survey in October, 2015, that yielded the following distribution of primary care providers across the network.

Medical Practice Type (multi-selection) (n=86)

of Primary Care types: 26

Geriatrics: 8

Primary care: 6

Family Medicine: 5

Pediatrics: 4

Internal Medicine: 3

of BH practice types: 23

Given the proportionately fewer primary care practices across the network as compared to the number of specialist practices, timely access to primary care services in certain zip codes will be a priority as we pursue various strategies outlined in this document.

Primary Care Practitioner Composition:

Based on the compensation and benefits information that we received from most of our participating partners as part of our Workforce workstream deliverable, the following is the breakdown by practitioner and facility types:

of Primary Care Practitioners: 323

Physicians: 187

Article 28 PC facilities: 55

Non-article 28 PC facilities: 120

Nurse practitioners: 74

Article 28 PC facilities: 20

Non-article 28 PC facilities: 48

Physician Assistants: 62

Article 28 PC facilities: 16

Non-article 28 PC facilities: 45

As we look at strategies to expand primary care services, increasing the number of Advance Primary Care Practitioners at our partner sites will be one of the areas of focus to support the expansion of the Team-based care model across all our primary care sites.

MAPP Data Analysis:

Analysis of PPS wide data available on NYSDOH Medicaid Analytics Performance Portal (MAPP) has provided us with valuable information on maldistribution of primary care services by specific ZIP codes within our PPS region. Not surprisingly, Albany and Greene counties with urban and rural populations have the highest number of ZIP codes with maldistribution of PCPs to attributed members. Within Albany County, 5 out of the top 10 ZIP codes (12206, 12202, 12189, 12210, and 12047) have limited PCP coverage based on members/PCP analysis, including 4 ZIP codes without a participating PCP located in their respective ZIP codes. Furthermore, the ratios of attributed members to PCP are significantly higher in Columbia and Greene Counties than the average ratio across our PPS. According to an internal analysis, the ratios for Columbia and Greene County are 358 patients per every 1 PCP and 631 patients per every 1 PCP, respectively. This is 2-3 times that which is observed for Albany, Saratoga and Warren Counties.

Needs Assessment:

The needs of the residents of the community were assessed using reported data, capturing first-hand accounts from consumer focus groups, reaching out to key stakeholders for input and analyzing survey data. AMCH's assessment of community need included the following sequential components.

First, the PPS conducted a comprehensive baseline assessment of the five-county region. This assessment identified provider locations, hours of operation, plans for future development, utilization and other volume indicators, payer mix, appointment availability and other critical items from all participating primary care providers who are part of the PPS network. The resulting data was collated and thoroughly analyzed. The data generally demonstrated a disparity between neighborhoods with the highest number of Medicaid enrollees and access to primary care, as measured by appointment availability, hours of operation and self-reported utilization data. The resulting "picture" that was "drawn" of the five-county region showed what the current state of care was in the catchment area. When matched with ED utilization data, clear patterns emerged. Results were statistically significant linking zip code, payer and race/ethnicity to predictive ability in terms of avoidable ED usage. A key variable, whether the patient had an identified primary care provider, proved to have a strong correlation with avoidable ED use and other health outcomes. In fact, over 70% of the Medicaid patients using AMCH's ED did not have an identified PCP. On further analysis of the data, it was clear that there were several "hot spot" areas with higher concentrations of patients without an identified PCP. These hot spot or underserved neighborhoods include Albany's South End and West Hill neighborhoods and the City of Cohoes.

Additionally, In Fall 2014, multiple regional community forums, focus groups and listening sessions were conducted in an attempt for the AMCH and Alliance for Better Health Care PPS's to collaboratively identify the barriers faced by consumers. Several barriers to the overall goal of reducing avoidable ED and hospital use were identified. Common themes that manifested during these sessions included:

- Confusion/knowledge gap
- Inconvenient service access
- Lack of transportation
- Home environment & living conditions (unstable housing, frequent moves, lack of social supports and communication resources)
- Lack of coordination & consistent follow-up
- High diagnosis rates of anxiety, depression and chronic conditions

Many patients, especially the working poor, may lack knowledge of the health care system, familiarity with and access to primary care and, as a result, make the emergency room their primary source of care. Expanding primary care hours of operation to accommodate the working poor will help. In addition, providing navigators at the point of entry of emergency rooms to triage patients' needs with a corresponding link to primary care that is convenient and accessible is necessary. Patients with multiple co-morbidities, especially those dually diagnosed with mental or emotional health issues and chronic illness, must navigate a system that is neither user friendly nor readily accessible. Service locations tend to be either primary care or behavioral health; rarely do they coexist. An additional change in the regional composition of providers that will help address this will be the co-location and integration of primary and behavioral health services. There may also be technologic solutions to some issues, modifying the provider mix by bringing the specialist to the PCP electronically. Changes that are implemented as part of the transformation process for PCMH will help to further build capacity and team-based approaches to care. This is described in greater detail in the following section(s).



The consulting firm, BDO, which also provided the Target Workforce State Report for Albany Medical Center Hospital Performing Provider System, will be making recommendations through the Workforce Transition Roadmap, which will guide long-term workforce development. According to the Workforce Target State Report prepared by BDO Consulting, the demand for primary care providers will increase as much as 50 FTEs by year 2020 (Target Workforce State Report for Albany Medical Center Hospital Performing Provider System.) This is a projection based on non-DSRIP changes, such as predicted changes in patient demographics, combined with DSRIP-dependent changes due to project implementation. This report clearly indicates a significant need for PCPs to meet the growing demand in our region, and suggests urgency for the AMCH PPS to address the PCP shortage issues with long-term solutions. Based on a brief hotspot analysis and feedback from PCPs, the AMCH PPS Project Management Office (PMO) has recognized the ways in which various practices are identifying and prioritizing solutions at their respective sites. A particular theme is the need for providers, and resources to supplement their income.

