



## Primary Care Plan Narrative

**PPS Name:** Sisters of Charity Hospital of Buffalo, New York

**1.) Provide an 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?)**

**Current Primary Care Capacity**

There are two major sets of physician teams inside Community Partners of WNY PPS. First, Catholic Medical Partners (CMP) IPA is approximately 990 independent primary care physicians, pediatricians and specialists. For the purposes of this report, it is important to note that CMP serves as the project management office of the PPS and is under contract with Sisters of Charity Hospital (SOCH) to manage and ensure timely delivery of all NYS Department of Health requirements for the DSRIP program.

CMP’s physician network and provider support teams are united with the common goal of improving the delivery of healthcare. CMP providers and their practices are primarily located inside the counties of Niagara and Erie. Inside the CMP network are 98 community based primary care group practices, many of which are already PCMH recognized. Almost 25% of the eligible CMP practices have already achieved PCMH Level 3 recognition under the 2014 standards and 40.8% of practices have complied with the 2011 standards. The remaining practices have no experience with PCMH.

Second, the Chautauqua County Health Network (CCHN) is a health care innovations organization partnering with CPWNY to provide primary care support to key practices that serve large portions of the Medicaid population in Chautauqua County. Additionally, CCHN provides practice level support for key projects of CPWNY. Currently, CCHN is working with seven large community practices to move them to Level 3 PCMH recognition under the 2014 standards. Two of these practices have Level 3 PCMH recognition under the 2011 standards, and one has 2014 Level 3 recognition in place now. The remaining practices have limited experience with PCMH standards; and will need more support to move to this model.

In late March 2016, CPWNY requested re-categorization of state-assigned PPS provider type for 72 providers. There was a discrepancy between the New York State claim-based categorization and CPWNY’s understanding of partners’ provider types based on evidence such as: NPI registry, NPPES documentation, office operations file, Catholic Health System provider registry, CMP provider registry, each provider’s website, and assignment made by MCO website.

CPWNY requested the following primary care related re-categorizations: 27 practitioners listed as non-primary care changed to 27 practitioners listed as primary care providers (PCPs), and 33 practitioners listed as primary care changed to 33 practitioners listed as non-primary care. 10 providers were requested to be re-categorized for other reasons other than PCP category type. By re-categorizing the providers, we hope to better understand provider capacity and resource needs for supporting and building additional primary care resources in the area.

As stated above, the PPS has requested re-categorization of PCPs. Nonetheless, CPWNY staff observes the following information in the State-provided network analysis of PCPs:

- 308 PCPs are accepting new Medicaid Patients, 369 currently offer Medicaid Services. This is re-stated in the NYs network analysis as 94.4% of the PPS’s PCPs being able to provide Medicaid services.



- There is a substantial overlap of CPWNY's network with other PPSs; 42.5% of PCPs overlap with a close regional PPS partner, Millennium Collaborative Care.
- Within the state provided definition, CPWNY is categorized as a small PPS with just over 80,000 patients attributed to the system.
- As a state designated upstate PPS, CPWNY providers tend to work longer hours and have a track record of success in achieving the PCMH designation.

Both CMP and CCHN continue to review the Advanced Primary Care (APC) model for implementation at primary care practices within the PPS. In its original implementation plan, CPWNY planned to use the APC model to incentivize PCMH achievement, specifically for smaller and solo practices. However, APC requirements and planning at the statewide level remain in progress, and guideline clarification will most likely not align with DSRIP target completion dates. Communication is ongoing and recommendations are being made to assist the practices in developing the groundwork needed for PCMH.

