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DSRIP PPS Primary Care Plan

PPS must submit a Primary Care Plan (PC Plan) that addresses 6 fundamental questions

PPS Name: State University of New York at Stony Brook University Hospital

Fundamental #1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs
The overall plan for addressing primary care capacity across the Suffolk Care Collaborative (SCC) considered the findings from the SCC Current State Workforce Survey, the Workforce Target State and Gap Analysis which determined the primary care need by project, the contracting strategy to prioritize primary care practice sites for onboarding, the solicitation plan for adding new providers during the open enrollment period, and the Patient Centered Medical Home Model (PCMH) to re-engineer workflows, utilize care teams and adapt new technologies to realize better efficiencies throughout the targeted practice sites. To meet the objectives of the current state survey and assessment criteria outlined by the Department of Health, a comprehensive, electronic survey was designed and used for collecting and analyzing the workforce data. This effort was a collaboration between the SCC and KPMG, the workforce consultant. Data was collected through a web-based questionnaire that was emailed to partner organizations across each Hub. There were two (2) distinct surveys, one focused on the Primary Care Practices. The survey assessed the types of services provided by our network partners. The SCC had over a 50% response rate and the survey results provided SCC with a good understanding of the incumbent primary care workforce. Based on self-reported current headcounts for the incumbent workforce the breakdown included 2,264 physicians, 277 Nurse Practitioners, and 379 Physician Assistants. The physician category included community and institution-based providers specializing in Internal Medicine, Family Medicine, Pediatrics, and Primary Care with a small portion of reported Emergency Physicians. To identify the target primary care workforce state needed to support the DSRIP projects, the SCC conducted a rigorous analysis of our PPS workforce demands related to the DSRIP projects. Focus groups were formed to complete the initial target state planning and forecasting process. A position-by-project staffing model based on the DOH job categories was used and considered the target population for each project. Current and national ratios or estimated benchmarks were used to calculate the estimated number of positions needed by job type which included primary care. Based on the workforce allocation numbers reported by partners for primary care, the SCC has projected a relatively small gap i.e. .40 FTE for Primary Care Physicians supporting behavioral health sites, .10 FTE for PAs and 1.8 for NPs. This may change as the healthcare landscape evolves and the DSRIP projects are further advanced throughout the PPS. The SCC has begun initiating work to develop a gap closing strategy and transition roadmap for each impacted DSRIP project. The SCC expects to have the transition roadmap completed October 2016. The workforce plan includes identifying and addressing the gaps by partner. The transition roadmap will be adjusted as we learn more about our partners through the contracting process. To build the SCC Primary Care Network physicians were tiered for contracting based on Safety Net and PCMH status, location in geographic areas serving a large volume of Medicaid lives as well as other key criteria. Just over 500 primary care providers have been identified for tier one contracting across all three Hubs. The primary care providers are organized by practice site and then by the parent organization, which is considered the “contracted entity”. The SCC has executed contracts to date that account for 263 primary care providers. All three Hubs within the SCC are engaging both community-based and employed PCPs. While there may be different approaches by Hub, the overarching strategy is consistent. A comprehensive partner onboarding program was created to standardize the process and education materials across the PPS which is available on the SCC website https://suffolkcare.org/forpartners/onboarding. During engagement meetings with partners, education to the DSRIP

program is provided as well as the resources that are available to support the practice transformation efforts including PCMH, Care Management, Behavioral Health Integration and Information Technology.

Northwell Health has two initiatives to support new primary care practitioners. Northwell Health has responded to the well-established paucity of graduating residents who pursue careers in primary care practices. Northwell Health (NWH) has committed to a loan forgiveness program for graduating residents in appropriate residency programs, in exchange for their commitment to work as primary care providers in their organization. NWH is also providing training and employment opportunities to physician extenders. Nurse Practitioner (NP) students in the newly formed Nursing School are provided on-the-job training in the last quarter of their graduating year. This includes the opportunity for Family NP students to start their NP careers in one of NWH's many primary care offices, where they would have already started to build a panel of patients. With each graduating class, NWH plans to increase the supply of physician extenders in the region.

In terms of assessing primary care capacity, the workforce survey captured information regarding each practice site's ability to care for patients outside of "normal business hours." Of the 116 practice sites that responded to the workforce current state assessment survey, 94 (81%) currently have extended hours that occur outside of the normal work week (Monday-Friday), and/or outside of regular working hours (9:00am-5:00pm). In an effort to better understand each practice site's capacity to increase patient panels the Provider Relations Teams across the SCC Hubs are gathering additional information regarding each site's ability to increase Medicaid patient volume and identifying the point person/process for referring new patients to each practice site.

The SCC has received and reviewed the PCP Network Analysis and Unaffiliated Provider Report provided by the DOH and has identified additional primary care providers to target during the open enrollment period. Solicitation plans are currently underway to engage these providers with the SCC.