Moreover, the combined impact of a growing and aging population and expanded medical insurance coverage will increase demand for health providers by approximately 3-6% for the population of the AMCH PPS—with the amount differing by health occupation and medical specialty, and with much of this increase driven by the growing needs of the Medicare population. While the DSRIP projects are largely targeted at the Medicaid and uninsured populations, most providers in the PPS network also provide services to the Medicare and commercially insured populations. In addition, DSRIP has the potential to increase demand for some provider types, such as PCPs (Target Workforce State Report for Albany Medical Center Hospital Performing Provider System).

Expansion of primary care capacity: current initiatives/plans for addressing identified needs:

The AMCH PPS has Master Project Agreements with three hospitals employing 162 PCPs, two large community-based primary care groups employing 237 PCPs and several community-based pediatric practices and FQHCs employing 35 PCPs. PCPs participating in the AMCH PPS have given considerable thought to the role that primary care will have for the transformations that will be brought by DSRIP, and the years that will follow.

Many of the needs that have been identified relate to the actual number of providers that are within a practice. The ability to recruit providers to support practice expansion varies by practice. Providers consistently raise the issue of expanding in order to offer weekend and evening hours in an effort to operate “clinics” that could potentially divert avoidable ED use that occurs out of convenience, or without considering that another option may be available.

Albany Medical Center Hospital, lead entity for the AMCH PPS, has submitted an application on behalf of the AMCH PPS, in collaboration with Community Care Physicians PC, to procure funds through the **Statewide Health Care Facility Transformation Program** to expand primary care capacity in high-needs areas of Albany County.

The purpose of the project is to provide capital funding support through AMCH to facilitate expanded access to primary care services by creating 2 new clinical sites in hot spot neighborhoods as well as one site dedicated solely to meet the needs of pediatric patients. These service locations will be constructed or renovated by AMCH. The rapid access pediatric site will be staffed by the Medical College’s Faculty Physician’s Practice, where they will be integrated into the existing provider network and delivery system. The two free-standing outpatient clinics will be created in two of the following hot spot, underserved neighborhoods: Albany’s South



End and West Hill neighborhoods and the City of Cohoes. The pediatric rapid access site will be constructed on AMC's main campus in the South Park neighborhood and will be limited to the region's pediatric patients.

The overall strategy used to develop the Project Plan included in this section was based on work efforts conducted in support of DSRIP as well as strategic input from the executive leadership team at AMCH. The Plan is a collaborative effort between Community Care Physicians (CCP) and AMCH, bringing the organizational strengths of the two organizations together in synergistic ways. The Plan is consistent with the institutional strategic plan developed by Albany Med, particularly as it relates to refining the primary care strategy, focusing recruitment on additional adult and pediatric primary care practitioners and investing in the communities most in need. As a teaching institution, it is also consistent with the mission of the Medical College to train tomorrow's medical professionals in a variety of settings. It will create a new cadre of trained professionals who understand the importance and value of working in a patient-centered medical home environment.

Albany Family Medicine, a division of Community Care Physicians, P.C., located in Albany County providing primary care services to a large number of our attributed members has brought on two new physicians and has increased patient slots for family medicine residents.

Harmony Mills Pediatrics, a privately owned practice located in a hotspot ZIP code has submitted a proposal to the PMO requesting funds to support the addition of a second pediatrician to expand hours for two evenings per week and Saturdays.

Koinonia Primary Care, located in a hotspot neighborhood, aspires to do as much as possible under one roof for their patients; they face limitations with available resources, especially in the staffing of their providers. They have identified a number of opportunities for extending services not just at their site, but throughout the community where space could be utilized at little to no cost.

Albany Medical College Faculty Practice, another large multi-specialty hospital-based group is looking to several strategies, which include addition of new providers within existing practices, acquisition of existing primary care practices into the larger organization, relocation and enlargement of existing practices, and the development of a hybrid PCP/Urgent care site located in the identified urban catchment areas.

Three of our Behavioral Health partners, **Capital District Psychiatric Center, Addiction Care Center of Albany, and Northern Rivers Family of Services** are planning to embed primary care services within their existing BH facilities to address many unmet medical needs of their clients.

Columbia Memorial Health System, our partner in Columbia and Greene counties, has been awarded two NYSDOH grants through Essential Health Care Provider Support Program (EHCPSP-I) and Capital Restructuring Finance Program (CRFP) to support expansion of primary care services across the two counties. Specifically, they plan to address the primary care physician shortages in their high-needs areas by:

- Recruiting for 2 Family Physicians in Greene County via multiple recruiters
- Recruiting for 2 Family Physicians and 1 Internist for Columbia County via multiple recruiters
- Development of a 5-year plan for a large Primary Care Office in Hudson that will merge two existing offices plus add space for 4 additional FTEs, a clinic for the noncompliant and walk-in services to help decompress the ER.

Saratoga Hospital System is currently assessing their primary care physician needs and plans to bring on two (2) additional FT Primary Care MDs in 2017 while looking to fill a handful of advanced clinician roles as they roll out "Team Pod Approach" in their existing practice locations.

Center for Disability Services has increased their primary care capacity from 1.5FTEs to 3.1 FTEs and is planning to introduce 'Open Access' to enhance access to primary care services for their at-risk members.



Whitney M. Young Jr. Health Center has recently hired a RN coordinator to conduct walk-in blood pressure screenings and improve the quality and access of hypertension care for patients, while creating additional capacity within PCP schedules.

AMCH PPS has adopted and promoted a strategy aimed at addressing both capacity and access issues through the provision of walk-in blood pressure checks with a staff member other than the PCP. Koinonia Primary Care has been providing walk-in blood pressure checks to community members during the hours of 10-4, Monday through Friday (community members are defined as both established Koinonia patients and non-patients.) Those who present themselves to the clinic and request blood pressure screening will be accommodated. Koinonia nurses will take blood pressures according to best practice standardized technique as determined by best practices as approved by the AMCH PPS.