CPWNY's lead entity, Sisters of Charity Hospital (SOCH), is a part of the Catholic Health System (CHS). All other CHS hospitals are members of the CPWNY PPS. As part of efforts to provide accessible primary care, CHS Article 28 clinics are working hand in hand with many CPWNY project teams. The CHS health centers serving the needs of the Medicaid population by providing community based primary care are:

- Ken-Ton Family Health Center
- Mercy Comprehensive Care Center
- Mt St Mary's Neighborhood Health Center
- Mt St Mary's Primary Care
- OLV Family Care
- St. Vincent's Health Center

### **Performance and Needs & Addressing Those Needs:**

As noted in the PPS community needs assessment, primary care shortages exist throughout the region, including an inadequate number of primary care physicians and mid-levels (PA, NP) working in primary care settings. Further investigation identifies a need for open access to primary care. Open access is defined as same day sick visits and, more generally, short lead times for patient visits, including provider availability for new patients. Additionally, the PPS must focus on key primary care capacity building in communities such as the City of Buffalo and areas of higher Medicaid population in Chautauqua County. The State-provided network analysis of CPWNY PCPs states that 83.5% accept new Medicaid members, and 32% of PCPs/extenders offer after-hours care. Both CMP and CHS are continuing their education and recruitment efforts to fill these access gaps wherever possible.

Currently, CMP has 30,000 Medicaid patients enrolled in its provider network, who are part of existing health plan contracts. These contracts are being converted into Value Based Payment (VBP) arrangements. In order to expand primary care reach, the CHS provider recruitment team works to identify physicians and mid-levels to work in the community based clinics listed above, as well as all CMP private practices. There is a substantial signing bonus offered to new clinicians for serving at the CHS clinic sites, and additional re-location expense coverage if the providers come from out-of-area.

In 2015, CHS recruited 6 primary care physicians, 4 primary care graduate medical education (GME) residents, and 27 mid-level providers. In order to align provider supply with medical demand in the region, CHS reviews national guidelines for the appropriate amount of providers in any given geographic area. As appropriate, its team performs a community needs assessment, assesses provider gaps, then recruits based on filling the identified gaps.

CHS has applied for the designation of three of its community-based primary care health centers as National Health Service Corps sites. These include Neighborhood Health Center in Niagara County, St. Vincent Health Center, and Mercy Comprehensive Care Center (MCCC), both in Erie County. All are located in medically underserved areas and



have significant Medicaid patient populations. MCCC was recently awarded a “Doctors Across New York” \$100,000 grant to secure and retain a primary care physician who began practice in August 2016.

One of CCHN’s practice and hospital support activities also includes physician recruitment. Agency staff maintains a medical student registry, allowing CCHN to keep in contact with local students to provide shadowing opportunities, loan repayment programs and other incentives to return to the area to practice medicine. CCHN coordinates a paid summer externship program for medical students to rotate through local hospitals and clinics. Twice a year, CCHN hosts a mixer for Chautauqua County graduates in residency programs as well as medical students and local physicians to meet and build relationships. Last year, four “home grown” physicians were recruited to the area to practice.

Additionally, CPWNY is in the process of determining how it can best support primary care pathways for high emergency room utilizers with low acuity concerns. The PPS’s ED Triage project team (3biii) is working to address the need for a unified system/EMR to track patient engagements. CHS has selected the Crimson Care Management tool as the application to track and house all pertinent metrics associated with these high ED utilizers. The Crimson Care Management tool will enable all members of the care team across the care continuum to see real time updates in a patient’s files and generate the necessary reportable metrics to support both the project and primary care expansion efforts.

Metrics gathered as part of the PPS ED triage project will guide CMP, CHS and CPWNY efforts in any future expansion of primary care facilities and practices. CHS and CMP have initiated leadership discussions to find ways to fund start-up capital for additional primary care sites. For example, SOCH is a potential future expansion site and may use patient navigators on its hospital campus to assist with patient introductions to primary care facilities. The PPS team will support SOCH’s ability to expand its community outreach; SOCH is the PPS’s highest volume Medicaid service provider and the lead entity for the DSRIP funds.

Another initiative involves CPWNY and CMP continuing to work in partnership with Health Homes. The PPS sees this as a contributing factor to its overall success in connecting patients with chronic conditions to primary care resources. The emergency departments are using community health worker staff as well as Health Home staff to match Health Home candidates with Health Home providers. They also plan to track their interactions using the Crimson tool cited above.