Based on the PCP Network Analysis, the SCC feels confident in the PCP network composition and the ability to engage key PCPs across Suffolk County, some highlights include:

- 98.6% of PCPs in the Provider Network Data System
- 41% of network offer after-hours care
- 94% of PCPs are accepting New Medicaid Members
- 14.7% have achieved PCMH 2011 Level 3 – Opportunity to rollout PCMH efforts to improve rate

Compared regionally across other PPS, our PPS was categorized as a "Medium PPS." Here are some comparative highlights of the SCC when comparing against the other 6 PPSs in this category:

- The SCC has the highest number of PCPs enrolled in our network at 777
- The SCC has the highest percentage of PCPs offering after-hours care
- The SCC has the highest average total care hours per PCP per week
- Alongside the NYUL PPS, the SCC has the highest number of PCPs accepting New Medicaid Members
- Alongside WMC PPS, the SCC has the highest number of PCPs who have achieved PCMH 2011 L3

PLAN FOR NAVIGATING ATTRIBUTED MEMBERS (Community Health Activation Program)

Beginning March of 2016 the SCC began to take a closer look at the State-provided data sources (CPA file, Member Roster and available Claims Data Extract) in an effort to design an approach towards engaging our attributed members through primary care providers. To date, we've designed and began to roll-out two strategies based on four member cohorts we've identified and categorized:

1) Number of Members with no Assigned MCO PCP and claims history
2) Number of Members with no Assigned MCO PCP and no claims history
3) Number of Members with an Assigned MCO PCP in the SCC Network
4) Number of Members with an Assigned MCO PCO not in the SCC Network

The two strategies are:

- Strategy 1: We've carved out #2 above into its own strategy called "*Engaging Non-Utilizers*" where we plan to move these members into a direct outreach model through our contracted Community Based Organizations participating in the SCC's Community Health Activation Program. Our primary goal is to engage via outreach and navigate them to a Primary Care Preventive Wellness visit. Along the way our Community Health workers will use tools such as motivational interviewing to complete a Patient Activation Measurement survey, Coaching for Activation (when applicable), community navigation services to support needs such as social services, food banks, housing, etc. This strategy includes building a network of Primary Care Providers across Suffolk County, who are contracted with the SCC to support receiving this member cohort and provide them with appropriate access and care.
- Strategy 2: The remaining member cohorts outlined in #1, 3 and 4 above will be moved into our Population Health Management planning. The SCC has developed an attribution algorithm to determine the established physician using the claims history and other clinical data sources. The SCC intends to test the accuracy of the MCO assigned PCP based on claims history as well as identifying the primary provider driving the majority of services. In instances where primary care is being provided by specialists, those relationships will be examined with the goal of navigating the patient back to a primary care physician. This strategy also includes a robust provider engagement plan to ensure that providers in our PPS are aware of their role as an attributed PCP.

In addition to evaluating the effectiveness, testing, ensuring security checks and balances in order before implementing the strategies defined, we've also logged a set of risks and requests that have been shared with the NYS DOH or our DSRIP Support Team directly. An example of one of our requests to support navigation activities of the PPS is the following:

Very high on our wish list would be the ability of each PPS to access the downstream health home tracking system. In addition to provide access to the tracking system to our Hospitals – as they participate in our TOC program, we want to make sure patients are aligned to the correct care management agency seamlessly. Being able to appropriately identify and navigate these individuals back to their associated health home and/or provider would help secure a warm handoff from our hospitals to their care management agency.

The NYS DOH announced on August 22nd that it is possible at this time for PHI-authorized users of the DSRIP Dashboards to identify members attributed to our PPS as Non-Utilizing Members. We are very thrilled with this new filter to ensure we're moving this member population into appropriate strategies in the future. We do intend to use this as an actionable field going forward.

Patient Centered Medical Home (PCMH) Practice Transformation Program

The SCC Clinical Integration Needs Assessment highlighted current gaps in the SCC PCMH certified provider Network. It is SCC's belief, that by transforming primary care sites into Patient Centered Medical Homes, the SCC will be well positioned to improve the quality of care provided to patients and increase access to care for the most vulnerable populations. The SCC's strategy is to have care teams work to the highest capacity of license or scope of practice; an approach vastly different from the way healthcare has been provided in the past. Practices are required to create policies that empower non-physician staff to provide the necessary services, within the scope of their practice, that a patient may require. By reallocating tasks, physicians are thereby made available to complete physician specific care such as increasing time allotted for more complex patients, scheduling additional patients to their schedule.

Providers will be required to have appointments outside of regular business hours, as well as offer healthcare advice by electronic methods or by telephone. Further, practices should have the capacity to offer same-day appointments for both routine and urgent visits. Practices are also charged with providing alternate types of clinical encounters, such as nursing visits, to manage chronic conditions, group visits, and visits with other health care providers in the primary care office.

A PCMH strategy has been developed to bring providers (as per the SCC provider engagement speed and scale commitments) to PCMH Level 3 status with submissions for recognition being completed by September of 2017. The first step in the PCMH strategy is to contract with providers in the SCC Network. Through contracting, greater detail is gained on the status of each practice and provider and relationships are built which facilitate a team based approach to PCMH recognition. Vendor contracts have been executed with PCMH specialists (i.e. PCDC and HANYS) which provides a facilitated recognition process and support for the practice sites.