Koinonia's walk-in blood pressure policy and procedure has been presented to partners and is being piloted at other sites. The AMCH PPS PMO also created a template policy and procedure using elements from Koinonia as well as the Million Hearts Campaign. Enhancing access to blood pressure screenings through an open-access model is rapidly being adopted by our partners across the PPS. Albany Medical College Faculty Practice, Albany Family Medicine, a division of Community Care PC, and our regional partners at Columbia Memorial Hospital have adopted this policy and procedure. Albany Family Medicine planned to pilot this process at their site in September, and all applicable staff was trained as appropriate. As noted above, Whitney Young has also implemented a RN Care Coordinator to provide blood pressure checks to walk-in patients.

Expansion of primary care capacity – Additional Approaches under consideration:

With the goal of enhancing access to timely and effective primary care services to the attributed members, AMCH PPS, in collaboration with participating partners and relevant PPS governing committees, will evaluate the feasibility of implementing one or more of the following approaches:

- Financial incentives for new physicians and non-physician practitioners to join existing safety-net primary care organizations.
- Financial and other appropriate support for partnering organizations with their efforts to expand primary care access in high-need areas of Albany County. Specifically, the three ZIP codes; 12202, 12206, and 12047, with the large numbers of attributed members and limited primary care capacity, will be the initial areas of focus.
- Align incentives for primary care practitioners to enhance AMCH PPS's ability to meet Pay for Performance measure targets.
- Incentives and other appropriate support for partnering organizations with their efforts to integrate primary care and behavioral health services.

Clinical governance:

As will be seen throughout this Primary Care Plan, clinical governance is vitally important and is the focus of the AMCH PPS Clinical & Quality Affairs Committee (CQAC), and the underlying Project-specific Subcommittees. CQAC draws upon the expertise of the AMC Faculty Group Practice's Clinical Quality Committee and the medical directors of the two largest primary care groups in the region, CapitalCare Medical Group and Community Care Physicians. With cross-departmental expertise and a dedicated focus to clinical quality improvement, CQAC has positioned itself within the PPS to assist with establishing quality standards and measures, clinical care management processes, and accountability for clinical outcomes. The Project Subcommittees include representation from specialists, subject matter experts, and a diverse



representation of the partners who will be participating in the projects. Committees and subcommittees include representation from institution-based PCPs and community-based PCPs. The AMCH PPS has also developed a Primary Care Advisory Group to ensure continued engagement of PCPs. AMCH PPS recognizes the need to provide various incentives, support for PCMH transformation/ expansion, community-based care coordination, access to specialists, linkages for transitions of care, and enhancing technical capabilities/ usage. The subsequent sections of this Primary Care Plan will elaborate further on AMCH's plans for preparing and supporting the primary care partners through the changes that will be required for, and a result of, meeting the expectations and deliverables associated with DSRIP.

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

- What are your PPS's plans for working with Primary Care at the practice level, and how are you supporting them to successfully achieve PCMH/APC?
 - Resources could include collaboration, accreditation, incentives, training/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?

Primary care expansion is imperative to truly gain successful transformation. The AMCH PPS is committed to the expansion of Primary Care through assisting and supporting its practices with NCQA Patient Centered Medical Home (PCMH) Level 3 2014 transformation. PCMH is seen as the bedrock of DSRIP's success as it is cross cutting to many of the project deliverables, and focuses on the shared goal of the quadruple aim; improving clinical outcomes, enhancing the patient experience, increasing provider and staff satisfaction, while reducing the number per capita cost.

Current State Assessment of PCMHs in AMCH PPS

In January 2016, the PPS performed a current-state assessment of all primary care partners to better understand the practices' current PCMH recognition status, provider make up, Medicaid volumes, EMR capabilities, and both prior and intended Meaningful Use attestation. We also sought to learn about our partners' driving motivations for becoming NCQA recognized, along with their actual or perceived operational, technical, and financial barriers to achieving the recognition. We discovered a divergent landscape across the region comprised of practices who had never applied for PCMH recognition, those who were either recognized as NCQA Level 3 PCMHs under the 2011 standards or on their way to being recognized as Level 3 PCMH under the 2014 standards and everything in between. At the time of assessment, fewer than 50% of our 90 practices had current NCQA recognition. Since the assessment, four practice sites have earned recognition as Level 3 PCMH under the 2014 standards and several others are in the process of pursuing this achievement. To our benefit, all practices reported having a CEHRT with capabilities for bi-directional connectivity with the local RHIO, Hixny (Health Information Xchange of NY.) That said, it was reported that only 61% of providers would be attesting for Meaningful Use 2015, giving us some opportunity for improvement in the current year.

We learned that practices are eager to earn PCMH recognition for all the right reasons: they want to provide better coordinated care in a team environment, enhancing the outcomes and experience for patients; they want to identify and assist high risk patients in getting the care and community connections they need; they want to engage their patients in a partnership to keep them well. Many practices, however, cited the same barriers to transformation, most notably the need for more financial and human resources to manage the



application process and the ongoing monitoring needed to maintain true practice transformation. Many practices also stated a need for technical assistance around EHR functionality like building templates, automating reports, and technical assistance with the NCQA application.

Organization	Practice/Site	No. PCPs @ site	Sites w/2011 recognition	Sites w/ 2014 recognition	Sites w/no recognition
Albany Medical Center	5	41	4	N/A	1
Capital Care	23	111	18	N/A	5
Center for Disability Services	1	2	N/A	1	N/A
Columbia Memorial Hospital	15	41	12	1	2
Community Care PC	26	156	N/A	N/A	26
Koinonia Primary Care	1	3	N/A	N/A	1
Harmony Mills	1	2	N/A	N/A	1
Riverview Pediatrics	1	3	N/A	N/A	1
Saratoga Hospital	9	50	1	N/A	8
Shaker Pediatrics	1	6	N/A	N/A	1
Whitney M. Young Health Center	2	12	N/A	2	N/A
	85	427	35	4	46

**Primary Care Practice data from January 2016*

Up-To-Date PCMH Supporting Efforts and Future Plans

Both a clinical and an operations manager were hired in DY1 to support the primary care practices on their transformation endeavors. As a first step in the journey to become content expert certified, the managers attended two NCQA PCMH trainings, Introduction to PCMH: Foundational Concepts of the Medical Home and Advanced PCMH: Mastering the Medical Home Transformation. Upon returning from NCQA training, the managers presented a training session in an effort to inform the project management staff on the fundamentals of the medical home. Because PCMH recognition is a requirement of six DSRIP projects, we felt it important for the PMO to understand the complexities of the PCMH and their relationship to project specific DSRIP objectives.