In addition to supporting Health Home recruitment, CHS’s Health Connections department will play an important role in linking patients with PCPs. Health Connections is a patient call center that can contact and assist individuals who do not have a PCP and link them with an appropriate provider and other health and wellness resources. Project leadership for the ED triage team have identified Health Connections as an essential asset to overall success in connecting high ED utilizers with primary care. This team will also be using the Crimson tool for patient tracking, and documenting follow up with primary care.

Last, it is important to note that the PCMH practices and networks of CMP and CCHN both engage in annual CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys. PCMH practices also initiate and review the results of these surveys. Surveys cover topics important to health care consumers and focus on the aspects of quality that patients are best qualified to assess. The results inform actionable patient satisfaction goals for practices and monitor improvements or deficits in patient interactions.



**2a.) 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.)**

Lead PPS entity SOCH, as a member of CMP, has been engaged in a population health model for approximately 10 years and has been training clinical and administrative staff in this model. CMP provides centralized resources to its physician and organizational partners, including the PPS partners. This effort includes support of primary care practices by linking them with talented clinical transformation specialists and care management advisors. Both teams work with practice providers and practice staff to support PCMH recognition efforts and workflow enhancements that support quality outcomes. As the project management team for CPWNY, CMP provides PPS partners with skills, training and resources, including support to its Chautauqua County partner, CCHN, and their similarly structured clinical transformation and care advisors.

CMP resources provided to the PPS include a mobile team of practice transformation staff trained to assist practices in achieving PCMH recognition, achieve meaningful use and transition to a population health management model of care. In addition, a team of nurses, pharmacists and social workers are available to support practices in enhanced care management and disease management using a proactive approach to patient care.

The SOCH, CHS and CMP project teams employ staff educators and trainers experienced in teaching rapid cycle improvement, case management and chronic care management for high risk conditions, palliative care and behavioral health. These staff have developed training materials and manuals to support practice-based education, a learning network, and population health based education.

CMP and CCHN clinical transformation teams will continue to assess the interest and ability of practices to meet the requirements of PCMH Level 3 standards. As practices are able to meet the standards, CMP and CCHN will work individually with the practice with the goal of attaining 2014 Level 3 by 11/30/2017, or meeting the requirements of the new 2017 standards by 3/31/18. There are many examples of support to primary care through DSRIP projects. Detailed below are three noteworthy linkages:

- CPWNY has contracted with key partners to assist primary care practices in providing specialty services in an integrated setting. CPWNY has developed relationships with hospice teams and palliative care partners from all three designated PPS counties. The partners train practices on 'what is palliative care,' how to identify eligible patients, and how to establish referral agreements and processes to increase patient access to palliative care.
- CPWNY has engaged key behavioral health partners to work with primary care sites to provide training, consultation, care coordination, and triage to appropriate behavioral health services. CPWNY primary care providers have established screening policies and referral agreement relationships with behavioral health providers that allow for timely access and care coordination between primary care and behavioral health.
- CPWNY has partnered with the NYS Smokers Quitline to provide training to CMP and CCHN primary care practices on Quitline cessation resources and counseling services, as well as information on how to enroll in the Opt-to-Quit program, which allows providers to identify and refer patients to free Quitline services.



## 2b.) How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

A large number of CPWNY members are also members of an Accountable Care Organization (ACO), whether CMP or CCHN. This designation limits the access of CPWNY partners to certain state resources (e.g. PTN, SIM). Notwithstanding these limits, CPWNY team members have succeeded in appropriately leveraging available statewide technical assistance resources. Below is a brief summary:

- Both CMP and CCHN clinical transformation team leadership will continue to assess the APC model as guidelines are developed and interpreted by New York State. The clinical transformation teams will assess the interest and ability of practices to meet APC requirements. CPWNY will work individually with the practices with the goal of attaining APC status by 3/31/18.
- CMP and CCHN will compare and contrast APC against PCMH and perhaps offer another option for practices that are not PCMH. These practices will be offered training collaborations when possible.
- New York eHealth Collaborative grants (NYeHC) have assisted our PMO organization, CMP, in capacity building. As the lead regional extension center, NYeHC provides resources, regulatory interpretation, and guidance on meaningful use and interoperability.
- CPWNY project teams have been participating in statewide conference calls for the palliative care (3gi) and behavioral health integration (3ai) projects. They are working collaboratively with other PPSs to develop processes for expanding access and integrating services at primary care sites.
- CCHN has applied for Practice Transformation Technical Assistance (PA TA) Services funding through the New York State Department of Health. Should funding be approved, CCHN will help the small rural providers that have been left out of other funding streams because they were not identified as a safety-net providers. The PA TA program focuses on capacity building in the areas of Meaningful Use, Advance Care Planning, Quality Improvement, Care Management and Coordination of Health Information Technology, Population Health, and Payment Models. The providers will receive assistance from CCHN staff who bring a variety of different skills and expertise to support eligible practices in their pursuit of Advanced Primary Care. CCHN estimates that up to twelve practices will be assisted through the PA TA program if funding is received.

## 3a.) 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?

Primary care has a central role in our PPS network and in our existing value-based risk contracts. In fact, primary care has been and will continue to be essential to the performance of both the CMP managed ACO and the ACO operated by CCHN. Because of this, the ACO and IPA teams have developed a strong support network for our providers. These components include technical support, social work and care management support, data sharing, performance measurement, and training and education efforts.

### **Provider Networks & Centralized Efforts in Erie and Niagara Counties**

CMP provides centralized resources to its physician and organizational partners, including social work support and care management advisors. The CMP licensed social work team provides comprehensive social work services to patients associated with the primary care providers in the primary care physician network. Working as members of an interdisciplinary team, the social workers develop and coordinate a need-based social work plan of care. Care management advisors educate, mentor and support PCP practice based care teams in delivering high quality and well-coordinated care.

For example, CMP providers (the largest portion of the PPS provider network) establish referral agreements between PCP practices and specialty providers. Key components include communication channels, contact information, and best practice on warm handoffs. Additionally, regular formal communication is encouraged between internal



medicine, sub specialties, behavioral health and surgical specialties. CMP supports PPS members with trainings and meetings that encourage cross specialty communication and efficient use of specialty referrals.

In some practices, the social workers have access to the Electronic Health Records (EHRs), and document care notes directly into the PCP EHR. Social work referrals are also tracked via EHR with many practices. If EHR access is not available, a fax based referral system is used among provider and social worker. A social worker will follow up with the referring provider within 1 to 2 days of receiving a referral. A call is placed to the patient and/or care giver, needs are assessed, and if warranted, a home visit is scheduled. In the CMP network, encompassing 80% of PCP providers within the PPS, social workers are integral to connecting patients and families with needed secondary and tertiary services.

In the future, coordination between inpatient care teams (including a social work teammate) will be supported by communication tools in the Crimson Care Management module. For example, the social work team in the hospital creates comprehensive care notes in the module, which can be seen and supported by the CMP social work team, the PCP practice care management team, and the CMP care management advisors. Reporting from this module will assist in analyzing utilization rates and help identify high utilizers. The first phase of using this tool has already begun with the CMP social work team, as they are using Care Notes for communication about care activities they conduct.

Additionally, CMP supports the PPS primary care providers by facilitating appropriate level of care placement through diversions from IP hospital beds to sub-acute rehabilitation. All of this is directed by the PCP with support from the CMP social work team.

To facilitate referral, partnerships between behavioral health providers and the provider network have been formalized. This relationship ensures access to behavioral health services, typically with in-network appointment availability within 1 to 2 days of referral.

### **Provider Networks & Centralized Efforts in Chautauqua County:**

As an organizing principle, CCHN and its partners have been using the Collective Impact Model as a framework for multi-sector planning, alignment, and change. Hospitals and PCPs collaborating through CCHN have a strong track record for innovative models to improve the health care delivery system by focusing on five conditions for success: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support. CCHN utilizes the Collective Impact framework to build consensus to plan, implement, and evaluate key components of service redesign initiatives.