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Fundamental #2: How will primary care expansion and practice and workplace transformation be supported with training and technical assistance?

The primary care expansion, practice and workforce transformation is supported through an established workforce training plan and alignment of key resources for the SCC primary care practices. Early on, the SCC recognized the importance of properly engaging its primary care physicians by establishing a comprehensive onboarding program. For contracted partners, the onboarding program provides education regarding the DSRIP projects, performance reporting requirements, SCC resources and other essential need-to-know topics. The onboarding program and all associated reference materials are available on the SCC website located at https://suffolkcare.org/forpartners/onboarding. Although there is some degree of variability as to how each Hub completes the activities, each Hub generally follows a three-step process to onboarding partners which includes an introductory meeting to discuss the contract, a follow-up meeting with contracted partners to provide general orientation to the SCC, and finally, education and training to the DSRIP project requirements.

The Suffolk Care Collaborative has developed a training strategy and plan to equip the workforce with the skills and competencies needed to address the needs of the population served. The training program development started with a Training Needs Assessment, which relied heavily on the knowledge and input of the SCC and HUB Project managers with input from the project leads. Information was also gleaned from the workforce current state assessment survey. Findings from the training assessment identified the requisite courses, skills and processes that would need to be acquired in order to successfully participate in DSRIP projects as well as the staff impacted by the transformation.

The SCC training plan identifies the individual courses and targeted audience for training. For the primary care practice, this includes clinicians as well as administrative staff as applicable to the course content. The SCC is utilizing a blended learning approach for training and has built a forward facing Learning Center on the SCC website to supplement in person training. The e-learning modules currently on the SCC website focus on population health (DSRIP 101), performance improvement and reporting as well as cultural competency and health literacy. Future e-learning modules are in the work queue which will help the SCC educate and outreach to the primary care practices. The SCC is currently finalizing the core curriculum for the primary care practices which will orient partners to the DSRIP projects. The SCC will be relying on a train-the-trainer approach to orient the primary care practices by training the assigned DSRIP champion at each practice site who will in turn orient the practice staff.

The Patient Centered Medical Home (PCMH) is at the forefront of transforming the delivery of primary care to a model that is patient centered. The SCC Director for Practice Transformation and Community Engagement is a central resource responsible for managing the process of recognition across the entire PPS. The Director leads a monthly PCMH Certification Workgroup which is comprised of key stakeholders across the PPS, including PCMH specialists, subject matter experts, practice staff engaged in PCMH transformation activities as well as representation and report out from all three Hubs on their progress toward transformation. In addition to supporting the DSRIP deliverables, the workgroup meetings are opportunities to provide education on healthcare transformation and industry trends (i.e., MACRA, 2017 NCQA PCMH Standards); share lessons learned; discuss innovative ways to enhance access, workflows, integration and efficiencies. Furthermore, funds have been allocated to hire dedicated PCMH staff at all three HUBs to assure that resources are available to support the primary care practice sites. Staff include PCMH Certified Content experts.

Contracts have been executed with PCMH specialists (i.e. PCDC and HANYS) to provide resources to individual practice sites to support PCMH transformation across the PPS. Both PCMH specialists have proven records of customizing primary care practice transformation activities to support the unique needs of individual practices. There are varying degrees of support for the PCP practice teams which include on-site and virtual facilitations at regular (i.e., weekly, biweekly) intervals, as well as ongoing email and phone communications throughout the transformation engagement period. PCDC, HANYS, and HUB specific teams work with the PCP practice champions and their teams providing education, training and guidance in improving patient workflows and operational efficiencies; integrated care coordination; and optimizing the practice team's roles and responsibilities in the medical home to successfully transform their practice to meet NCQA 2014 PCMH Level 3 and sustain the standards beyond recognition. The use of information technology (IT) is a necessary component to achieving Level 3 and true transformation. Our PCMH teams will emphasize the importance of maximizing the practice's IT capabilities to achieve recognition as identified, for example, across the three elements in Standard 1, Patient-Centered Access: Element A - Patient-Centered Appointment Access; B - Access to Clinical Advice; and C - Electronic Access as well as Standard 3D, Use of Data for Population Management which is a Must-Pass Element in PCMH transformation. HUB specific Learning Collaboratives have been initiated so that similarly scaled practices can learn from one another's experiences and share best practices. In addition, discussions are currently underway regarding an alignment of resources with the Transforming Clinical Practice Initiative (TCPI) to support the primary care practice sites.

As part of the onboarding process, an Information Technology (IT) Discovery phase is facilitated within each HUB to understand the practice site's current technology and prepare for ingestion of data to support performance improvement and population health efforts. Connection to either Healthix or NYCIG RHIOs is expected of each partner and is supported by the IT departments within each HUB. IT recommendations to workflow related to the electronic health records, documentation requirements for DSRIP and reporting are incorporated into the support provided to each practice site.

