

# Primary Care Plan Update 2017

## Adirondack Health Institute

September 29, 2017

### Introduction

The New York State (NYS) Delivery System Reform Incentive Payment (DSRIP) Program’s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent by 2020. To transform the system, the DSRIP Program focuses on the provision of high quality, integrated primary, specialty, and behavioral health care in the community setting, with hospitals used primarily for emergent and tertiary levels of service. The integration of services and the path to value-based care puts primary care at the center of the health care delivery system. Primary care is the cornerstone of the DSRIP Program and is critical to NY State’s success in the overall improvement and coordination of health care.

### Instructions

The DSRIP Primary Care Plan Update is an opportunity for each PPS to highlight, and inform the New York State Department of Health (the Department) and the DSRIP Project Approval and Oversight Panel (PAOP) of, progress towards and challenges to the improvement of Primary Care under the DSRIP program.

For each fundamental, the PPS is asked to provide a series of brief updates in the space provided (approximately 250 words) to questions under each fundamental in its final Primary Care Plan submitted in 2016. The PPS should reference its previously submitted Primary Care Plan when completing this Update. Completion of the Primary Care Plan Update includes the progress the PPS has made within a fundamental, an outline of any challenges related to implementing the Primary Care Plan strategies, an explanation of any changes that need to be made to the Primary Care Plan, and other related questions where applicable. The Department requests that the PPS be as concise as possible in its responses; where elements are not relevant to their Primary Care Plan, ‘N/A’ should be written. Under fundamentals where no strategic changes have been made, please describe how the PPS’ initial strategies continue to support that fundamental. Throughout the Update, some fields have been auto-populated for the PPS’ convenience based on figures available to the DSRIP team. The Department requests that the PPS review these fields for accuracy and make revisions where necessary. The completed template is **due September 29, 2017** to the DSRIP Team at [dsrip@health.ny.gov](mailto:dsrip@health.ny.gov) with subject line: ‘Primary Care Plan Update’.

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## Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

*a. From April 1, 2016 to March 31, 2017, describe any overall strategic changes the PPS has made and the impact of these changes on the PPS' final Primary Care Plan submitted in 2016.*

The AHI PPS's new governance structure of five Population Health Networks (PHN) is fully in place. Each PHN has a triad leadership structure comprised of a physician, hospital executive and community-based organization representative with formalized roles and responsibilities outlined in a Triad Leader Support Agreement. Each triad is supported by an AHI Executive Director who serves as a liaison for coordinating project management support. The leaders, well-known and respected in their respective regions, are uniquely qualified to serve as project leads because of their relationships and in-depth familiarity with the needs and available resources in their communities. We have established an optimized PPS operating model based on LEAN continuous rapid cycle improvement principles. The AHI governance structure remains unchanged with the exception of the Network Committee which has been absorbed into the Steering Committee.

AHI became an Advanced Primary Care (APC) technical assistance vendor in November 2016. Dr. John Morley joined the AHI team as Chief Physician Executive for Population Health in March 2017. Adding physician leadership and an APC professional to the team has helped direct and engage our physician partners in transformation efforts.

In March 2017, we conducted an evaluation of current partners to identify potential gaps. As a result, five new practices have been brought into the fold to help fill those gaps.

The AHI PPS learning management system was contracted in March. The implementation plan was completed and went live in August 2017.

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

- PPS' 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 Primary Care Practitioners (PCPs), as well as institution-based PCPs?

*a. Describe the PPS' progress in addressing primary care capacity and needs from April 1, 2016 to March 31, 2017. Include efforts to extend hours and increase access to primary care services:*

As part of the Medical Home transformation, primary care practices have been evaluating their ability to offer after-hours care. There are several approaches that have been taken: opening earlier/later in the day for urgent and routine care; offering weekend hours for urgent and routine care; establishing agreements with urgent cares and other primary care providers for coverage of the office if the practice has a limited number of staff members; and establishing 24/7 access to clinical advice.