In April 2016, under the auspice of the CQAC, the first meeting of the Primary Care Advisory Group was held. The purpose of this work group formation is to promote active primary care participation in DSRIP projects, facilitate and promote PCMH recognition and the adoption of standards in primary care, promote integration of primary care and behavioral health, assist the PPS in determining current primary care capacity, performance needs and developing a plan for those needs, and lastly to facilitate primary care participation in the development of value based payment models. During the first work group meeting, we assessed our partner’s readiness or current standing in their PCMH efforts along with any barriers or challenges they faced in successful implementation. As a follow up to the initial meeting of the Primary care Advisory Group, a secondary questionnaire was developed and disseminated to assess what level of support each practice felt they would need in order to develop an appropriate RFP.

As an initial support strategy, in early July, AMCH PPS supported more than 30 clinical and administrative leaders from participating organizations to attend the two-day training in Saratoga Springs, NY which was hosted by HANYS and sponsored by the PPS’ Workforce Coordinating Council. The course, “Primary Care Practice Transformation-People, Processes, and Technology” addressed not just the fundamentals of the



PCMH framework, but also concepts around how to create meaningful and sustainable transformation within the primary care practice setting. Valuable feedback was provided by our partners indicating needs from their perspective which we have taken into consideration as the PPS determined an appropriate course of action for PCMH transformation.

Based on the information collected in both assessments, as well as the feedback provided after the HANYS learning collaborative, the AMCH PPS has launched efforts to engage a vendor to support true practice transformation in order to create a sustainable primary care network that supports the efforts of DSRIP. In September 2016, the PMO sent out a request for information to five potential PCMH vendors. Four of the five responded to our request; Primary Care Development Corporation (PCDC), ECG Management Consultants, Health Care Association of NYS (HANYS), and CDPHP. Vendor demonstrations were held during the month of October. Currently, the PPS is in the process of developing an appropriate request for proposal (RFP) that will meet the needs of our partners and the populations they serve. After the RFP process is completed, we plan to have a vendor selected by the beginning of December, and then a thorough gap analysis, readiness assessment, learning collaborative process, among others will start in early 2017.

Several key support strategies will be leveraged during the vendor engagement. It is our intent to offer the following but not limit to: a readiness assessment across all identified practices/organizations within the PPS , and a detailed gap analysis between the current state and achievement of NCQA 2014 Level 3 recognition at all sites identifying needs related to people, processes, and technology at the site level, as well as a detailed plan based on the result of the gap analysis for addressing the varied needs of the practices in a succession that ensures all practices will achieve NCQA PCMH Level 3 recognition. Customized levels of support may be needed based on the needs of the practice. Additionally, we plan to offer group learning collaboratives, whereby key clinical and administrative leaders from our partnering practices attend regular sessions that will assist them to understand how they can effectively create transformation in their organizations. It is also our intent to host frequent webinars to succinctly review the PCMH framework including standards and elements, policies and procedures, and best practices within partnering organizations who have already achieved PCMH recognition further enhancing our collaboration efforts. A core component to successful maintenance of NCQA PCMH Level recognition is a robust sustainability plan. It is imperative to the AMCH PPS, that the vendor provides a detailed plan indicating how key PMO and practice staff will be trained to provide ongoing support to ensure sustainability of transformation. Lastly, it is an expectation of the PMO that the vendor selected will provide a training strategy to include the provision of curricula, tracking of training at the individual level, and the assurance of successful knowledge transfer to all participants. The PCMH co-leads for the PPS will be available during the engagement to offer basic technical support and respond to inquiries that practices may have or to serve as a liaison between practices and the vendor or NCQA.

Additionally, the PPS in collaboration with Accenture LLP developed a comprehensive Clinical Integration Strategy Care Coordination Model (CICCM) in an effort to support Primary Care expansion. This strategy includes the standardization of the ED/observation processes, transitions of care processes, readmission management, risk identification/stratification, and the standardization of clinical and supporting information exchanged at care transitions across the continuum, all key functions for strengthening the primary care system. The PMO has held several in depth trainings on the CI CCM for key clinical and administrative staff from our partnering organizations. Comprehensive care management and care coordination is a fundamental function of an effective PCMH; therefore training on the CICCM is vital for primary care practices.



AMCH PPS is working with participating Health Home care management organizations and other regional partners to develop a comprehensive care coordination care management program to strengthen and expand the capabilities of our primary care partners.

Leveraging Statewide Resources

To support primary care initiatives, the data analytics team for the AMCH PMO remains very much committed to utilizing and leveraging the statewide data resources made available. To date, eight members of the PMO have been formally trained in Salient Interactive Miner (SIM); the intent behind sending these individuals to these intensive trainings were to not only expand the PMO's collective knowledge of the capabilities and functions SIM can offer, but to ensure that those with access to SIM cover a wide array of PMO responsibilities – ranging from project managers and data analysts to the Chief Medical Officer. Ensuring that all subject matter experts have the tools necessary to support these primary care initiatives remains a strategic tactic for the PMO. Important to note that when any trainings or informative webinars take place through the DOH, HANYS, Hixny, among others – members of the AMCH PMO are responsible for attending as a means to stay up-to-date and well-informed. Whether the objective is to review the DSRIP Dashboards for trending analytics, MAPP snapshots to gain an accurate picture of progress being made towards the Performance Measures' goals, or to understand the network in a more detailed manner, the Medicaid Analytics Performance Portal (MAPP) remains very much an integral tool for the data team. Pairing the information that can be extracted from Salient and/or MAPP with the Claims DB provides the PMO with a well-versed macro-perspective of the progress being made towards improving the primary care objectives. Not only is the data team tasked with writing meticulous code through SQL Server to perform detailed analytics regarding the AMCH PPSs Primary Care Network, but they are currently underway with identifying patients that can be categorized as being part of the high-need attributed population who will very much benefit from enhanced primary care.