The SCC is leveraging existing statewide resources as much as possible to support the primary care practices. For primary care practices without an electronic health record, arrangements have been made to connect providers with the New York eHealth Collaborative (NYeC) for support. Northwell Health is also facilitating a discovery workgroup aimed at connecting the New York State Smokers' Quitline to the SHIN-NY through the Healthix QE. The specific business objective is to use the QE to transmit opt-to-quit referral from the provider's EHR to the Quitline, and if possible to then transmit a response back from the Quitline. This will benefit all interested PPS participants connected to a QE through the State. The SCC is also represented in two important workgroups funded by New York State Department of Health Bureau of Tobacco Control with the goal of designing a statewide solution to successfully implement the 5A's of Tobacco Cessation modules within Allscripts and eClinicalWorks EHRs. Once successfully implemented the goal will be to incorporate these enhancements into the provider EHRs.

The SCC funds flow model incentivizes primary care physicians to meet predefined performance factors in order to be paid according to the payment schedule described in the SCC Participation Agreement. For the primary care physician there are 5 performance factors that are linked to the distribution of funds. These performance factors include an initial and ongoing commitment for engagement; technical onboarding; progress with implementing the Domain 3 Clinical Improvement Programs; achieving 2014 level 3 PCMH

certification or Advanced Primary Care (APC) and meeting the Domain 2 and 3 Clinical Outcome Measures improvement targets.

All three HUBS have dedicated staff to support performance reporting, measurement and quality improvement throughout the PCP sites. Practices receive education regarding patient engagement and quality reporting. Provider's performance 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. Each HUB will work with the providers aligned to them to develop a corrective action plan. The action plan will be monitored by the respective HUB and teams will be assigned to 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.

The SCC continues to expand Care Management Support for the primary care providers both employed and community-based. The Stony Brook Hub has created a Care Management Organization, embedding care managers in PCP sites and allowing them to be part of the Patient Centered Medical Home. The Care Managers are fully funded by the PPS. The SBU Hub CMO assists PCPs in managing complex conditions, comorbid behavioral health and substance use disorders and social determinants of health so the PCP can focus on the treatment of their patients. Northwell Health has its own Care Management Organization and deploys care managers (licensed RNs) for practices who elect to participate. CHS provides its own care management services to help practices manage chronic and high-risk conditions.

In addition, PCPs can utilize the assistance of Transitions of Care (TOC) Care Managers who work directly in Suffolk County Hospitals and accept warm hand offs from discharge planners in order to initiate a 30 day transition back in the community.

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

The Suffolk Care Collaborative has developed strategies around successful implementation of Population Health Management within a Clinically Integrated Network for use throughout our Integrated Delivery System. These strategies first required defining the models and identifying the key stakeholders. This scope of work was managed by the Population Health Management/Integrated Delivery System Workgroup, herein the PHM/IDS Workgroup, which contains physician leadership from all three Hubs. The output of this group was the creation of the Clinical Integration Needs Assessment, the Clinical Integration Strategy and the Population Health Management Roadmap. In order to be successful in these programs, Primary Care Physicians must be engaged and supported. Key highlights of this acknowledgement within these strategies include:

- PPS wide facilitated transformation of Primary Care Practices to Patient Centered Medical Homes
- Integration of behavioral health services in Primary Care Practices
- PPS sponsored IT connectivity from practice to PPS Enterprise Data Warehouse to create longitudinal patient records and monitor performance at the PPS and practice level and provide feedback to providers on their patient populations
- Risk stratification of cohorts of patients that may require intensive care management support
- Support to patients leaving acute care facilities and navigating back to community settings including appointment scheduling for PCP appointments and timely notification of the Primary Care Provider complete with a copy of the discharge summary to support further clinical decision making

The SCC recognizes the key role that Primary Care Physicians play in creating a truly integrated delivery system. PCPs must be kept up to date with all medical care provided to their patients in order to successfully care for, treat, and navigate their patients appropriately. In the past, care has been given in silos and PCPs must piece back together the complex picture of their patient's health, more often than not leading to duplication of services and unnecessary utilization. In the SCC Integrated Delivery System, coordination of care is necessary at every step of the patient's health journey. There are mechanisms currently in place to assist providers in this coordination which include Health Home Care Management, Managed Care Organization Care Management and Community Based Organizations. While these programs are extremely beneficial and provide one on one care to patients in need, the PCP may still be unaware of the care being provided to the patient.

In order to address this concern, and place the PCP in the center of the care, right alongside their patients, the PPS developed a Care Management strategy which includes the initiation of a Care Management Organization (CMO) for the Stony Brook Hub and expansion of the scope of the pre-existing CHS and Northwell Hub CMOs. The vision of these organization is to create a patient-centered coordinated network by directly supporting PCP sites with Care Managers and allowing the Care Mangers to become part of the Patient Centered Medical Home. These team members work with patient's at the PCP office and in the community, whether in patient's homes or through accompanying them to appointments at specialists or even the Department of Social Services. The CMOs assist PCPs in managing complex conditions, comorbid behavioral health and substance use disorders, and social determinants of health. This resource allows the PCP to focus on the treatment of their patients while knowing that a warm handoff can be given to follow up and ensure the patient is able to put their plan of care into action.