The AHI PPS has also connected offices in need of additional practitioners with DSRIP workforce for funding related to recruitment/retention. During the time period of 4/1/16-3/31/17, partners reported successful recruitment of nine (9) nurse practitioners, seven (7) primary care physicians, three (3) primary care physician assistants, six (6) psychiatric nurse practitioners and four (4) psychiatrists. The AHI PPS supported the recruitment of these providers through the Recruitment and Retention Fund in the amount of \$599,840.35.

Project 3.a.i has three (3) behavioral health practice sites integrating primary care into their behavioral health services. This development will help to expand primary care capacity.

*b. Describe the PPS' challenges from April 1, 2016 to March 31, 2017 with addressing primary care capacity needs:*

AHI identified a gap in the number of primary care partners in the PPS. We identified key practices that could assist with the transformation of population health in the region. As a result, we added five (5) new practices in March.

AHI PPS partners also struggle with recruiting primary care providers in remote areas of the PPS, where populations are underserved. We identified the absence of a Federally Qualified Health Center (FQHC) in the Clinton County area.

*c. Based on the PPS' progress and challenges addressing Fundamental 1 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 1 outlined in the final Primary Care Plan submitted in 2016?*

In addition to fully implementing the PHN structure and Steering Committee, AHI recruited several new practices to the PPS in March 2017. As part of our Advanced Primary Care (APC) transformation work, Planned Parenthood is expanding their primary care capacity at several sites throughout our region. Approximately 68 percent of medical residents practice medicine where they grew up or where they were educated. Because of this, the AHI PPS has supported and strongly advocated for the expansion of rural residency programs in our region. In January 2017, funding was awarded to UVMHN-Champlain Valley Physicians Hospital to expand their program from four to six residents per year beginning in 2019.

AHI's Telemedicine Coordinator developed a plan to conduct outreach in eight of the 11 counties served by the program, meeting with 15 DSRIP partners in the specified timeframe. The Telemedicine Coordinator also worked simultaneously on developing a comprehensive Telemedicine Implementation Guide to distribute to partners to be used as a how-to guide on developing their telehealth programs. Several telehealth programs specific to tele-behavioral health were implemented in the specified timeframe.

Hudson Headwaters Health Network (HHHN) opened a new Federally Qualified Health Center (FQHC) in Champlain, NY and is in the construction phase of opening a new FQHC in Plattsburgh, NY that will include behavioral health rooms integrated within primary care. Nathan Littauer Hospital has opened a new primary care office in Fonda, NY to increase access to patients.

During DY1, contracting with partners was an ongoing process. The PPS attempted to recruit the Accountable Care Organization of the North Country but they were advised against joining the PPS by their consultant Joe S Duhl Inc. As a result, engaged primary care provider numbers are lower in DY2 than anticipated.

*d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:*

In March 2017, AHI PPS recruited five (5) new practices to expand engagement of community-based primary care practices (PCPs). AHI PPS's Provider Engagement Manager for project 2.a.ii is in frequent communication with partners to help ensure success and facilitate connections to needed services, via bi-weekly meetings with the 2.a.ii Physician Champion. Dr. John Morley has met with many providers throughout the PPS to assure their needs are heard and AHI is responding accordingly. As an example, the physicians on the Steering Committee discussed their concerns with the medication reconciliation process. As a result, Dr. Morley invited key stakeholder, including physicians, pharmacists, care managers, and others to become part of a medication reconciliation task force and an initial LEAN process work team meeting. The purpose of the task force and meeting is to identify new and more effective workflow methods to better meet the patient's medication reconciliation needs with a goal of decreasing avoidable hospital use due to medication errors; this meeting occurred in September and November 2017.

Several practices have expressed the need for assistance with integration of behavioral health and primary care. AHI has leveraged our telemedicine programs to help meet these needs.