CCHN is working with Health Managers and Guided Care Nurses within the PCPs to strengthen care coordination and chronic disease management with their patients. The Health Managers' Learning Collaborative and Guided Care Nurse Learning Collaborative both meet monthly, facilitated by CCHN's Quality Improvement Program Manager. Learning Collaborative members learn and share about individual system achievements and issues, new services, and creative problem solving, taking valuable information back to their organizations.

CCHN's two Clinical Transformation Coordinators hold a monthly Learning Community meeting, to which PCPs and their representatives are invited. At these meetings, one or two topics are presented to assist the practices with PCMH Recognition. In addition, staff gives PCMH updates to inform attendees of any important changes. Attendees also share with peers, on topics such as difficulties overcome while meeting the deliverables needed for PCMH recognition.

Moreover, CCHN is convening local eye care specialists to determine how network PCPs can collaborate more closely with them to more consistently share patient data needed to improve care management. CCHN has also reached out to hospitals beyond Western New York to determine how local PCPs can receive reliable, meaningful communication regarding inpatient and ER admissions and discharges to improve care coordination for local patients that they share.

**3b.) How is Primary Care represented in your PPS's governance committees and structure and clinical quality committees?**

Practitioner professional committees and stakeholder groups are represented in the PPS governance structure as well as to disseminate information to the practices in a systematic geographic allocation of resources. This includes participation by the PCP community. Professional peer groups of CPWNY include:

- CHS/CMP Clinical Integration and Standardization Group (CISG)
- CMP Territory/Regional Primary Care Lead meetings
- Representation on CPWNY Clinical Governance Committee (CGC)
- CPWNY Executive Group Board (EGB)
- CHS Clinical Quality Committee.

There are 3 community-based (non-hospital) primary care providers and 2 hospital-based providers within the 19 person voting member roster of the EGB board of the CPWNY PPS.

There are 3 community-based (non-hospital) primary care providers within the 12 person voting member roster of the CGC board of the CPWNY PPS.

Additionally, CMP clinical staff meetings occur semiannually to disseminate information and engage practice care coordinators regarding, but not limited to, the Clinical Integration program, care management program goals, Cultural Competency and Health Literacy, patient engagement, readiness to change and self-management.

Regional interest meetings are held regularly by CPWNY partners in Chautauqua County. These meetings and two-way feedback sessions include primary care practices engaged in the practice transformation work led by CCHN. Its Clinical Integration Committee meets quarterly and oversees the development, implementation and enforcement of evidence-based clinical policies and quality standards set by the Board, and makes recommendations for improvement in the quality, cost, and utilization of physician services. Its Health Information Technology Committee (HITC) facilitates access to data and reporting and assists with the ability of local PCPs to report on clinical quality measures.

**4.) 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 primary care members of the PPS are also members of two physician stakeholder groups, CMP and CCHN. Both groups already participate in value based payment (VBP) arrangements. Currently, CMP is the only member of the PPS participating in VBP arrangements targeted to the Medicaid managed care population.

CMP's Board of Directors includes Primary Care and Specialty Care representatives. While the total number of physicians may fluctuate depending on the Board's needs, one-half (1/2) plus one (1) of these members shall be Primary Care Physician Board Members with the remaining members being Specialist Physician Board Members. This gives Primary Care one more vote for representation when reviewing VBP contracts or determining the strategic direction of the organization.

Members of the CMP executive team meet regularly with MCOs in the local community, including Fidelis Care, Independent Health Association (IHA), YourCare, HealthNow NY, and WellCare. They represent the primary care providers within their network, as well as other types of providers. CMP will use its experience with VBP to educate and guide the PPS partners, including primary care providers, through the transition to VBP. Of the regional MCOs, CMP currently participates in VBP arrangements for the Medicaid patient population with:

- Fidelis Care, serving 25,000 PPS patients



- Independent Health Association, serving 17,000 PPS patients
- WellCare, a new payer in the region building its patient market share.