In addition to embedded and community resources, PCPs can also utilize the assistance of Transitions of Care (TOC) Care Managers who work directly in Suffolk County hospitals and accept warm hand offs from discharge planners in order to initiate a 30 day transition plan back in the community. This level of assistance works to reduce the need for avoidable readmissions and successfully navigates patients to secondary and tertiary resources as well as back to the PCP for that vital post discharge follow up appointment. SCC believes that with the support of Care Managers directly assigned to PCPs, Primary Care Providers will be better positioned to create meaningful linkages to services required to improve patient outcomes and do so in the least restrictive environment.

The Suffolk Care Collaborative has several workgroups, committees and governance structures that include Primary Care representation. The greater the ability for providers to engage in the development of programs, the more successful these programs will be when implemented. PCPs are represented on the SCC Board of Directors, the Project Advisory Committee, the Clinical Governance Committee, the Workforce Committee, the Community Needs Assessment, Cultural Competency, Health Literacy and Outreach Committee, the Population Health and Integrated Delivery System Workgroup, the Promoting Asthma Self-Management Program Workgroup and Committee, the Community Health Activation Program Workgroup and Committee, the Diabetes Wellness and Self-Management Program Workgroup and Committee, the Cardiovascular Wellness and Self-Management Program Workgroup and Committee, the Value Based Payment Team, the Primary and Behavioral Health Integrated Care Workgroup and Committee, the Practitioner Engagement Workgroup, the Performance Evaluation & Management Workgroup, the Interventions to Reduce Acute Care Transfer Program Committee, the Transition of Care Program for Inpatient & Observation Units Committee, the Cultural Competency and Health Literacy Workgroup, the Suffolk County Tobacco Cessation Coalition, the Access to Chronic Disease Preventive Care Initiatives Committee, the Substance Abuse Prevention and Identification Initiatives Workgroup and Committee, the Patient Centered Medical Home Workgroup. In each of our workgroups and committees, the SCC has medical providers who serve as experts in Primary Care and inform decisions being made to ensure accurate reflection of the work done in Primary Care sites and how project implementation affects and is affected by PCPs. Topics of these workgroups and committees include but are not limited to, development of training around cultural competency and health literacy, work being done to achieve PCMH recognition at our provider sites, development and implementation of clinical guidelines for Diabetes, Cardiology, and Asthma, strategy development for practitioner engagement, and creation of an integrated delivery system through successful clinical integration and population health management approaches.

During practice onboarding, Stony Brook, CHS, and Northwell Hub Provider Relations Managers make newly contracted PCPs aware of the many initiatives ongoing throughout the PPS and provide an open invitation to their joining a committee or workgroup of interest. When a practice begins work with a CMO, providers and practice staff are asked to participate in touch-points with the Care Management Leadership in order to ensure that the CMO is meeting the needs of the practice and patients and to adapt to any changes in workflow that would be better suited for the practice site. Similar touch points are requested for PCMH transformation, and behavioral health integration. PCPs may elect to nominate an office manager, medical assistants, etc. to speak on their behalf on these touch points in an effort to manage time and prioritize patient contacts over administrative meetings. These nominees will speak to what is best for the practice and will receive updates from the various PPS departments. SCC refers to these individuals as facility champions.

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

The Suffolk Care Collaborative PPS is structured as 3 HUBs. Each HUB is responsible for contracting and providing their primary care providers (PCP) with support for Patient Centered Medical Home (PCMH), IT technical on-boarding, Behavioral Health and Primary Care Integration, Care Management (CM) and performance management. The PPS has workgroups that are comprised of representatives from all HUBs to develop strategies.

The Suffolk Care Collaborative will be providing resources to assist aligned primary care providers (PCP) in obtaining Patient Centered Medical Home (PCMH) designation through this HUB strategy by engaging a number of vendors such as Primary Care Development Corporation (PCDC) and The Healthcare Association of New York State (HANYS) Solutions to help transform primary care provider practices to NCQA 2014 Level 3 PCMH. This will not only help PCPs achieve the goal associated with DSRIP but it will also position practices to be eligible to pursue Value Based Payment (VBP) agreements.

As each PCP practice is contracted, "technical on-boarding" is provided as part of our package of support services through the HUB strategy. As part of the technical on-boarding process the practice's EHR vendor will be contracted with to establish data acquisition. This will allow for data interoperability between all sites that are technically on-boarded and provide PCPs with access to a unilateral patient record. This will support management of their patient population effectively and efficiently. Data will be used to risk stratify patient populations and provide each HUBs Care Management Organization (CMO) the requisite information to prioritize management of a PCP's more complex and high risk patients. Additionally, practice data will be analyzed to identify gaps in care at the time of an established patient visit. Overall, this will help improve patient outcomes and best position the practice for participating in VBP agreements.

The PPS is also providing resources and facilitating the development of Behavioral Health and Primary Care Integration (model 1, 2 or 3 as applicable) for each aligned PCP practice. Model 1 integrates behavioral health services into a primary care setting. Model 2 integrates primary care services into Suffolk County OMH and OASAS licensed facilities. Model 3 implements the IMPACT model at primary care sites. By implementing the Behavioral Health Primary Care Integration model, patient outcomes will be greatly improved, avoidable ED visits decreased, and care will be more accessible.