<i>Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:</i>	157
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**e. Additional Information**

<i>Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:</i>	285
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<i>Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:</i>	171
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<i>Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:</i>	16
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**Fundamental 2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?**

- What are your PPS plans for working with Primary Care at the practice level, and how are you supporting practices to successfully achieve PCMH or APC recognition? (Resources could include collaboration, accreditation, incentives, training and staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.)
- How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

*a. From April 1, 2016 to March 31, 2017, describe the PPS' progress in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:*

The AHI PPS has encouraged practices to send employees to NCQA Patient Centered Medical Home (PCMH) training to increase their knowledge and comfort level with going through the transformation process. Five partners participated in NCQA PCMH training from 4/1/16-3/31/17. As part of funds flow to partners, practices are incentivized to achieve PCMH status through payments tied to project activities. The AHI PPS has also become an Advanced Primary Care (APC) vendor and hired an APC Technical Assistant to help support practices choosing to obtain APC. The PPS also has a PCMH Transformation Coach (TC) on board to assist practices without adequate support. In some circumstances where a practice requires more intensive support, AHI has plans to engage consultants through funds flow. The PCMH TC works closely with the Adirondack Medical Home Plattsburgh pod, who employs PCMH CCEs for their practices.

*b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:*

Some primary care providers, such as Planned Parenthood, did not meet the NCQA threshold for primary care visits. At the start of the 2017 Accountable Care Organization (ACO) contract year, Advanced Primary Care (APC) was not recognized in their contracts as a transformation certification.

Additional challenges pertain to NCQA and the increase in the number of applications they are receiving in NYS, creating the need to hire seasonal reviewers, resulting in different interpretations of NCQA standards.

*c. Based on the PPS' progress and challenges addressing Fundamental 2 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 2 outlined in the final Primary Care Plan submitted in 2016?*

The AHI PPS became an Advanced Primary Care (APC) Transformation Assistance vendor as a way to help support practices wanting additional recognition, or would otherwise have a difficult time meeting NCQA Patient Centered Medical Home (PCMH) 2014 Level 3 standards. We have contracted with Planned Parenthood to assist with certification as an APC practice as they are not eligible for PCMH certification (they do not meet the 75 percent primary care visit threshold). As part of APC transformation, Planned Parenthood is increasing the number of primary care services they are offering to expand the type of care they can offer in their service area.

AHI was able to encourage the Adirondacks ACO to amend their contracts to include APC as an alternative to NCQA PCMH certification.

*d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?*

The AHI PPS Transformation Coach (TC) conducts monthly meetings with the PCMH CCE's supporting the nine counties. The Adirondacks ACO requires primary care practitioners to have PCMH recognition in order to participate in the ACO and help support practices through increased PMPM Medicaid payments. The AHI PPS also recently expanded, in March 2017, by hiring an APC Transformation Assistant to offer APC support to practices. AHI had multiple staff members engaged in APC training, recruiting and overall technical assistance to selected primary care practices. AHI has also encouraged practices to send staff to NCQA in-person trainings, with five (5) organizations taking advantage of DSRIP workforce funding in DY2.

e. Additional Questions:

Is the PPS contracting with any vendor(s) for PCMH recognition assistance? Yes No

<i>Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:</i>	NA
<i>Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:</i>	NA

Is the PPS contracting with any vendor(s) for electronic health record (EHR) transformation assistance?  
Yes No



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

- How will the PPS strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services?
- How is Primary Care represented in your PPS' governance committees and structure, and your clinical quality committees?

*Number of Engaged Primary Care Practitioners*

285

*a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards implementing an integrated delivery system with Primary Care playing a central role. Be sure you address efforts to strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services:*

As we work with PCPs on integrating services to provide care for all of a patients' health needs, it becomes even more critical that all the patients' health information is contained and accessible in one integrated system. AHI has identified the RHIO (HealthConnections, Hixny) as integral in the integrated delivery system, as PCP practices send and receive patient-specific information from their EHRs to a RHIO. AHI conducted a Health Information Technology (HIT) survey in the second quarter of 2016, with an update planned in the 3rd-4th quarter of DY3. That information is being used to evaluate the need for support and services for our partners to achieve an integrated delivery system. Based on the HIT survey feedback and information obtained from Hixny, we are working with partners to ascertain their current level of interaction with the RHIO. Currently there are 285 PCPs connected. We continue to work with Hixny to connect practices and facilitate the sharing of data, along with the efficient and effective flow of messages and alerts to provide more efficacious and timely care for those at greater risk. Our long-standing relationships with community-based organizations have been a significant asset. We included them in our HIT survey and work with individuals to assist with connectivity to RHIOs, as regulations and consents allow. AHI leverages the Adirondack Rural Health Network and Enrollment Assistance Services and Education programs to improve patient engagement through patient activation and health coaching. As a lead Health Home, AHI is working to connect high utilizers with care management services. The Health Home EHR is in the planning phase for Hixny connectivity. AHI leverages telehealth to support primary care and behavioral health expansion and integration. We work with communities to develop mobile units with care and service providers to respond to the needs of their members.

