Nassau Queens
Performing Provider System
An Alliance for a Healthy Community

Nassau Queens PPS
Primary Care Plan

October 2016

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Primary Care Providers (PCPs) play an integral role in the development and performance of an Integrated Delivery System (IDS). The Commonwealth Fund described primary care providers as the country's "First Line of Defense" against poor health and high medical costs. In a 2013 brief, the Fund summed up the evidence on the importance of primary care: "Good access to primary care can help us live longer, feel better, and avoid disability and long absences from work. In areas of the country where there are more primary care providers per person, death rates for cancer, heart disease, and stroke are lower and people are less likely to be hospitalized. Health care costs are lower when people have a primary care provider overseeing their care and coordinating all the tests, procedures, and follow-up care."[1]

The Nassau Queens PPS (NQP) is committed to engaging PCPs in delivery system reform and transformation to improve population health. This plan describes NQP's efforts to engage PCPs and expand access to primary care to date, as well as its strategies to ensure positive health outcomes and support the journey to value-based care. NQP comprises of three Hubs: NuHealth (Nassau University Medical Center), Long Island Jewish Medical Center (LIJ), part of Northwell Health, and Catholic Health Services of Long Island (CHSLI). NQP's Hub model will deploy a team-based approach to maximize expertise and resources to support successful PCP contracting, transformation, communication and connectivity. NQP's model maximizes the engagement between individual PCPs and their health system partner.

NQP's primary care network includes small and large physician practices, community health centers, outpatient hospital clinics, and safety-net, non-safety net, institution-based and independent providers. NQP's approach to physician engagement reflects differences in infrastructure and capabilities, as well as the variations in the composition of the primary care network.

[1] Naomi Freundlich and staff of The Commonwealth Fund, Primary Care: Our First Line of Defense, The Commonwealth Fund, June 2013. Available at: http://www.commonwealthfund.org/publications/health-reform-and-you/primary-care-our-first-line-of-defense

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Fundamental 1: Primary Care Capacity Assessment and Recommendations

NQP is committed to assessing and, where needed, increasing primary care access and capacity to ensure Medicaid beneficiaries in Eastern Queens and Nassau can receive timely and routine primary care. Physician capacity is of particular concern in Medicaid because fewer physicians accept Medicaid patients, relative to Medicare and privately-insured patients.

Assessment of Primary Care Capacity

The Center for Health Workforce Studies published a count of health professionals in 2013. The size of the Primary Care workforce in Queens County and Nassau County are shown in Table 1. All rates are based on 100,000 individuals and leverage data from the 2011 census.

Table 1: Primary Care physicians per 100,000[2]

	Nassau	Queens	New York City	New York State
PCPs (includes Peds, Ob/Gyn)	145.5	98.4	134.0	120.0
Physician Assistants	87.0	43.6	36.0	61.0
Nurse Practitioners	99.2	36.2	47.0	76.0

Nassau County ranks 3rd in New York State based on the number of Primary Care physicians per 100,000 individuals; Queens County ranks 17th.[3] However, barriers to access persist, particularly for Medicaid beneficiaries and the uninsured. To assess current primary care capacity and inform a plan for addressing the needs, NQP reviewed nationally published data, reviewed key indicators related to utilization, and conducted stakeholder interviews.

National Data: Health Professional Shortage Areas

Two communities in Eastern Queens, comprising 72 census tracts, and one community in Nassau, have been designated primary care Health Professional Shortage Areas (HPSA) by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) as show in the table below.[4]

Table 2. Health Professional Shortage Areas (HPSA)