In an effort to improve access to care and identify inhibiting factors that may result in a patient not accessing care, the PPS is working collaboratively with Managed Care Organizations (MCO) to obtain lists of non and low utilizing beneficiaries within their respective plans. Through project 2di, the Community Health Activation Program (CHAP), we are working to contact these individuals directly and re-connect them to a primary care physician. In addition, coaching services will be provided to engage individuals in their health care and social determinants that may exist as barriers will be addressed by first identifying and then connecting beneficiaries to CBO partners within our PPS. These collective efforts will help to reduce gaps in care.

Each HUB has created a Care Management Organization (CMO) to provide care management, care coordination and transition of care services to those patients who are not already aligned to a CMO or care management agency. These services are provided directly to patients of aligned PCPs. Each HUBs CMO may include RN Care Managers, Social Workers, Community Health Associates, and/or Mental Health

Counselors. For example, the SBUH HUB has embedded RN Care Managers in primary care settings and will work to also embed Social Workers in primary care settings based on identified needs of a particular population. Embedded Care Managers are integrated members of the patient's healthcare team. The NWH HUB will be providing care to their advanced illness patients via the use of a House Calls program. The CHS HUB has partnered with an outpatient home visitation service that will see the most vulnerable or home-bound patients to ensure their continued health outside of the hospital. In collaboration with primary care providers, Care Managers develop care plans, monitor ongoing symptoms, and coach patients to manage their conditions. They help to build continuity of care, reduce barriers to care and enable patients to receive the right care in the right place at the right time. Such efforts have been shown to improve health outcomes and help patients avoid complications and unnecessary hospitalizations.

The SCC has developed a performance reporting and improvement plan to establish an organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided by the SCC. Recognizing the importance of improving performance measures and outcomes, the SCC has incorporated performance measurement as one of the key performance factors partners will be held accountable for in order to be eligible for performance payments. The SCC continues to develop business rules for partners' payment for performance model recognizing that sole attribution for a particular performance measure is challenging for some of the DSRIP metrics.

The SCC has begun utilizing the MAPP data to identify trends by MCO assigned primary care physician and practice and is also reviewing a broader scope of work thinking through an attribution methodology to identify the "established physician" through claims information for unassigned beneficiaries. The PPS will identify performance trends from the DOH data and share those results with the primary care providers and the supporting care management teams to begin collaborating on improving results.

The SCC is also working with each HUB to standardize data ingestion from partners into a common enterprise data warehouse (EDW). The SCC EDW will be used for HUB specific and PPS-wide concurrent performance reports. The SCC is working with population health vendors to develop performance dashboards at the provider level. The goal is to operationalize a concurrent action planning process through the HUB model to allow evaluation of implemented interventions for performance improvement in proximity to the intervention. All of these efforts support providers' transition from a fee-for-service to a value-based payment model.

By introducing and managing our aligned PCPs against this performance reporting and improvement plan, PCP's will be positioned to effectively participate in payment models that are outcomes based.
For all the small primary care practices who have no leverage with the MCOs, through alignment with the PPS who has an IPA structure, we will help them transition from fee for service to a VBP arrangement. The PPS foresees that smaller primary care practices will be able to coordinate VBP contracting activities, such as pay for performance, through the resources established by the IPA. Additionally the support provided by the PPS to PCP's as referenced above (care management, IT interoperability, behavioral health integration, data analytics, etc.) will enable PCPs a smoother transition towards VBP.

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Fundamental #5: How does your PPS' funds flow support your Primary Care strategies?

The Suffolk Care Collaborative PPS is building a foundation for primary care practitioners (PCP). Our efforts are geared towards supporting primary care and providing our aligned PCPs the tools they'll need to not only achieve the goal associated with DSRIP but also to prepare and position them for VBP agreements. The Suffolk Care Collaborative is providing resources to transform aligned PCP practices.

The PPS funds flow model for contracted PCPs provides two sources of funding. One comes from the cost incurred by the PPS on behalf of the PCP to help in providing foundational elements including costs of vendors to transform aligned PCPs practices to NCQA 2014 Level 3 PCMH; provide resources and cover vendor costs for technical on-boarding and RHIO connectivity; provide Behavioral Health Primary Care Integration support (model 1, 2 or 3 as applicable); provide Care Management resources; and provide support through the development of toolkits and support specialists to implement specific project requirements. The SCC has estimated that these costs will represent approximately 60% of anticipated revenue over 5 years. At 100% achievement this equates to approximately $179M. The second source of funding to PCPs, comes from a Performance Payment Pool, which accounts for approximately 40% of all revenue. At 100% achievement this equates to approximately $119M. The Performance Pool dollars are spread across various providers types (PCPs, Hospitals, SNF's Behavioral Health, etc.) and are released to providers upon the achievement of performance factors. The performance pool to PCPs accounts for approximately 50% or the equivalent of $60M.