*b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in implementing an integrated delivery system with Primary Care playing a central role:*

Some major challenges with implementing an integrated delivery system (IDS) in the AHI PPS revolve around the large geographic, rural area we serve and its evolving infrastructure. Physician and clinician utilization is a challenge as the Regional Health Information Organization (RHIO) is still a fairly new concept. Information may not be as up-to-date as needed depending on where services are provided, or information is not available from neighboring states. Patient services that may have been provided are not always reflected in the RHIO. This requires several extra steps to retrieve patient information. Ascertaining the quality of the data connected by the RHIO can be challenging, as is the reconciliation of data from multiple sources. Maintaining accurate business logic and provider information to direct messages and alerts will be a significant undertaking, as will the difficult task of maintaining provider engagement at levels that will effectively support the coordination required for the IDS.

*c. Based on the PPS' progress and challenges addressing Fundamental 3 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 3 outlined in the final Primary Care Plan submitted in 2016?*

We are working with providers to assist with their connectivity to the RHIOs. We developed the "Roadmap to an IDS" with partners. AHI worked with the vendor to share our partners' challenges. We have shared with the vendor feedback from our partners as they build upon their product to improve the ease of use, level of relevant information and data, and enhanced tools to assist with provider communication. We are working on educating all involved on the importance of providing and connecting information around the patient and the tools available. We contracted with a Learning Management System that will provide online educational sessions. Access will be available to partners in August 2017. The system allows tracking and reporting of completed training sessions. We are formulating PCP funds flow to continue to reward providers who participate meaningfully in a successful IDS.

*d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices with implementing EHRs and reaching Meaningful Use Stage 2:*

Nearly all of our primary care practices presently have their own EHR system that meets Meaningful Use requirements. The focus of the PPS is to gather accurate information and update it in the RHIO so that it may be utilized by all entities that provide care and services to the patient. Additionally, the goal is to enable the sharing and processing of that information via the data platform (Health Catalyst). Information from the data platform will then be used to provide data metrics and reporting to further improve processes and ultimately foster better quality care. Through our required reporting and quality metrics tracking, we are working with practices to assist them with obtaining reports and information so they may look at their practice-specific performance as it pertains to quality metrics for DSRIP, CMS, and other regulatory and quality initiatives.

*e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices to connect to Regional Health Information Organizations (RHIO)/Qualified Entities (QE) and the State Health Information Network of New York (SHIN-NY):*

AHI contracted with partners for project-specific work efforts, specifically projects 2.a.i: Create an Integrated Delivery System and 2.a.ii: Increase Certification of PCP with PCMH and/or APC. We included deliverables in the contract tied to payments to partners to assure connectivity. We have communicated information about the Data Exchange Incentive Program (DEIP) which provides financial rewards to primary care as well as other types of organizations to connect with a RHIO. We have engaged and entered into agreements with our partners and Hixny to create a population health gateway which will aggregate clinical data on our attributed population contributed to Hixny by our partners. This data will be fed to our analytics platform and help support coordination and performance improvement activities.

*Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:*

285

f. Additional Information

<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:</i>	9 practitioners (3.2%)
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:</i>	5 practitioners (55.6%)
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:</i>	4 practitioners (44.4%)

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

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

##### *a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards VBP Readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan:*

AHI is assisting primary care providers (PCP) with the transition to value based payment (VBP) by assessing current readiness, utilizing the VBP assessment, planning for education and conducting data analysis and creating dashboards. Through dashboards and VBP education, AHI is helping partners understand how to utilize their data to manage the health of their populations. Through LEAN workgroups, including the Medicaid Accelerated eXchnage (MAX) series, providers are learning to flag high utilizers and create care transition plans to manage their care needs within community-based services, preventing unnecessary utilization. Additionally, our Population Health roadmap and information technology (IT) strategy is focused on data to support VBP. AHI has a longstanding relationship with the ADK Medical Home and Adirondacks ACO. The ADK ACO is working together with the NYS DOH to negotiate with partners to complete VBP contracts.

The Learning Management System (LMS) was vetted through the AHI PPS Workforce Training and Resources Workgroup and Workforce Committee. The contract was executed in March 2017 and full rollout to PPS partners is to occur in DY3. This tool will be used to disseminate training.

The analytics platform we are implementing will use claims and clinical data to help inform the AHI PPS partners regarding performance and provide critical information on which to base VBP contracting negotiations.

##### *b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working towards VBP Readiness among the PPS' primary care providers:*

Some of our challenges have been related to access to current data to understand total cost of care and utilization patterns across populations. AHI is not a contracting entity and therefore may not enter into VBPs. We have experienced the balancing of data sharing and HIPAA compliance. Some particular challenging areas are substance use and children's behavioral health issues. Our implementation timeline for our population health management system, Health Catalyst, has been pushed back about six months while DOH clarified requirements and processes for sharing Medicaid confidential data with our data analytics vendor. Our collection of partner-contributed data was similarly impacted. Implementing this platform in essentially an MSO model will be a challenge as well, especially for an organization of our size.

*c. Based on the PPS' progress and challenges addressing Fundamental 4 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 4 outlined in the final Primary Care Plan submitted in 2016?*

In the past year, AHI has refined our strategic processes based on partners' needs assessments. As reflected in the IDS and Population Health Roadmaps, AHI has an IT and IDS plan to utilize the RHIO and Health Catalyst for Population Health data analytics. In the interim, we are utilizing P4P measures and partner data to assist providers in understanding their populations' utilization. AHI has provided financial support to the Adirondacks ACO LLC (ADK ACO) aimed at building an infrastructure in the region that will help to support the transition to VBP for providers, including Primary Care Providers. That support has included sharing costs for a contracted services agreement with the Advisory Board Consulting group for a scope of services that included review and prioritizing strategic initiatives, data-driven decision-making support, financial and analytical guidance, operational expertise, and care management support, all related to delivery system transformation efforts. Other financial support included a Data Services Subcontract to assist the ADK ACO with implementation of data analytics platform that will be critical in providing data needed for the transition to VBP. Additionally, through holding seats on the ADK ACO Board of Managers and ADK Medical Home Governance Committee, AHI is involved with regional discussions, strategic initiatives, and decision making regarding VBP contracting. Representatives from Primary Care Providers and MCOs are included on these governing bodies.

*d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers to engage Managed Care Organizations (MCOs) for VBP contracting:*

AHI employs an Advanced Primary Care (APC) vendor hired as a Technical Assistant (TA) with value based payment (VBP) experience. This experience has proven helpful as they assist practices in attaining APC status since the requirement for VBP is significant compared to NCQA PCMH.

AHI is a member of the ADK ACO Board of Managers and the ADK ACO/DOH Governance Committee.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers in levels 2 & 3 VBP arrangements to address social determinants of health and engage Tier 1 Community-Based Organizations (CBOs):

AHI has not yet addressed level 2 and 3 of VBP arrangements to address social determinants and tier 1 CBOs. To date, the PPS focus has been on providing education around social determinants and patient utilization trends.

f. Additional Questions

Is the PPS planning to form a contracting entity (e.g. ACO Certificate of Authority)? Yes No N/A

...If yes, has it been granted? Yes No

Has the PPS provided technical assistance to primary care partners planning to form a contracting entity (e.g. ACO or IPA)? Yes No

...If yes, describe: [Click or tap here to enter text.](#)

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

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

### a. Describe how the funds flow model(s) support(s) primary care in the PPS network:

The funds flow model for primary care has not changed since the November 2016 submission. Funds were distributed based on engagement, workforce, and project addendums. Hospital partners all have primary care providers, except for Moses Ludington. Within each hospital partner, AHI does not get feedback on how the funds are distributed internally by an organization.