Furthermore, Hixny and Statewide Health Information Network for New York (SHIN-NY) are being utilized to provide linkages among numerous organizations as well as to serve as a platform for various project needs and deliverables such as connectivity, real time alerts, sharing of care plans, and registries.

In addition to leveraging analytic resources, the AMCH PPS recognizes the importance of augmenting regional and national population health initiatives. Million Hearts is a national initiative to prevent one million heart attacks and strokes by 2017. Prior to DSRIP, two of the AMCH PPS' partners, The Albany County Health Department and Whitney M. Young Jr. Health Center, took part in this NYSDOH led state wide initiative working with the CDC and ASTHO. As a PPS, we are using the experiences from these partners as a demonstration of best practices to support our primary care practices with the implementation of the Million Hearts tools and framework into their respective organizations.

The AMCH PPS also leverages its close connection with the Asthma Coalition of the Capital Region (ACCR). ACCR is one of the Regional Asthma Coalitions in NYS that receives funding specifically to implement interventions in communities with high rates of asthma hospitalizations and ED visits. ACCR's mission is to coordinate sustainable initiatives that will reduce the burden of asthma in NY's Capital Region. ACCR worked closely with AMCH PPS Leadership during the DSRIP application process, and continues to be involved with the PPS and the Asthma Project Subcommittee. The AMCH PPS Medical Director is also ACCR's Physician Director, and the lead/ fiscal agency of ACCR is a PPS partner. Furthermore, many PPS PCPs in the asthma project are also participating with ACCR. The PPS has an opportunity to scale up on the activities/ projects of



Department of Health

ACCR to support implementation of evidence-based guidelines for managing asthma in the primary care setting, as well as enhancing the clinical-community linkages.

Lastly, the Advanced Primary Care Model (APC) framework, which is based on the principles of PCMH and CPCI model, will be used to support practices in the transition to value based payment arrangements.

What is the PPS's 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's governance committees and structure and clinical quality committees?



Primary care is essential in improving patient health and providing equitable access to health care. The AMCH PPS recognizes that a seamless linkage between episodic care, such as hospital inpatient and emergent care services, and primary care is critical to ensure a full continuum of care for our patients. Therefore, utilizing the following strategies, we will strive to assure that primary care physicians (PCPs) are key players who orchestrate other members of the integrated delivery system (IDS).

Emphasis on Linkages to Health Homes and Behavioral Health Providers under DSRIP Projects

Under many of our DSRIP projects, PCPs are committed to pursue the PCMH certifications. As part of this endeavor, practices are asked to demonstrate improved care coordination with other health care partners. As a sustainable effort to transform the regional primary care system, the AMCH PPS will provide technical assistance and support for PCP practices to acquire this recognition and help strengthen their relationships with secondary and tertiary services in the area.

Furthermore, the AMCH PPS will work with other PPS partners, such as behavioral health providers and Health Home agencies, for various DSRIP projects to encourage improved linkages to their local PCPs/PCMHs. By working directly with primary care practices and other secondary and tertiary service providers, the AMCH PPS will act as a liaison and foster relationships between providers who often did not collaborate prior to DSRIP.

Implementation of Clinical Integration/Care Coordination Model

The AMCH PPS has developed a Clinical Integration/Care Coordination Model (CI/CCM) that fully describes the future state in which PCPs play a central role. Under this model, community-based primary care is a critical component of the cyclical continuum of care coordination from acute to community settings. The AMCH PPS is currently working on implementing various parts of this model, including the establishment of a centralized care management entity in our PPS, improvements in Hixny connectivity, and placement of care coordinators in various clinical settings such as EDs and PCP offices.

Establishment of Centralized Care Management Entity

The AMCH PPS is in the process of identifying a regional entity that will function as a centralized care management organization. We are hopeful this centralized body will greatly contribute to improving our PPS's current care coordination system and create linkages to PCMHs and Health Homes. In addition, any qualifying patients will be connected to the 2.a.iii Health Home At-Risk Intervention Project through this care coordination process as appropriate. We envision that this entity will receive referrals from any of our PPS providers and initiate care management/coordination services for Medicaid patients attributed to our PPS. For providers and practices that cannot have their own onsite care coordinators, PPS-wide centralized care management services will be a tremendous help to complement their existing resources that are limited for care coordination.

Improvements in Hixny Connectivity

Efficient electronic communication between providers is critical for successful implementation of the CI/CCM. In addition, enhanced Hixny connectivity will ensure meaningful linkages between PCPs and other regional providers with timely communications and information sharing. The AMCH PPS is actively working with PPS partners and Hixny to establish necessary connections for alerts and care plan sharing, and intends to continue coordinating efforts between various partners.

Placement of Care Coordinators

The AMCH PPS plans to utilize care coordinators in several clinical settings, including the EDs and PCP offices, in order to help patients get connected to necessary clinical and social services. As part of the ED Care Triage



project, patient navigators are being implemented within the three EDs in our PPS region. Furthermore, the AMCH PPS PMO team will offer needed technical assistance to PCP practices undergoing the PCMH transformation in the areas of care coordination, care management, and linkages to community resources.