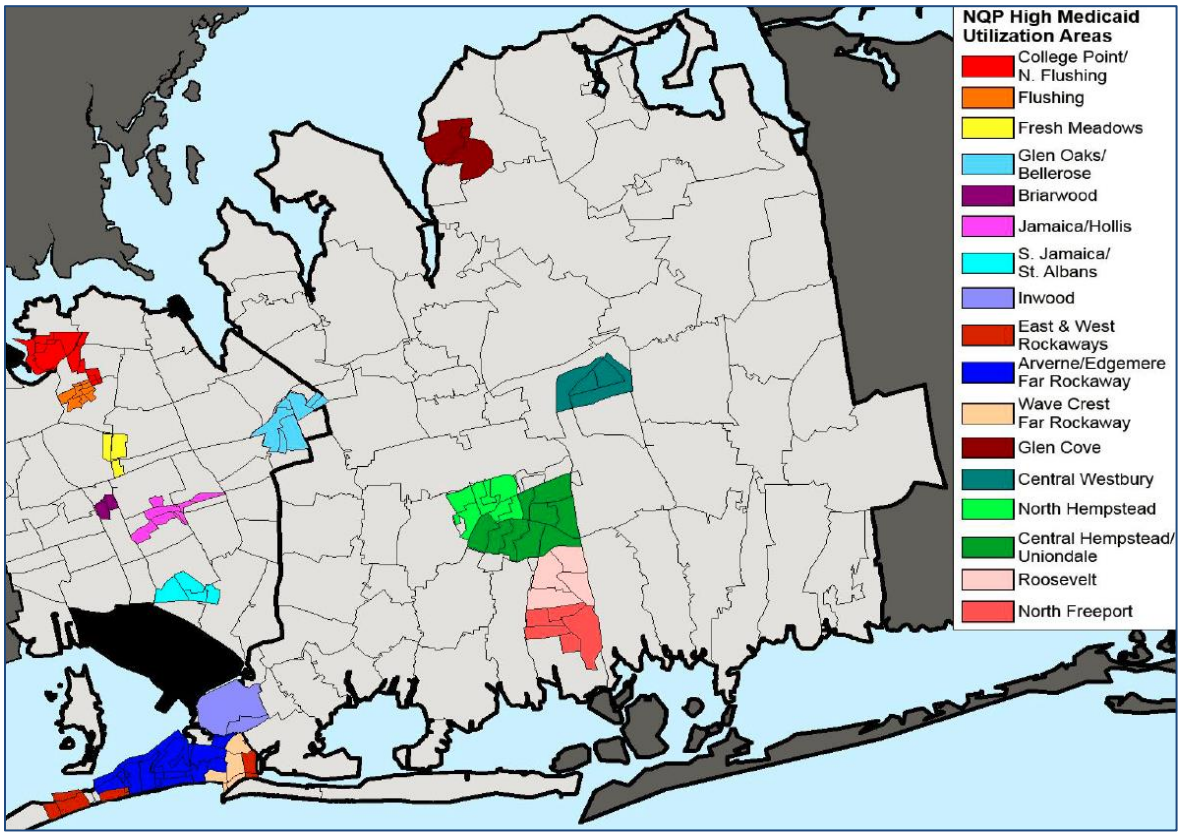
[2] Center for Health Workforce Studies. 2013. "New York State Health Workforce Planning Data Guide" Available at: http://chws.albany.edu/archive/uploads/2013/09/nys_health_workforce_planning_data_guide_2013.pdf
[3] Center for Health Workforce Studies. 2013.
[4] Health Resources & Service Administration HRSA Data Warehouse. Available at: https://datawarehouse.hrsa.gov/Tools/Analyzers/hpsafind.aspx

County Name	HPSA Name	HPSA Discipline Class	HPSA Designation Last Update
Queens County	Medicaid Eligible – Rockaway	Primary Care	09/13/2013
Queens County	Medicaid Eligible – South Jamaica	Primary Care	01/05/2012
Nassau County	Medicaid Eligible – Rockaway	Primary Care	09/13/2013

Utilization of Health Care Services

High Medicaid inpatient and emergency department utilization can be an indicator that a community faces barriers to timely preventive and primary care. NQP completed a hot spotting analysis (Exhibit 1) that identified the top quintile with the greatest utilization, based on the Statewide Planning and Research Cooperative System (SPARCS) inpatient and emergency department usage data from 07/2011-06/2013. To identify geographic areas with high Medicaid inpatient and emergency department utilization, the inpatient and emergency department data was filtered on insurance class of Medicaid or Medicaid HMO, both primary and dual-eligible. Utilization records were indexed by applying a weight of 1 to inpatient cases and a weight of 1 to emergency department cases. The indexed records were summed. The census tracts were divided up into quintiles and the first and second quintiles were highlighted and mapped, as shown below in Exhibit 1.

Exhibit 1 High Medicaid Utilization Areas



Stakeholder Input

In stakeholder meetings conducted in 2014, the NQP community highlighted access to primary care as a challenge, especially for those without insurance. Stakeholders commented that it can take many weeks to obtain an appointment at a site with a sliding scale fee policy and that the uninsured, particularly in the immigrant community, rely on stand–alone physician storefront offices that are unaffiliated and work on a sliding scale for care.

Plan to Improve Primary Care Capacity

NQP is taking steps to increase primary care capacity through several approaches. Each Hub has tailored these strategies to meet its specific network needs. Examples include:

Practice management

NQP, through the efforts of its hubs, has been actively contracting with Primary Care physicians in the PPS network. Presently there are over 500 Primary Care physicians, either employed or independent, that have agreed to work on key DSRIP initiatives, including becoming PCMH certified and connecting to the RHIO. These initiatives will allow our Primary Care physicians to be more efficient and effective in managing their patients. As part of PCMH certification process, NQP physicians will increase access through same-day appointments and expansion of evening and weekend hours. Access to more comprehensive medical information via the RHIO from hospitals, ERs and specialists will allow our Primary Care physicians to manage patients in their practices more effectively. Over time, our Primary Care physicians will be able to manage a larger number of patients and more efficiently manage their practices.