CCHN will work with its physician partners to obtain VBP for their Medicaid populations independently of the work of CMP. CCHN's contracting entity is their IPA, the Chautauqua Integrated Delivery System (IDS). IDS has plans to pursue VBP contracts for Medicaid lines of business for its provider members and can serve as a guide as other partner's transition to VBP. CCHN has been educating providers on VBP programs and their potential impacts. This spring, CCHN will hold a county-wide educational event that will highlight initiatives available to providers, as well as provide tools to remain viable and effective in this environment.

CPWNY will provide guidance and mentoring, where appropriate, to PPS partners who would like to be engaged in contracting with Medicaid MCOs. CPWNY will continue to support the CCHN team in pursuing VBP arrangements, including risk based value added contracts, for its IPA, the Chautauqua Integrated Delivery System. CPWNY will continue to build partnerships with the CMP IPA and its existing VBP agreements. This will include recruiting new members to the CMP IPA so they may take advantage of the VBP arrangements in place now and in the future.

The work of CPWNY MCO equity payments contracting and CMP IPA VBP contracting is shared between the Catholic Medical Partners Board of Directors, CPWNY Executive Governing Body, CPWNY Financial Governance Body and Catholic Health & Catholic Medical Partners Managed Care Negotiations Team. This facilitates learning across many interest areas of the PPS and beyond.

## 5.) 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?)

Clinical transformation specialists and care management advisors at CMP and clinical transformation staff at CCHN are supported by DSRIP funds. This model provides centralized support for primary care practices. The teams work with practice providers and practice staff to support PCMH recognition efforts, and workflow enhancements to support quality outcomes. At CMP, there are 6 full time employees working as clinical transformation staff to support practices pursuing PCMH. DSRIP funds support 1 full time equivalent spread among 6 full time employees to allow for flexibility in resource planning. Approximately 84 primary care practices are supported by this staff. As cited in section 1 above, many practices are already PCMH recognized or at varying levels of recognition (i.e. 2011 standards). The staff cited above also provide technical support for data systems at CMP PCP practices. This staffing support is planned to continue through DY2.

At CCHN, there are 2 full time employees working as clinical transformation staff to support practices pursuing PCMH. DSRIP funds support 1 full time equivalent spread among the 2 full time employees to allow for flexibility in resource planning. 7 primary care practices are supported by this staff under DSRIP funds. 2 practices are already PCMH recognized, others are varying stages of completion for the recognition. The staff cited above also provide technical support for data systems at CCHN PCP practices. Additionally CCHN also has on staff data analyst that bills at an hourly rate to support practices, and is budgeted at 10 hours per month to offer support. This staffing support is planned to continue through DY2.

The DSRIP initiative also funds technical analysts to help practice staff better use and understand practice data. Common best practices for reporting and use of technical infrastructure across PCP teams are managed by centralized staff at CMP, CHS and CCHN.

A total of \$1.1 million was accrued in DY1 and paid in DY2 Q1 to 228 primary care practitioners in 99 CMP primary care practices. (All providers and practices were in the Counties of Erie and Niagara.)





In DY1, a total of \$39,240 was accrued as payment to 3 primary care practices in Chautauqua County. This payment was paid out in DY2 Q1 along with the first DY2 quarterly payment of \$71,978 to Chautauqua County practices which included 7 practices with 71 primary care providers.

Funds provided to practices support performance reporting and clinical integration activities. PCPs across the network have received DY1 funds for participation in projects and PCMH efforts. This includes a portion of the clinical integration payment for CMP primary care practices, which is supported by DSRIP funds. In DY1, the DSRIP payments to CMP primary care practitioners are determined by:

- participation in the Clinical Integration (CI) plan
- participation in DSRIP projects
- serving the Medicaid population
- successful project reporting
- DSRIP performance distribution

Additionally, engagement payments have been made to large Medicaid practices working with projects in Chautauqua county. The payments to Chautauqua County primary care practices are determined by:

- participation in DSRIP projects
- serving the Medicaid population
- successful project reporting
- DSRIP performance distribution

Moving forward, DY2 funding is based on project reporting for patient engagement and continued efforts to achieving PCMH recognition. This is for both CMP and CCHN practices. For CMP practices, work on Clinical Integration and progress towards common integration activities is paid via the clinical integration payment as cited above.