<i>b. Funds Flow</i>	<i>Total Dollars Through DY2Q4</i>	<i>Percentage of Total Funds Flowed</i>
Total Funds Distributed	\$15,846,529.20	<b>100%</b>
Primary Care Provider	\$8,952,111	56.5%
Hospital-Ambulatory Care	\$6,446,194	40.7%
Federally Qualified Health Centers (FQHCs)	\$1,644,255	10.4%
Primary Care Practitioners	\$861,662	5.4%
PMO Spending to support Primary Care	\$2,343,420	14.8%



*c. Based on the PPS' progress and challenges addressing DSRIP performance from April 1, 2016 to March 31, 2017, what strategic changes have been made to the funds flow model outlined in the final Primary Care Plan submitted in 2016?*

In the first two quarters, contracting had not been initiated. The MPAs and project addendums were released beginning in the third quarter. Obtaining partner engagement related to patient engagement and payment activities in addendums resulted in delayed funds flow. New Project Managers supported partners in project activities and reporting for patient engagement. This effort increased funds flow to primary care providers. Some project activities were revised in addendums to better align project activity payments and DSRIP goals.

d. Additional Questions

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving PCMH or APC recognition? Yes No

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving defined performance measurement targets? Yes No

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

- Including both collaborative care and the development of needed community-based providers.

*a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i. within the quarterly report):*

Workforce assists with recruitment and retention for sites not participating in 3.a.i. Hudson Headwaters Health Network (HHHN) is in the process of opening a site in Plattsburgh that will be fully integrated. Primary Care Provider and Behavioral Health Provider Recruitment has been identified as one of the AHI PPS priority areas. During this time period, AHI PPS partners successfully recruited 9 nurse practitioners, 7 primary care physicians, 3 primary care physician assistants, 6 psychiatric nurse practitioners and 4 psychiatrists. AHI PPS supported this effort through the Recruitment and Retention Fund with funding totaling \$599,840.35 to our partners for recruitment related activities.

Telehealth is not specifically mentioned in 3.a.i, so utilizing this method of care delivery is one way that AHI is going beyond 3.a.i project requirements to integrate primary care and behavioral health. The North Country Telehealth Partnership is working closely with numerous primary care practices in the PPS to connect them to mental health clinics and mental health providers who have capacity to provide tele-behavioral health services. The AHI Telemedicine Coordinator occasionally uses resources outside the PPS to provide the services needed within. In addition, an innovation grant was awarded to implement a telepsychiatry program at Glens Falls Hospital. This will increase psychiatric capacity in the area, allowing increased resources for integration.

*b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health (not including regulatory issues):*

The AHI PPS has challenges with recruiting behavioral health providers. In January 2017, Warren and Washington Counties were updated with a mental health Health Professional Shortage Area (HPSA) designation score of 16 which will assist behavioral health providers in qualifying for additional assistance for recruitment efforts via the National Health Service Corps (NHSC). This designation will assist organizations with recruitment efforts via loan repayments for eligible providers and a commitment of the provider to remain employed by the organization for a specified amount of time.

Travel between sites becomes an issue with regard to the amount of time it can take to go from practice to practice, reducing the amount of time a provider has available to see patients and increasing travel-associated costs. Billing for services is another challenge. Space issues also present a challenge in terms of finding a designated area for an on-site behavioral health provider.

The number of pediatric psychiatrists/providers is limited and the comfort pediatricians and PCPs have with pediatric behavioral health medication management is limited.