Open New Practices and Expand Existing Practices

NQP recognizes that there is a need to open new practices and to expand existing practices in geographic areas that have been designated HPSAs or have high rates of utilization and/or unmet needs. Examples of new practices that have opened or will open as a result of NQP's project implementation include the following:

— Nassau University Medical Center (NUMC) re-located and expanded its hospital-based Primary Care Practice in April 2016. Between April and July, the newly re-opened clinic had 11,941 visits – 31% (3,656) of which were new patients. The collocated primary care practice will continue to grow as new patients that were previously using the ER for non-urgent services are now referred to primary care for ongoing prevention and chronic medical management.

— The Long Island Federally Qualified Health Centers (LIFQHCs) retain family medicine residents that rotate with them, and over the past several years have hired many of them as attending physicians post completion of their GME. In addition, the LIFQHCs have recently been deemed a HRSA loan forgiveness site for medically underserved areas through the National Service Corporation. LIFQHCs have expanded evening hours Mondays through Thursdays as well as Saturdays. They are in the process of adding two more primary sites by the first half of 2017.

— Long Island Jewish Medical Center (LIJ) received an award through the CRFP program to create an ED-based primary care practice inside the hospital, adjacent to the Emergency Department (ED), as well as a larger community-based primary care Level 3 PCMH practice. LIJ currently operates a primary care clinic in its Ambulatory Care Unit (ACU), which has operated at capacity for many years. As part of this project, the clinic will be relocated into the community and expanded significantly to allow for 100% anticipated growth in Medicaid patient visits over a 5-year period. The Certificate of Need for this project was filed in 2016 and a lease for a new location has been secured. The new center is expected to open in late 2017/early 2018.

— St. John's Episcopal Hospital (SJEH) just opened its co-located primary care practice across the street from the Emergency Room. There is a commitment to grow the number of primary care providers who will be PCMH certified. In the near future it will be implementing an EHR and undergoing PCMH transformation. Prior to this initiative, SJEH had extremely little Primary Care presence in its area and most patient volume was redirected to Joseph P. Addabbo Family Health Center.

— Mercy Medical Center currently has small, part-time internal medicine and pediatric clinics located in the hospital. These clinics serve a great number of uninsured and Medicaid recipients, but are very much in need of an expansion. By the end of the year, Mercy will be opening its co-located primary care practice that will offer open-access scheduling and longer hours. Also by the end of DY3, Mercy will have a new outpatient center anchored by a PCMH with complimentary specialty services, which will dramatically increase access for the Medicaid and uninsured population to primary care as well as to elusive specialty care services.

Increase in Number of Mid-Level Practitioners

Nurse practitioners (NPs) and physician assistants (PAs) can play a key role in improving access to quality primary care by providing some of the services currently provided by physicians. Increased use of Mid-Level Practitioners allows physicians to become more productive (e.g., in terms of seeing more patients), which increases capacity and reduces the number of physicians needed. Research demonstrates that NPs provide exceptional care at a lower cost, due to the models in which they work and their efficiency. NQP is committed to increasing the number of mid-level practitioners (NPs, PAs) in the region's workforce.

The future demand for Primary Care physicians will exceed the existing capacity. Working with physicians to understand the benefit of mid-level providers and how to incorporate them into their practices will be essential. NQP is committed to supporting and increasing the number of mid-level practitioners in the region's workforce.

One way that NQP is hoping to increase the NP workforce is in partnership with universities in Long Island that offer specialty programs for Nurse Practitioners, such as Adelphi University and Molloy. In 2015, Hofstra University and Northwell Health launched the Hofstra North Shore-LIJ School of Graduate Nursing and Health Professions to meet the increasing need for NPs and Pas to deliver community-based health care. The three-year program will lead to a Master of Science degree in nursing as a family NP or an adult-gerontology acute care NP.

Partner with Urgent Care Practices

The number of urgent care practices has been increasing. Patients choose these practices for convenience, after hour's accessibility, and affordability. Although urgent care practices sometimes compete with Primary Care physicians, they can also complement PCP efforts. Both LIJ and CHS have partnerships with Urgent Care organizations (GoHealth and CityMD, respectively) to improve access and help ensure that the network delivers the right care, by the right person, in the right location.

— CityMD and CHS agreed on a formal collaboration in July 2016; going forward, CHS will refer patients to CityMD, during the hours outside those of its primary care doctors, as an alternative to the emergency room. CityMD will connect patients who do not have a meaningful connection to a PCP to an appropriate resource. CityMD currently has 55 locations in New York City, on Long Island, in Rockland and Westchester counties, and New Jersey.