Primary Care Representation in the AMCH PPS Governance Structure

The AMCH PPS’s governance structure reflects how primary care is involved in the decision-making processes. The Project Advisory Committee (PAC) Leadership Committee, which consists of representatives of the 10 largest providers of Medicaid services in our PPS and chairs of workstream committees, have several PCPs as voting members. In addition, the CQAC consists of PCPs and clinical leaders from various partner organizations, all of whom provide valuable input and guidance regarding the PPS’s direction for supporting primary care system. Six project-specific subcommittees, including the ED Care Triage, Health Home At-Risk Intervention, Asthma, Cardiovascular, Primary Care/Behavioral Health Integration, and Community-Based Crisis Stabilization Project Subcommittees, were established to engage practitioners, including PCPs, who regularly meet and discuss the implementation of our DSRIP projects.

In addition to the governance structure that includes PCPs, the Primary Care Advisory Group was established in August 2016 to create another avenue for PCPs to become involved in our PPS activities. This advisory group consists of PCPs from institutional-based and community-based practices that provide insight and expertise on DSRIP initiatives related to strengthening the primary care system. This group will continue to meet on a regular basis to offer guidance and input on the AMCH PPS’s project implementation and transformational efforts.

Our largest participating primary care organizations are well represented by primary care providers on the CQAC (governance committee) and the underlying project subcommittees reporting up to the CQAC:

Governance Committee/ Project Subcommittee	Name and Title	Organization
PAC Leadership Group	Ronald Pope, DO, Dir. of Ambulatory Care Network	Columbia Memorial Hospital
PAC Leadership Group	George Davis, MD, Family Medicine Physician Representative	Columbia Memorial Hospital
PAC Leadership Group	Neil Mitnick, MD, Family Medicine Physician	Albany Family Medicine at Community Care PC
Clinical & Quality Affairs	Carrin Shottler-Thal, MD, Section Head, Div. of General Pediatrics	Albany Medical Center
Clinical & Quality Affairs	Kallanna Manjunath, MD, CMO for AMCH PPS and Staff Pediatrician at Whitney Young	AMCH PPS, Whitney Young
Clinical & Quality Affairs	Paul Sorum, MD, Assoc. Professor, Peds and Internal Medicine	Albany Medical Center
Clinical & Quality Affairs	Ronald Pope, DO, Dir. of Ambulatory Care Network	Columbia Memorial Hospital
Clinical & Quality Affairs	George Davis, MD, Family Medicine Physician Representative	Columbia Memorial Hospital



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Clinical & Quality Affairs	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
Clinical & Quality Affairs	Sean Roche, MD, Medical Director	Albany Family Medicine at Community Care PC
HHAR	Kallanna Manjunath, MD, CMO for AMCH PPS and Staff Pediatrician at Whitney Young	AMCH PPS, Whitney Young
HHAR	Ronald Pope, DO, Medical Director	Columbia Memorial Hospital
HHAR	Ted Zeltner, MD	Whitney Young Health Center
3.a.i	Bob Paeglow, MD	Koinonia Primary Care
3.a.i	Henry Neilley, MD	Shaker Pediatrics
3.a.i	John Rosenberger, MD	Albany Medical Center Internal Medicine
3.a.i	Kallanna Manjunath, MD, CMO for AMCH PPS and Staff Pediatrician at Whitney Young	AMCH PPS, Whitney Young
3.a.i	Mary Kathleen DiTursi, MD	Harmony Mills Pediatrics
3.a.i	Renee Rodriguez-Goodemote, MD, Medical Director	Saratoga Community Health Center
3.a.i	Ronald Pope, DO, Medical Director	Columbia Memorial Hospital
3.a.i	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
3.a.ii	Kallanna Manjunath, MD, CMO for AMCH PPS and Staff Pediatrician at Whitney Young	AMCH PPS, Whitney Young
3.a.ii	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
CVD	Bob Paeglow, MD	Koinonia Primary Care
CVD	Joseph Wayne, MD	Albany Medical Center Faculty Practice
CVD	Kallanna Manjunath, MD, CMO for AMCH PPS and Staff Pediatrician at Whitney Young	AMCH PPS, Whitney Young
CVD	LaTasha Turner, PA	Whitney Young Health Center
CVD	Lawrence Perl, MD, Chief Medical Officer	Columbia Memorial Hospital
CVD	Lawrence Robinson, MD	Albany Medical Center Faculty Practice
CVD	Maria Kansas Devine, MD, Medical Director	Center for Disability Services
CVD	Paul Lemanski, MD	CapitalCare Medical Group
CVD	Paul Sorum, MD	Albany Medical Center Faculty Practice
CVD	Ronald Pope, DO, Medical Director	Columbia Memorial Hospital
CVD	Sean Roche, MD	Albany Family Medicine at Community Care PC



Department of Health

CVD	William Murphy, MD	Columbia Memorial Hospital
Asthma	Christine Lee, MD	Columbia Memorial Hospital
Asthma	Gina Nickels-Nelson, NP	Albany Medical Center General Pediatric Group
Asthma	Henry Neilley, MD	Shaker Pediatrics
Asthma	Janet West, MD	Whitney Young Health Center
Asthma	Kallanna Manjunath, MD, CMO for AMCH PPS and Staff Pediatrician at Whitney Young	AMCH PPS, Whitney Young
Asthma	Lawrence Robinson, MD	Albany Medical Center Faculty Practice
Asthma	Mary Kathleen DiTursi, MD	Harmony Mills Pediatrics
Asthma	Nancy Getzke, NP	Columbia Memorial Hospital
Asthma	Stephen De Waal Malefyt, MD	Albany Medical Center General Pediatric Group
Asthma	Vishalakshi Sundaram, MD	Albany Family Medicine at Community Care PC

What is the PPS’s strategy to enable primary care to participate effectively in value-based payments?

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



The PPS recognizes the importance of providing education to facilitate the transition to value-based payment (VBP) arrangements, as well as the necessity of PCP involvement. The PPS has taken numerous steps towards this education, all of which help manage the issues related to the evolution to a VBP structure.

The PPS formed a VBP workgroup that has met monthly since April 2016. The membership includes four MCOs and twelve partner organizations, half of which are primary care providers. The primary charge of the workgroup is to provide education and guidance to partner organizations and to collaboratively create a VBP roadmap.