*c. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health specific to regulatory issues:*

The AHI PPS's challenges specific to regulatory issues relate to licensure thresholds, data sharing, co-location, and billing. DSRIP licensure thresholds allow for higher percentages of services, but they are a cost to the practices to implement with no guarantee that after March 2020 they will be able to continue at the higher level. Another licensure challenge is the level of providers allowed to offer services to adults under the NYS DOH. Data sharing between behavioral health and primary care puts up roadblocks with a lack of allowed communication. Federally Quality Health Centers (FQHCs) have the challenge of only being able to bill at one site and have challenges related to shared space and co-location. The NYS Office of Mental Health has strict regulations for their clinics that are looking to implement telehealth. They have specific provider, location, equipment, and licensure requirements that make it difficult for mental health clinics to navigate when trying to add telehealth to their service offerings. In addition, Medicaid places strict limitations on geographic locations of spoke sites (the location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this services) and types of providers allowed.

*d. Based on the PPS' progress and challenges addressing Fundamental 6 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 6 outlined in the final Primary Care Plan submitted in 2016?*

AHI was able to revitalize the 3.a.i project by hiring a Project Manager. Provider team meetings for all participants are held on a quarterly basis, allowing for the sharing of best practices and challenges. These efforts have been helpful in moving integration transformation forward.

AHI has connected three (3) behavioral health providers with pediatricians and primary care practices (PCP) to expand behavioral health (BH) integration into primary care. We have used tele-psychology to meet these needs. We have helped mitigate the challenge for pediatric BH medication management through expanding the use and knowledge around Project Teach, which offers consulting assistance to providers on Behavioral Health Management in pediatrics.

AHI obtained waivers to mitigate some of the issues described above. We are in the process of assuring appropriate partners complete their component of the waiver application. FQHC is negotiating with their lab partner to assure restrictions with on-site requirements do not interfere with access and care delivery.

In collaboration with project 4.a.iii, AHI has implemented evidence-based initiatives focusing on mental, emotional and behavioral well-being constructs that foster health promotion, disease prevention and increased provider and patient knowledge.

<i>e. Model</i>	<i>Number of Sites Planned</i>	<i>Number In Progress</i>	<i>Number Complete</i>
Model 1	58	29	29
Model 2	4	2	2
Model 3 IMPACT	NA	NA	NA

f. Please check all trainings that the PPS provides directly, or supports partners in delivering, to Primary Care Providers for Behavioral Health Integration within DSRIP projects from April 1, 2016 to March 31, 2017:

- Alcohol Use screening
- Billing for Integrated Care
- Collaborative Care for Depression, i.e. IMPACT model
- Depression screening
- EHR Integration
- Health Homes
- Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
- Mental Health First Aid
- Outcomes Measurement
- Patient Consent and Privacy regulations specific to Behavioral Health populations
- Person-Centered Care
- Peer Services
- Population Health
- PSYCKES
- Quality Improvement Processes
- Regulatory Issues
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Serious Mental Illness
- Tobacco Cessation
- Trauma Informed Care
- Other Mental Health screening (please specify): [Click or tap here to enter text.](#)
- Other Substance Use screening (please specify): [Click or tap here to enter text.](#)
- Other

Describe:

Bridges out of Poverty Training, Clinical Documentation: Ultimate Coding and OASIS training, Suicide Prevention Training.

## GLOSSARY OF TERMS

**Community-Based Primary Care Practitioner/Provider/Practice:** A practitioner/provider/practice servicing primary care that is not employed by a hospital or hospital-system

**Engaged Provider:** Providers reported in PIT/PIT-Replacement as engaged on at least one project

**Institution-Based Primary Care Practitioner/Provider/Practice:** A practitioner/provider/practice servicing primary care that is employed by a hospital or hospital-system

**PPS-defined Network:** Provider Network in the MAPP DSRIP PPS Network Tool filtered to Practitioner-Primary Care Provider (PCP) for Provider Category or PPS-defined Provider Category

**Primary Care Practice:** Individual sites providing primary care services

**Primary Care Practitioner (PCP):** Individual practitioner providing primary care services

**Primary Care Provider:** Entity providing primary care services

**RHIO/QE Connectivity:** Providers sharing data with RHIO/QE or have an active BAA in place with the RHIO/QE