— GoHealth has 23 clinics in New York and plans to almost double its presence by the end of 2016. Desk clerks at GoHealth work with each patient to determine if they have primary care doctors and, if not, offer to help the individuals find a primary care doctor that can provide continuous care. GoHealth's relationship with Northwell Health allows it to direct patients to specialists or other types of providers, if necessary.

Urgent care centers are a much better alternative to the use of the emergency room for acute, but non-emergent, services and are additive and not duplicative of primary care services. The strategy around the use of the urgent care centers is focused on directing patients back to primary care for their ongoing medical needs. This is built into the contractual relationships and workflow processes that have been created with these vendors.

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Fundamental 2: Support for Primary Care Expansion and Workforce Transformation

NQP aims to strengthen primary care and support physician and administrative champions to successfully achieve PCMH recognition. Several examples of NQP's assistance for PCPs include:

Education and Training
NQP's project implementation has a strong emphasis on training for PCPs and their office staff. Training modules will be developed both by NQP, with input from the Hubs, as well as by the Hubs individually for specific audiences. Examples of training modules for Primary Care physicians and their staff that are in development or have been finalized include:

— DSRIP 101
— Million Hearts Campaign
— Cultural Competency & Health Literacy
— Performance Reporting (including Actively Engaged, Medical Chart Reviews)
— Collaborative Care Model with Behavioral Health
— Depression Screening
— Proper Techniques for Blood Pressure Monitoring
— 5A's of Tobacco Cessation

Trainings will be provided through a combination of in-person trainings and online modules. For the in-person trainings, each Hub is hiring educators or consultants who can provide trainings to PCPs and their staff (RNs, MOAs etc.). For the online modules, NQP plans to purchase an online training platform that can host and store training materials. NQP is currently in the process of evaluating vendors for the online platform. Each Hub will be able to use the platform to automate reports on how many providers have viewed the training modules.

NCQA PCMH Level 3 Transformation and Recognition Support
NQP is committed to supporting Primary Care Practices achieve PCMH recognition by the end of DY3. PCMH achieves many of the primary care goals that are essential to a highly functioning health care delivery system, such as better care coordination and linkages to services outside of the provider practices. As a result, and to support PCMH transformation requirements related to performance measurement and quality improvement against clinical metrics, NQP is devoting considerable DSRIP resources to aid with PCMH transformation.

EHR Enhancement and Implementation
The DSRIP projects require primary care practices to have and utilize an Electronic Health Record (EHR). Each Hub will assess the IT capabilities of the participating practices and recommend modifications, and provide training and technical assistance to improve the EHR. Some Hubs may provide financial assistance specifically for EHR implementation or modification, or it may be included as part of the practice's bonus payments.

Incentive Payments

NQP has already begun to flow funds to PCPs based on participation in the DSIRP program. Each Hub designed its own program and structure for bonus payments to incentivize and support PCPs. At a high-level, payments to an individual PCP are related to the number of attributed Medicaid lives, receiving PCMH recognition, quality performance, and successful and timely completion of the DSRIP project requirements.

RHIO Connectivity

NQP is partnering with Healthix with the goal that all participating PCPs will connect to a RHIO. NQP is educating PCPs so that they are aware of and appropriately leveraging statewide resources, such as the Data Exchange Incentive Program (DEIP). Each Hub is responsible for helping individual primary care practices connect to Healthix through a combination of financial incentives and technical assistance.

Care Management Resources

Each Hub has care management programs that will be scaled to support PCPs in addressing the DSRIP project requirements and NCQA standards for PCMH recognition. Each Hub has a slightly different model for supporting primary care practices with care management resources and has expressed a plan to hire and deploy Care Managers to participating practices. In some practices, one Care Manager will be embedded full-time. In other practices, Care Managers will be assigned based on need and availability of resources. The Hub care management programs complement and extend the care management services provided by MCOs and Health Homes.

Analytics, Reporting, Performance Measurement and Quality Improvement

Each Hub has an analytics team with access to MAPP to pull and build provider-level dashboards on quality metrics. Practices will receive education and support on patient engagement and quality reporting. Providers' performance on quality metrics will be tracked and reported quarterly. If a provider's performance falls below the agreed-upon standard for one or more metrics (referred to as "in variance") for two consecutive quarters, an Action Planning process is triggered. Once an Action Planning process is triggered, each Hub will work with the provider to develop a corrective action plan. The team will monitor performance and work with the provider to improve the action plan as needed to ensure that the corrective action has been implemented and achieved the desired improvement.