**Other practice level offerings:**

CPWNY offers training in cultural competency, health literacy and rapid cycle evaluation to all providers in the network, including PCPs. Additionally, performance reporting initiatives have begun to help the practices understand their Medicaid patient population and what data is available via NYS Salient and MAPP tools.

Additionally, DSRIP funds are paid to practices to help offset the cost of PCMH application fees to NCQA.

**6.) 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.)**

CPWNY has developed a model for key behavioral health partners to establish a counselor at designated primary care practice sites to do initial screenings and consultations, and connect patients with the appropriate level of behavioral health care within their organization. The counselor will also work with designated practice sites to educate personnel on mental and behavioral health and act as a consultant to the CPWNY team to help develop work flows and best practices for improving outcomes on Project 3ai performance metrics. DSRIP funds have been offered under contract to behavioral health providers to obtain these formal linkages to primary care. This helps mitigate start-up risk on the part of the behavioral health providers, as there may be limited billing opportunities with this “foot in door” strategy of an informal linkage between primary care and behavioral health.

One of CPWNY’s key Partners, Horizon Health Services, is working with multiple sites of a large primary care practice, Primary Care of WNY. Horizon will be on site to accept referrals for behavioral health eligible patients, perform substance abuse screens, provide initial counseling, and triage patients and assist in getting them expedited access to the appropriate level of services at one of Horizon’s licensed sites.



Spectrum Human Services has adopted a similar model at CHS's Article 28 clinic site, Our Lady of Victory. The agency is seeking to transition to a full satellite clinic pending regulatory approval on the colocation of Article 31 and Article 28 providers.

CPWNY is in the process of contracting with a key partner, Catholic Charities of Buffalo, to implement a pilot model for using community health workers to offer care management support for behavioral health patients and assist in connecting them with primary care services. This project is designed as a test pilot with the intention of expanding out to additional partners if it is proven to be effective.

Niagara Falls Department of Mental Health (NFDMMH) is another key partner looking to integrate a satellite clinic site at a large primary care practice in Niagara County. This project is still in the initial phases, but the goal would be for NCDMMH to offer a full range of mental and behavioral health services at the primary care site, including substance abuse screenings and onsite counseling for patients of the designated primary care practice as well as potentially offering services to patients from near-by Article 28 clinics.

Additionally, CMP practices pursuing PCMH recognition have adopted evidence based behavioral health screening as a part of their work flow and have established referral agreement relationships with key community behavioral health providers. CPWNY is looking into developing new strategies to share real time data between primary care and behavioral health partners to allow for a more comprehensive understanding of the patient and improve quality of care. Current data resources are based on self-report or claims data, which has a significant delay. Both of these data sources offer limited value to providers.

Currently, 65% of CPWNY primary care providers are PCMH recognized and have adopted PHQ-2/9 screenings as a part of their requirements for recognition. Our goal is to get over 90% of CPWNY Practices to achieve NCQA PCMH 2014 recognition by the end of DY3 Q4, which will include adoption of behavioral health screening protocols. CMP has formalized a referral agreement process with behavioral health providers for expedited access to services for patients identified through the screening process as in need of behavioral health services.

Currently, 77 CMP practices hold referral agreements with CMP behavioral health providers, covering around 240 of our primary care providers and 5 of our key behavioral health partners. For model 1, CPWNY has formally implemented or are in the contracting process for 9 behavioral health satellite clinic sites at primary care practices. We plan to analyze the progress of these sites and expand out to additional primary care sites as needed.

CPWNY's behavioral health team works closely with our regional health homes and our behavioral health partners have been educated about the services offered and how to refer patients. CPWNY's lead behavioral health partner, Spectrum Human Services, is one of three lead agencies that comprise of CPWNY's partner health home, Health Home Partners of WNY. Spectrum brings to the partnership their expertise in working with the behavioral health population and are able to help patients diagnosed with mental and behavioral health conditions better manage their care, reduce unnecessary hospital utilization, and remove barriers to care. Health Home Partners currently has over 1,200 providers in their network and is responsible for managing 3,151 patients.