The PMO conducted a comprehensive baseline survey in the fall of 2015 that included several questions related to VBP. The PMO, in collaboration with the VBP workgroup, is now in the process of facilitating a more focused assessment that will survey all funded partners about current state of VBP contracts, education and technical/data needs, perceived barriers to success, and preferred VBP compensation modalities. This information will be used to obtain an updated current state, define learning and technical needs, and assist with the development of the PPS-specific VBP roadmap.

The PPS had several organizations represented at the Region 1 VBP boot camps hosted by the State in June and July 2016. Additionally, the PMO has provided the link to the recordings to the PPS network and encouraged all partners to view the sessions. An in-depth recap of each boot camp was provided at both the VBP workgroup and PAC monthly meetings. Discussion ensued as to gaps remaining post boot camp. As a result, the PMO is in the process of planning a PPS wide learning collaborative. Based on feedback from the VBP workgroup members, it was determined that organizations with robust experience with VBP arrangements should be recruited to present on real-life examples and to provide feedback on the process of their transition. Additionally, the PMO has reached out to the Department of Health to inquire about State representation at the learning collaborative to answer PPS-specific questions regarding the transition to VBP in our five-county region.

To help incentivize partners to transition to VBP, the PPS has contracted COPE Health Solutions to assist in the funds flow and partner contracting process, which delineates project involvement and contract deliverables for each individual project. The second phase of partner contracting, which will begin in January 2017, is largely focused on processes to transition the applicable PPS entities towards value-based purchasing along with other essential components needed for successful health system transformation.

The PPS developed a Target Workforce State Report in collaboration with BDO Consulting and their partner Iroquois Healthcare Association, Inc. (IHA). This report identifies the projected workforce needs of the PPS through the end of DSRIP Demonstration Year 5 (2020). These projected needs were determined through IHA's microsimulation model and were based on current state input provided by the PPS that included information about workforce, patient volumes by payer, and models of care, along with data-driven project planning assumptions, including anticipated staffing models and caseload ratios, many of which were forecasted through the Clinical Integration project led by the consulting firm Accenture.

In order to increase participating providers' interest in providing integrated/co-located substance abuse treatment, the PMO has provided education via webinar to executive leadership at participating organizations regarding the regional need for substance abuse treatment and the benefits for co-location of such treatment. Moreover, the PMO has had ongoing conversations with participating providers both individually and within Project 3.a.i Subcommittee meetings to support participation in this aspect of Project 3.a.i, and to proactively



address any barriers to implementation. Presently, a number of participating providers have expressed interest in ultimately providing treatment for substance abuse disorders after they develop or expand their abilities to provide co-located/integrated mental health and primary care services. The PMO has provided education to address participating providers' questions and concerns regarding how to provide integrated services without exceeding their respective licensure thresholds.

How does your PPS's funds flow support your Primary Care strategies?

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

The PPS, in collaboration with COPE Health Solutions, has created a funds flow methodology that supports the PPS network, specifically Primary Care. Over the course of the first phase of this contracting process, refined deliverables were created that range from project or work stream specific, to reporting or engagement. The funds are allocated based on project participation, safety-net designation, and attributed lives. Approximately 20% of AMCH PPS's partner organizations have a PCP designation, and almost 60% of the PPS's attributed lives are credited to these organizations. \$9.7 million was allocated to partner organizations during the first phase of contracting as described above. Primary Care providers represent over 77% of this allocation.

Several of the contract deliverables were created to incentivize Primary Care providers, including participation in a PCMH learning collaborative, completion of various project-specific registries and patient engagement data, an updated comprehensive baseline assessment, collaboration with Health Homes and EDs, policies and procedures on a wide array of topics (warm referrals, blood pressure checks, Behavioral Health screenings, crisis referrals, medication regimen simplification), as well as adoption of several best practice guidelines.

The PPS is in the process of contracting with a vendor to assist the network with care coordination. This arrangement will assist our Primary Care partners with organizing patient care activities and result in more effective care.

AMCH PPS recognizes that transforming toward PCMH is critical to the success of the DSRIP initiative. The PPS is currently in the process of issuing a request for proposal in an effort to recruit a PCMH consultant that will be able to provide assistance and guidance to PPS Primary Care providers. Additionally, the PPS will host PCMH learning collaboratives on an as-needed basis.



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

- This would include both collaborative care and the development of needed community-based providers.

The AMCH PPS is progressing well toward integrating primary care and behavioral health services, a key element of our primary care plan. We have demonstrated a methodical and comprehensive approach to planning and beginning to implement such service integration across the life of AMCH PPS. Much of the success of integrating Primary Care and Behavioral Health is predicated on the availability of behavioral health providers, primary care providers, and case managers/care coordinators. To that end, it is vital that we identify PPS needs, develop and implement a strategy to support the development of needed providers, and identify and engage existing providers available for integration.

Need for Integrated Services

Those managing serious mental illnesses often encounter significantly higher prevalence of severe comorbid conditions, including diabetes, obesity, high blood pressure, tobacco dependence, addictions and other issues that often shorten their life expectancy by decades. Behavioral health providers in our PPS serve a significant number of individuals at high risk for substantial medical need who continue to return to the EDs due to the lack of linkage to preventive medical care. According to the comprehensive current state assessment conducted in September 2015, numerous organizations in our PPS expressed great interest in integrating both primary care and behavioral health services at their current sites. We are currently conducting a current state assessment of primary care and behavioral health organizations participating in this project to obtain detailed information about their current capacity and processes, as well as specific needs identified for successful integration. Responses to this survey will provide guidance to the PPS on tailoring DSRIP support and assistance to the needs of each organization.

Governance Structure

During the DSRIP application phase, the AMCH PMO convened a committee of key behavioral health stakeholders, including executive leadership, clinicians, and content area experts from behavioral health organizations, local governmental organizations, and community organizations throughout our PPS. This group met regularly and, drawing from national and local best practices and findings, helped develop an application for Project 3.a.i that met the needs of the Medicaid beneficiaries attributed to AMCH PPS. To best meet regional needs, this group of stakeholders determined that the AMCH PPS should implement all three models of service integration.