Participation in Statewide Collaboratives to Streamline Requirements

There are several cases where NQP is working to streamline or standardize requirements so that individual PCPs will have an easier time completing the project requirements. Examples of Hub engagement include:

— Working with the Center of Excellence for Health Systems Improvement for a Tobacco-Free New York. The Hub is helping this workgroup develop common standards for 5As implementation in Allscripts and eClinicalWorks EHRs. This is functionality that NQP will leverage for all PCPs with these EHRs.

— Facilitating a discovery workgroup aimed at connecting the NYS Quitline to the SHIN-NY through the Healthix QE. The objective is to transmit an opt-to-quit referral from the provider's EHR to the

Quitline, and possibly to then transmit a response back from the Quitline. This would benefit all interested PPS participants connected to a QE throughout the state.

— Serving as a pilot site for an electronic DSRIP care plan that is being developed as part of a collaborative effort with Greater NY Hospital Association (GNYHA). The ability to share information from a care plan across the continuum of care will be an integral part of establishing and maintaining meaningful linkages with a wide range of provider types.

Fundamental 3: Primary Care in an Integrated Delivery System

Strong primary care is essential for a successful, integrated delivery system. Through its project implementation, NQP has developed several strategies, detailed below, to strengthen primary care and to improve linkages to other providers of care, including nontraditional members of the health care team, such as social service agencies.

There are several key elements to Integrated Delivery that NQP believes will help transform the current system. Primarily, ensuring access to primary care and other needed community-based resources. Secondly, engaging and educating patients. And third, communicating and sharing data across patient access points.

RHIO connectivity

For Primary Care Providers, connecting to a Regional Health Information Organization (RHIO) is one of the easiest ways to improve quality of care for patients and facilitate successful practice transformation. Exchanging health information across care settings and among all providers is essential for improving healthcare delivery and patient care and the RHIO enables providers to securely share and access comprehensive patient records. For these reasons, NQP is working with Healthix, which represents the majority of providers in the PPS network to create and strengthen meaningful linkages between all providers in the care continuum. Each Hub has already made a substantial investment in the RHIOs for data sharing and Healthix has been an excellent and accessible partner.

PCPs can use a RHIO to securely exchange clinical data with other providers when co-managing care for patients, receive hospital discharge notifications for timely follow up, and look up patient data across settings for coordinated care. These capabilities help providers successfully meet foundational requirements of key quality improvement programs like Meaningful Use and Patient-Centered Medical Home (PCMH).

Healthix leadership attends NQP workgroup meetings to discuss and explore functionality and the creation or expansion of various use-cases. This effort has been particularly focused on alerts related to patients in particular categories (missing services, Health Home enrolled or eligible, ED or hospital utilizing), at both the PPS and the Hub level. NQP expects there will be incremental progress in creating an alerts process for various events and patient types. NQP recently participated in the KPMG-sponsored Target Operating Model (TOM) project; Healthix representatives were active participants in these discussions. The TOM will integrate the concepts of event alerts and data communication.

PCMH transformation

In order to receive PCMH recognition from the NCQA, a Primary Care Practice must demonstrate that has a process to track and follow-up on all important referrals (Standard 5B) and to coordinate care that patients receive from specialists, hospitals, other facilities and non-traditional members of the health care team, such as social service agencies (Standard 5C). Standard 5B, which is a “must pass” element, specifically requires the PCP to implement a process to track referrals until a consultant/specialist report

is available, flag and follow up on overdue reports (Critical Factor), and to ask patients/families about self-referrals and requests reports from clinicians.

NQP has made the NCQA 2014 PCMH Level 3 recognition a priority for all participating providers and each Hub is devoting resources to support the PCMH transformation and application process. Each Hub has elected to work with consultants who can provide readiness assessment, work plans, care team development, training, education, coaching, and assistance with application preparation and submission.

Engaging and Educating Patients

An important factor to guaranteeing true system change is ensuring that our patient population is educated on proper health care utilization (i.e. when it is appropriate to visit the emergency room and what sort of regular care to see from a PCP). Through our patient navigation efforts, discussions with providers at various touchpoints and interaction with the patient population, NQP aims to improve the Medicaid population's understanding of appropriate medical care and more efficient use of healthcare resources.

In order to aid this effort, NQP has engaged in Project 2.d.i, "Implementation of Patient Activation Activities to Engage, Educate and Integrate" the uninsured and low/non-utilizing Medicaid populations into Community-Based Care. NQP is contracting with a variety of CBOs to target low/non-utilizing patients using PAM to 1) gauge their current understanding of and interaction with the health care system and 2) provide "coaching for activation", where patients will utilize goals and actionable steps to better self-manage their healthcare. With Coaching for Activation (CFA)-guided support, individuals steadily will build their knowledge, skills, and confidence over time. Gains in health activation will reflect increased positive self-care behaviors that improve the individual's quality of life and decrease utilization of high-cost health resources. Success of patient engagement will be measured when patients are resurveyed in year two, and a comparative assessment of their scores is compared.