Each HUB is responsible for the management of funds to support contracted PCPs, both for implementation costs and performance payments. A PPS guiding principle is that HUBs will be consistent in their approach towards supporting providers and managing performance payments. The PPS Provider Participation Agreement (contract) for aligned PCP practices outlines the expectation, performance factors and payment distribution plan. Table 1 (shown below) from the Participation Agreement outlines 5 performance factors that trigger a payment once achieved. The performance factors are Engagement, Technical On-Boarding, Clinical Improvement Program (Domain 3), PCMH Certification, and Domain 2 & 3 Clinical Outcome Measures.

Table 2, distribution of the performance factors, outlines the weight of each performance factor and the value each year throughout the term of the agreement. Each HUB utilizes the same performance factors. The timing of the payments to the providers and the weight of each performance factor may vary between HUBs.

As an illustration, in terms of the SBUH HUB, a provider is eligible for an initial engagement payment 3 months post the effective date of their signed contract if they have met stipulated requirements. After another 3 months, the provider would be eligible for the first semi-annual payment. The semi-annual payment would include payment for any completed performance factors in addition to engagement. Over subsequent contract years, as additional performance factors are completed semi-annual payments would be increased accordingly. Providers are incentivized to complete each performance factor as soon after contracting as possible as once achieved the provider is then eligible for that payment in the year the factor is met and all subsequent years of the contract.

As of DY2 Q2, the SCC PPS has distributed approximately $1.1M in performance payments to providers, of which approximately $745K was distributed to PCPs.

SBUH - EXHIBIT E

Performance Payment Distribution Plan

Primary Care Practitioner (PCP)

Funding: Consistent with the provisions governing the DSRIP program, funds will be received by SCC only to the extent that applicable milestones and metrics are found by DOH and the Independent Assessor to have been satisfied by the SCC, and to the extent that CMS has approved funding for the State of New York through the DSRIP waiver. Therefore, the exact amount of funding to be received in a measurement period cannot be known with certainty at this time. Funds distribution to participating providers will take place only to the extent that the SCC receives DSRIP funding from the DOH.

Performance Payment Distribution Plan: Defined as a "trigger event," upon successful completion would qualify a partner for a funds flow distribution.

Payment Schedule: Please refer to Table 2 below.

Table 1: Description of Performance Factors

#	Performance Factor	Description
1	Engagement Payment	**Initial Commitment** • Submission of Required SCC On-boarding documentation as outlined in the *SCC Contracting Plan* • Initiate performance factors # 2 - 5 **Ongoing Commitment:** 1. Good citizenship 2. Timely and complete quarterly Domain 1 patient engagement reporting 3. Data sharing 4. Participation in Population-wide-prevention programs (D4) – Strengthen Mental Health and Substance Abuse Infrastructure; Promote Tobacco Use Cessation, Especially among Low SES Populations and those with Poor Mental Health 5. Updates towards successful completion of the Domain 1 Process Measures 6. Updates towards successful completion of the Workforce reporting requirement 7. Participation in DSRIP Project 2ai (Integrated Delivery System), oriented to SCC Care Coordination program and other resources to ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services. 8. EHR meets connectivity to RHIO's HIE and SHIN-NY requirements (Safety Net Only) and returns required documentation. 9. Initial and ongoing training services
2	Technical On-Boarding	• Complete Technical On-boarding, i.e. technical data integration and system interoperability between the Partner's source system and the HUB data-warehouse, which will then feed the Suffolk PPS Population Health Platform.
3	Clinical Improvement Programs (Domain 3)	• Meet requirements of *Primary & Behavioral Health Integrated Care Program* • Demonstrate completion by submission of all required documents of Model 1 or 3 of DSRIP Project 3ai.
		• Meet requirements of *Cardiovascular Health Wellness & Self-Management Program* • Demonstrate completion by submission of all required documents of DSRIP Project 3bi.
		• Meet requirements of *Diabetes Wellness & Self-Management Program* • Demonstrate completion by submission of all required documents of DSRIP Project 3ci.
		• Meet requirements of *Promoting Asthma Self-Management Program*

		• Promote patient engagement in asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use and medical follow up. • Demonstrate completion by submission of all required documents of DSRIP Project 3dii.
4	PCMH Certification/APC	• Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards (EHR vendor Meaningful Use certification provided).
5	Domain 2 & 3 Clinical Outcome Measures	• Adhere to the Performance Reporting and Improvement Plan establishes a planned, systematic, organization-wide approach to performance reporting, performance measurement, analysis and improvement for the healthcare services provided.

Table 2: Distribution of Performance Factors

Performance Factor (PF) Name	Total Weight of PF	Payment Due Date *	Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4	Frequency of Payment
Engagement - Initial Commitment	30%	3 months following contract effective date	3.75%	0.00%	0.00%	0.00%	One Time
Engagement - Ongoing Commitment		Semi-annual payments**	3.75%	7.50%	7.50%	7.50%	Two payments per year once contracted
Technical On-Boarding	10%	Semi-annual payments**	2.50%	2.50%	2.50%	2.50%	Two payments per year once PF complete
Clinical Improvement Programs (Domain 3)	15%	Semi-annual payments**	3.75%	3.75%	3.75%	3.75%	Two payments per year once PF complete
PCMH / APC	20%	Semi-annual payments**	5.00%	5.00%	5.00%	5.00%	Two payments per year once PF complete
Domain 2 & 3 Clinical Outcome Measures	25%	Semi-annual payments**	0.00%	8.33%	8.33%	8.33%	Two payments per year based on performance

*Semi-Annual payments distributed net 60 days

**Each contract year's PF will be paid in semi-annual payments equal to half of the total percentage weight for a given year as described above

Notes:

1) If a performance factor is not completed by the contract anniversary, you will not receive payment. Money will not rollover to the next anniversary. This will reduce the overall PF weight.