In order to support the Project Subcommittee and workgroup activities, the AMCH PPS established an internal behavioral health team that consists of executive leadership, licensed medical and behavioral health providers, and project management staff. This group works closely, and shares members, with each of the AMCH PPS groups integral to our Primary Care effort, including: the CQAC; the PCMH, Clinical Integration, and Practitioner Engagement workstreams; and the Primary Care Advisory Group. Such cooperation ensures that primary care and behavioral health integration is a fundamental aspect of our overall primary care effort, and ensures that our efforts to integrate these services are consistent with relevant PCMH standards.

The AMCH PPS then convened a Project 3.a.i Subcommittee under the auspices of the CQAC. Co-chaired by the executive director of a prominent behavioral health organization and the AMCH PMO psychologist, the group consists primarily of executive leadership, clinicians, and content area experts from PPS primary care and behavioral health organizations, as well as representatives from managed care and community-based organizations.

To better support model-specific integration activities, two distinct workgroups were established under this project subcommittee; one focused on the primary care-based models of integration, and another focused on the behavioral health-based models of integration. Both workgroups consist of primary care and behavioral health clinicians, leadership, and experts. Each member of the primary care-based workgroup has significant interest and/or experience integrating behavioral health services into primary care sites, and their expertise and support are fundamental to our primary care plan. In order to guide service integration throughout the PPS, both workgroups meet monthly, excluding quarterly reporting months when the full project sub-committee meets. These workgroups are currently reviewing model-specific guidance documents for service integration by model that can be disseminated to participating providers.

Project Implementation Activities and Engagement of Partners

The PMO behavioral health team developed and presented two hour-long webinars to PPS partners to educate on the need for and benefits of co-located/integrated care and the AMCH PPS's three models of primary care and behavioral health service integration. Concurrently, key members of the AMCH PPS PMO's behavioral health team, including the Medical Director and Psychologist, met regularly with individual primary care and behavioral health stakeholders throughout our region. These meetings were aimed at educating partners on integration of primary care and behavioral health services, supporting partner participation in service integration, and early identification and mitigation of any identified risks and barriers. During these meetings, several organizations have shown interest in furnishing primary care and behavioral health providers for integration into other organizations in our PPS.

Partners' interest and engagement in Model 3 (IMPACT/Collaborative Care Model) have greatly increased after the AMCH PPS provided additional training and education via a webinar to the PAC and the Project 3.a.i Subcommittee. Discussion regarding the particular benefits and elements of the IMPACT Model has been ongoing at the subcommittee and workgroup level. The AMCH PPS PMO behavioral health team has provided, and will continue to provide, IMPACT/Collaborative Care guidance documents and resources to partners, workgroups, the 3.a.i Subcommittee, and primary care-related PPS partners as needed.

In addition to regular outreach and education of individual partners, the AMCH PPS sought the assistance of actively participating project subcommittee members in the development of a practice-specific assessment of readiness for service integration for participating organizations, as well as recommendations for preventative care behavioral health screening for depression in primary care settings. These recommendations for preventative care behavioral health depression screenings for adults and adolescents were subsequently approved by the CQAC. PPS-wide, many participating providers are already providing preventative care behavioral health screenings to patients, and the PPS has consistently exceeded speed and scale expectations. The subcommittee also provided recommendations to the AMCH PPS Clinical Integration



Workgroup regarding behavioral health screening in the future state model of clinical integration/care coordination.

A number of our participating providers are well-along in integrating behavioral health services into primary care sites, and will continue to provide important guidance to our less-experienced partners. For example, Koinonia Primary Care, Albany Medical Center Pediatrics Group, Albany Medical Center's Internal Medicine Group, and Saratoga Community Health Center all provide integrated/co-located behavioral health services within a primary care setting. Columbia Memorial Health system is working to integrate primary care with behavioral health and is currently investigating Tele-Health options to integrate with Psychiatry and Primary Care. Moreover, a number of our participating behavioral health providers are well-along integrating or co-locating primary care services into their sites, including our key partners: the Addictions Care Center of Albany and the Capital District Psychiatric Center. In addition to serving as guides to our less-experienced partners as they integrate services, each of these organizations has plans to expand their primary care integration programs. We are working closely with these important partners as they do so. Other key partners include the three hospital systems within our region, Albany Medical Center, Saratoga Hospital, and Columbia Memorial Health. Furthermore, Columbia Memorial Health has received a Capital Restructuring Financing award for the development of comprehensive preventative and primary care treatment center with co-located behavioral health care. We are working closely to support the efforts of all of our partners, whether they are far along or just beginning the process of service integration.

Much of the success of integrating Primary Care and Behavioral Health is predicated on the availability of providers. As such, we have developed and are implementing a strategy to support the development of needed providers. We distributed a comprehensive baseline assessment to all PPS partners, which assessed the type and number of behavioral health and primary care providers at each organization. We will conduct annual updates to this assessment. Moreover, we have disseminated a detailed Practice Evaluation to participating organizations, which collects further information regarding the availability of, and need for, providers. As previously described, the AMCH PPS engaged a workforce consulting firm to conduct a compensation and benefits analysis in order to generate a Current State Workforce assessment, and also to project the Workforce Target State. Using the Current State and Target state, we will perform a gap analysis, which we will use to develop the Workforce Transition Roadmap. This Roadmap will serve as the guide for workforce development moving forward. Additionally, AMCH PPS has established a Workforce Coordinating Council consisting of HR representation from multiple stakeholders and provider types, union representation, and subject matter experts. This council serves as a PPS governance committee to oversee current and future state resource needs across the PPS, including community-based primary care and behavioral health providers. Finally, we are working with the Project 3.a.i Sub-committee and its constituent work-groups, and individual partner organizations to identify organizations able to furnish primary care and behavioral health providers for integration into other organizations. Thus far, we have identified a few organizations interested in doing so.