Access to and Communication with Specialists:

Referrals are the link between primary and specialty care, yet the process has been a long-standing and well-documented source of frustration among patients, PCPs and specialists and a weak point in the care continuum. In a study of the adult referral process at an academic medical center, 28% of Primary Care physicians and 43% of specialists were dissatisfied with the quality of information they received from each other; 25% of the time, specialist consultation reports had not reached the primary care physician 4 weeks after the specialty visit.[5] Although this study was published in 2000, there is little to indicate that the process has improved – particularly for the Medicaid population.

NQP will play an important role in improving access to and communication between PCPs and Specialists, specifically due to its Hub model and access to healthcare systems with large, high-quality specialist networks. NQP, through the contracting efforts of its hubs, will work to expand the number of

[5] Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *J Gen Intern Med* 2000;15:626-31.

specialists who are contracted to support the DSRIP initiatives. Primary Care physicians will have access to specialists to see their Medicaid patients that require specialty services. A key component of PCMH certification is referral management. Primary care offices will be required to keep track of referrals to specialists and ensure patients are following up and receiving the services. The commitment to get both primary care and specialists connected to the RHIO will facilitate the exchange of clinical information that is central to the co-management of patients between primary care and specialty care. Each Hub will design incentive payments and engagement models to target specialists whose participation is critical for an integrated delivery system and the care of the Medicaid population.

Primary Care representation in Committees

NQP has involved PCPs in all aspects of planning and governance since the beginning of the DSRIP program. NQP's Executive Committee includes Dr. Kristofer Smith, who is board certified in Internal Medicine and Hospice/Palliative Medicine. In Demonstration Year 1 (DY1), NQP benefited from the leadership of Dr. Khousidai (Sandy) Balwan, who is a practicing Internal Medicine physician and directed the activity of the LIJ Hub, Dr. Laurie Ward, who is board certified in both Internal Medicine and Nephrology, and who was the acting Medical Director for NQP, and Dr. Jacqueline Delmont, a board certified Internist who has focused on helping the low-income and underprivileged populations her entire career, who has participated in planning workgroups. In all, there are eight physicians on the Executive Committee and seven physicians on the Clinical Oversight and Quality Committee who have primary care or behavioral health backgrounds. There is also primary care representation from our Federally Qualified Clinics. As part of our contracting efforts, we will be looking to get increasing participation from independent Primary Care physicians into our work groups and other activities such as webinars or local meetings.

NQP also has had participation from Primary Care physicians from small and large physician practices, community health centers, and outpatient hospital clinics in its project committees as well as the workgroups listed below:

- Clinical Integration
- Practitioner Engagement
- Workforce
- Cultural Competency/Health Literacy
- Performance Reporting
- Governance
- Information Technology
- Clinical Oversight and Quality

NQP actively seeks the opinions of and feedback from providers and incorporates this into its decision-making processes.

Fundamental 4: Strategy for Primary Care Participation in Value-Based Payment

Value-based payments build on the Triple Aim: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations. The progression to value-based payment cannot occur without the full engagement of PCPs, who play a key role in coordinating and managing ongoing care with a patient and family.

There are several key elements that PCPs need to successfully transition to Value-Based Payments: (1) Data & Analytics; (2) Care Management Programs; (3) Performance Measurement & Improvement; (4) Electronic Health Records and RHIO Connectivity; (5) Relationships with Payers; (6) Integrated Care.

NQP's Value-Based Payment Workgroup regularly meets to discuss strategies, but each Hub is responsible for engaging Primary Care physicians in the transition to new payment models. The elements are detailed below.

Data & Analytics
Strong analytic capabilities are essential in a value-based payment program. Providers need tools to be able to:

- Risk stratify the population
- Identify gaps in care
- Integrate clinical and financial (claims-based) data
- Create dashboards with performance metrics
- Manage payer reporting requirements

Each Hub is developing the analytics to support their attributed PCPs with these important analyses. Most Hubs have already provided this information to their employed physicians for whom they have clinical and financial data. As soon as Hubs complete the SSP workbooks and can access the claims data for the attributed and participating providers, their analytic activities will expand to include those PCPs as well.

NQP is contracting with Cerner to implement a population health software solution that will allow for more effective management of the DSRIP metrics across the PPS including using data from claims, EMRs and RHIO. This information will be sent to the hubs and their providers to more effectively manage their patients across the continuum from hospital, skill nursing facilities, ERs to specialists and primary care offices.

Care Management Programs
Care management, particularly in a medically and socially-complex patient population, is critical to improving health outcomes. Many people, especially those with chronic illnesses, need someone who can work with them to establish a care plan, help them navigate to appropriate services, advocate for them, and interpret clinical guidance. The ability to provide these services, especially those that go beyond traditional clinical care, is beyond the current capabilities of many primary care practices.