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

The Suffolk Care Collaborative is working with partners to integrate primary care and behavioral health in the community. The three Hubs, Stony Brook, Northwell Health and CHS have worked diligently toward creating a network of collaborative care providers, as well as expanding the resources in the county to meet the ongoing needs of its communities in order to provide patient-centered care for all. In order to meet the needs of the communities as well as those of providers, SCC has hired a Director of Behavioral Health to assist in implementation, education, collaboration, partnerships and behavioral health workforce development.

While integrated care is the ultimate goal, all of our Primary Care Providers are also using behavioral health screening tools in their offices at annual visits, as well as for those at higher risk for behavioral health conditions. The PHQ 2/PHQ 9, AUDIT, DAST and CRAFFT for adolescents are all being utilized by our partners in order to help identify those whose needs were previously not identified. As we build the workforce within our primary care practices, emergency departments and in the community we are creating an environment that will allow for seamless transitions of care based on our patients' needs.

SCC is collaborating in Behavioral Health and Primary Care integration strategies across Suffolk county. This is being accomplished in many different ways. For some practices, Behavioral Health Providers will be directly employed by the medical office as a member of the primary care team. The behavioral health providers will be available to the medical providers for consultation, warm hand-offs and treatment. This model enables providers to not only provide truly integrated care to their patients, but also supports sustainability as they move into a Value Based Payment model. In other practices, the SCC has partnered with Behavioral Health agencies and Community Based Organizations to embed behavioral health providers in primary care practices to be available for warm hand-offs and referrals for treatment. Family Service League (FSL) and the SCC have entered into a collaborative agreement to help build the workforce of BH providers in Suffolk County. The contract between the two allows the SCC to help FSL hire, and stand up, a behavioral health provider in our PCP offices. This agreement not only helps to improve access for patients and decrease unnecessary ED visits but also helps to build and sustain a workforce in Suffolk county that can support DSRIP goals well beyond 2020. Additionally, the SCC is involved in a great deal of community outreach and participation in order to help support the efforts to widen the reach of this integrated delivery system. This arrangement also includes a plan for sustainability developed collaboratively with the SCC and community based providers. The professional relationships and collaborative efforts are truly helping to provide the best, evidence based, cost effective care to our patients while helping to keep them in the communities in which they live. At this time, Secure Messaging is also being used by some of our Primary Care partners in order to effectively, and in real time, communicate with their embedded Behavioral Health providers during off-hours. This technology will be expanded to include more of our practices as we create a truly integrated system of care.

In the Emergency Departments of all hospitals in the SCC, a Screening, Brief Intervention and Referral to Treatment (SBIRT) program is being implemented. This program trains staff from each of the hospitals to administer screenings in the ED while the patient is there. Social workers are being placed in each of the EDs in order to then provide brief interventions and referrals to treatment as needed. Primary Care providers are involved in decisions made in ED as they refer patients to treatment. We have also aligned these efforts with community based OASAS providers in the area so as to not only prepare them for the rise in referrals,

but to include them in decision making regarding best processes to get those in need the care they require. Not only has this increased the number of individuals identified but it has allowed the SCC to help the community Substance Use Disorder (SUD) providers to begin to strategize on building their workforce to meet these new needs. SBIRT has been successfully implemented in some PC practices as well. In 2017 additional SBIRT training will be offered to other PC practices.

Telepsychiatry is also being explored as an effective means to deliver services to areas where such resources are limited. The SCC is identifying trainings, technologies and staff that may help to support this practice as we have begun to experience some regulatory relief. Telepsychiatry consultation services can provide direct support to providers and greatly improve access to services for patients.

Essential to the success of collaborative and integrated care is fostering effective linkages to resources that help to identify and mitigate social determinants of health. In addition to providing some of these services directly in the primary care settings, the SCC is fostering relationships in order to accelerate and streamline referrals to services for those in need. These expanded resources are vital to improving the health of our population. Additionally, the PPS developed a Care Management strategy which includes initiation of a care Management Organization for the Stony Brook Hub and expansion of the scope of pre-existing CHS and NWH CMOs.

The SCC participated in the MAX series for behavioral health. In conjunction with the Family Medicine practice at Stony Brook University the team participated with other PPSs to share and develop new and innovative ways to Improve access and delivery of essential services.

SCC has also been working with the NYC DOHMH RPC regarding behavioral health integration. While this group is primarily focused in New York City, the collaboration between counties and PPSs has proven quite important in our work as we begin to look toward value and outcomes. Best practices are discussed and shared in this workgroup with the goal of helping to define value based behavioral health care as the primary charge of this workgroup, as members work in conjunction with managed care organizations to determine models for sustainability.