In order to strengthen the continuum of primary care and ensure these linkages are appropriately made, each Hub is responsible for providing care management services to high risk patients identified by participating PCPs. The Hub-specific care management programs will assist patients in self-management, locate and coordinate appropriate medical, behavioral and social services, assist the physician in addressing gaps in care, and recognize and respond to patients' individual care needs and preferences.

Each Hub has different care management capabilities at present, but all Hubs have some experience providing inpatient and ambulatory care management. Each Hub has committed to scaling its programs to meet the needs of DSRIP and the Medicaid population.

NQP and the hubs are committed to care management supporting the transition of complex patients with both the medical and psychosocial challenges across the health system. The case managers will be pivotal in connecting the primary care providers, specialists, hospitals, behavior health specialists and other community based organizations.

Performance Measurement & Improvement

Value-based payment ties physician reimbursement to performance on quality measures and, thus, it is critical that PCPs access accurate and timely information on their clinical quality indicators and can receive support to implement improvement activities as needed. NQP is responsible for developing dashboards on PPS performance on key indicators and for providing technical assistance to the Hubs to access and interpret the measures. Each Hub is expected to provide the same information and assistance to the individual PCPs in their network. NQP is also considering proposals from Data Warehouse vendors to support real-time outcomes and performance measurement.

Collecting and displaying meaningful data is a challenge for all value-based programs; the claims data lags several months behind and the provider EHRs do not always have the capability to run reports. However, each Hub is committed to investing in the human and technology capital to enhance and expand performance measurement support for PCPs.

EHR Implementation and RHIO Connectivity

An EHR is critical for effective participation in value-based payment programs due to the need for data on physician performance on quality indicators. Each Hub will assess the IT capabilities of the participating practices, recommend modifications, and provide training and technical assistance to improve the EHR. Some Hubs may provide financial assistance specifically for EHR implementation or modification, or may include this in a practice's bonus payments. Additionally, NQP is partnering with Healthix with the goal that all participating PCPs will connect to a RHIO and is facilitating education for PCPs to ensure they are aware of and appropriately leveraging statewide resources, such as the Data Exchange Incentive Program (DEIP). Each Hub is responsible for helping individual primary care practices connect to Healthix through a combination of financial incentives and technical assistance.

Connectivity to the RHIO will be crucial for our Primary Care physicians to be able, in a timely fashion through alerts, to intervene in the care of patients, as well as have full access to the clinical information

from the hospital or emergency room to ensure appropriate continuation of medical care without unnecessary repetition of testing or prescribing of medications.

MCO collaboration

The relationship with payers, including Medicaid Managed Care Organizations (MCO), is important for the sustainability of the DSRIP interventions. Each Hub meets with MCOs to discuss their own contracts and performance. Each Hub will facilitate MCO involvement in project implementation and assist with escalation of issues, such as those related to funding and determining PCP assignments.

As part of the contracting efforts with our Primary Care physicians, NQP and the hubs will be incorporating information and educational activities to help PCPs better understand value-based payments. The demands of DSRIP will position our Primary Care physicians to manage pay for performance (PCMH certification) and outcomes (improving quality metrics). This will be part of the continuing dialogue to support our providers moving into value based payment arrangements with the MCOs over the next couple of years. NQP and the hubs will work with selected MCOs to leverage the resources being developed by the PPS such as care management, RHIO connectivity, data management and PCHM certification. This will interface with the MCOs' resources to more effectively collaborate in managing the patients under value base payment arrangements.

Integrated Care

A primary care physician will not be able to move into value based payments on his or her own, especially where there is significant downside risk. In order for a primary care physician to be successful in this model, he or she will need to be connected and collaboratively working with a larger network of providers. This network will need to include other Primary Care physicians, specialists, hospitals, skilled nursing facilities, behavioral health and substance abuse providers, care management services and potentially a broad range of community based organizations addressing many of the social determinants of health such as food, shelter and employment.

NQP is working with the hubs in supporting the creation of an integrated care process that brings together all the services that will allow our Medicaid patients to get the best care. By getting our Primary Care physicians to have PCMH NCQA certification, it will create a more consistent approach to delivering medical care for all our Medicaid patients.

In working with all our providers to have EMRs that are meeting meaningful use requirements and are connected to the RHIO, it will ensure that our Medicaid patients' clinical information is communicated in a timely and accurate manner. By developing care management services that will identify patients at risk and have care managers work with all types of providers, including behavioral health and other community organizations, we will ensure that our patients transition successfully across the PPS.

By using Cerner as a population health solution to track patient outcomes, including the DSRIP quality metrics and contracting with providers (pay for performance around those metrics), NQP will ensure a consistent focus and commitment to improve the care that it delivers to all its Medicaid patients. As

NQP supports the development of this integrated care process, it will ensure that Primary Care physicians and other providers will be successful under value-based payment arrangements.

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Fundamental 5: Funds Flow Support

The Hubs administer and distribute DSRIP funding, following the receipt from NQP, in accordance with the DSRIP Program categories: (1) Project Implementation and Administration (2) Revenue Loss; (3) Services Not Covered; (4) Provider Payments.

Each Hub is responsible for its own funds flow model to support PCPs. There are high-level similarities across the Hubs around five factors that are related to supporting the provider in DSRIP project implementation and care redesign activities:

1. **Engagement Payment**
   This initial payment is paid once a PCP completes the on-boarding process. The intention is to provide PCPs with initial funding with which to make investments to support the DSRIP program. Additional payments may be provided based on continuous engagement (e.g. reporting for quarterly reports, attending educational sessions/trainings, reporting S&S, etc.).

2. **Technical On-boarding Payment**
   Hubs will provide funds to PCPs to offset the cost of ensuring platforms meet the DSRIP standards, such as implementing/modifying an EHR and connecting to a RHIO. This payment may be provided as these activities are occurring or once they are complete.

3. **Clinical Improvement Payment**
   Hubs will provide funds to PCPs tied to the completion of the Domain 1 Project Milestones for the relevant projects, including Project 3.a.i, Project 3.b.i, and Project 3.c.i.

4. **Clinical Outcome Measures**
   Hubs will provide funds to PCPs tied to performance on clinical quality measures.

5. **PCMH Certification**
   Hubs will provide funds to PCPs for receiving NCQA 2014 Level 3 PCMH recognition.

Additionally, each Hub will use funds from its project implementation and administration funds to support the deployment of care managers and behavioral health clinicians. These resources will be available at no-cost to providers.

Fundamental 6: Primary Care and Behavioral Health Integration

NQP primary care providers and community stakeholders note that there is an immediate need to integrate the treatment and management of depression, anxiety, and other common behavioral health conditions into primary care. Prior to the DSRIP program, most PCPs did not integrate behavioral health services in their offices due to insufficient reimbursement and the scarcity of behavioral health providers.

NQP will support the progress toward integrating Primary Care and Behavioral Health through (1) training; (2) integration of behavioral health staff (on-site and with telehealth); (3) collaborative care; (4) connectivity with crisis stabilization programs, Health Home, and psychiatric hospitals (5) relationships with community based organizations and state programs; (6) expanded access to pain management providers.

Training on Behavioral Health Screening
Each Hub will provide training to primary care practices on evidence-based behavioral health screening, with an emphasis on administering and scoring the PHQ as part of every office visit. Each Hub will offer training to primary care practices in Behavioral Health diagnosis and treatment via toolkits, webinars and training videos to promote patient self-management through effective, culturally appropriate communication, greater patient, activation, shared goal development, and a focus on improving overall health and wellness.

Integration of Behavioral Health Staff
Each Hub is hiring, training and deploying behavioral health staff (e.g. LCSW, LMSW) to primary care practices to support the integrated care model. These individuals may be on-site at a practice on specific days to accept warm hand-offs and referrals. They will also be available via telehealth for real-time consultations. The integration is supported by a clinical and project management team that provides on-going monitoring and strategies to support the practice.

Collaborative Care
Beyond the 3ai requirements, NQP would like to establish collaborative care practices, and has developed a tool to assess each primary care practices' readiness for the model.

Connectivity with Crisis Stabilization Programs, Health Home, and Psychiatric Hospitals
Each Hub is educating primary care providers about resources in our network and in our community that could be beneficial to their patients. These programs include the Medicaid Health Home, respite programs, mobile response teams, crisis hotlines (including LifeNet in Queens and 227-TALK in Long Island), and the inpatient and ambulatory programs at Zucker Hillside Hospital.

Relationships with Community-Based Organizations and State Programs
Essential to the success of collaborative care is fostering effective linkages to housing, vocational, and other supportive social services to community organizations and resources, and for incorporation of relevant social determinants into care plans. Each Hub is engaging mental health providers in the DSRIP

program to support the social determinants and facilitate accelerated referrals from primary care to these services.

Promoting Statewide Programs

NQP is promoting New York State's CAP-PC program to pediatricians. CAP PC is a collaboration between the Departments of Psychiatry at the University at Buffalo, University of Rochester, Columbia University/New York State Psychiatric Institute, SUNY Upstate, and Hofstra Northwell School of Medicine, along with the REACH Institute to better meet the public health need of its children and families by bolstering Primary Care physicians' ability to assess and manage children and adolescents (to age 21) in their practices with mild to moderate mental health problems.