

Primary Care Plan Update 2017

Alliance for Better Health Care

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 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.

Alliance continues to integrate the delivery of health care throughout our partner network to reduce over reliance of hospital services and provide support to primary care offices. Through our partnerships with Providers, Innovative Health Alliance of NY (IHANY), and area MCOs, we aim to reduce the over-reliance on health care delivery by Primary Care under the current fee-for-service model and shift to a model that rewards better health. To realize this goal, Alliance is committed to supporting the needs of its partners by providing workforce resources, education, developing and testing models and creating opportunities for sustainability

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:

During DY2, Alliance dedicated considerable time to reviewing it's network of providers, attribution and services in order to enhance capacity in such a way that the patient population needs can be best served. Alliance worked to develop pathways that enable communication and integration among Community Based Organizations (CBOs) and PCPs.

During DY2 Alliance developed the Incentive Program. This program acts as an introduction to a longer term Transformation Program that rewards activities that are intended to result in improved quality metrics. One metric that is incentivized through the program addresses communication and capacity between CBOs and PCPs. CBOs have the opportunity to schedule appointments using a shared calendar called "Open Slots" which includes PCP offices available appointments for Medicaid patient visits, including well visits and new patients. Open Slots have maximized access and capacity provided by participating sites while meeting Patient-Centered Medical Home (PCMH), Advanced Primary Care (APC) requirements.

The following outlines examples of increasing capacity:

- Increased Open Access hours at high-need sites
- Increased Primary Care hours through St. Mary's of Amsterdam
- Opening of new urgent care facilities in Albany County
- Ellis added a new primary care/urgent care in Schenectady in early 2017
- Partners expanded existing practices by adding FTE faculty including, physicians, Advance-Practice Providers, nurses, nurse practitioners, and care managers
- Alliance partnered with community based organizations to include PAM results as a tool for connecting patients to primary care providers

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

Alliance continues to recognize the challenge of workforce shortages both within the PPS network and internally. Certain challenges faced in DY2:

- Alliance worked with both the workforce committee, local colleges and Practice sites to increase recruitment of primary care support staff, licensed clinical staff and advanced practice providers. Due to in part to expanding integration efforts and expanding the PCMH model mid-level clinical and licensed staff are in greater demand.
- Alliance worked with partners to define and expand the role of care managers. Care managers are vitally important in the engagement of patients and care coordination and have been a valued member of the PCMH care team. Alliance has worked to expand and define the role of care managers role, in part due to the efforts to create an integrated delivery system. The need for care managers across Alliance PPS has increased as the value of this role is realized, as such Alliance faces shortage in care manager workforce. Some efforts taken by Alliance to address these gaps include, retraining and redeploying staff, partners recruiting and hiring care managers.
- Alliance has expanded internal resource capacity by creating additional positions and proactively recruited staff who will be dedicated to supporting PCPs. Internal resources are charged with guiding practice transformation, PCMH/APC, transition to quality measurement through on-site education and training efforts.

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?

Alliance's strategic approach aims to reduce reliance on Primary Care by sharing delivery throughout our network of providers, including community based organizations. This means expanding care throughout the network of partners in order to better meet the needs of the individual patient. The PCPs will be integral to providing preventive health, sick care however population health goals will be met when the delivery system is integrated and health delivery is shared across the continuum. Alliance, in collaboration with Community providers, worked to develop models of integration that align with the triple aim and are sustainable in the long term such as connecting patients to resources that address social determinates of health, education and home based programs.

A specific example of our strategy is the Alliance Incentive Program, a results-oriented sprint initiative will be implemented from April 1, 2017 through June 30, 2017, aimed to achieve the following goals:

- Engage Alliance partner organizations in the achievement of specific DSRIP patient outcome objectives
- Offer direct funds such as unit based incentives associated health improvement activities with funds paid monthly beginning May 2017. Examples include: well-child reminders and open access appointments
- Facilitate and encourage communication between hospitals, health care providers and community based organizations
- Improve patient outcomes to meet New York State Department of Health DSRIP targets and receive associated funding
- The program incentivizes providers, hospitals, community based organizations (CBOs) and other partners to improve patient outcomes and impact a subset of DSRIP performance metrics.[Click or tap here to enter](#)

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

Our team of population health experts and data analysts have identified and engaged community based PCPs throughout our region. Our team provides resources and meets at practice sites with providers and staff. Alliance staff with expertise in PCMH requirements have been working with community providers and supporting sites in achieving PCMH recognition. Staff support various PCMH elements such as QI, Reporting, Scheduling and development of team based care. Additional examples of community engagement include:

-Alliance has made a concentrated effort to encourage community based providers to participate in the Incentive Program. The incentive program awards unit based performance around performance metrics that align with PCMH quality and reporting requirements. Alliance has used various outreach channels, education and on-site face to face visits to encourage participation in the program.

-Alliance continues to work on addressing Health Literacy by providing training for staff from Alliance partners, including community providers and CBOs, with the awareness and skills necessary to improve both oral and written communication with their clients and patients. This will reduce ED visits and rehospitalizations arising from inaccurate or incomplete understandings of health conditions, medication instructions, or difficulties in navigating the health care system caused by poor provider communication skills.

-Alliance has sponsored care coordinators and community navigators at various partner sites to increase the integration of health delivery throughout our network of providers.

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| <i>Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:</i> | 507 |
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e. Additional Information

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| <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> | 507 |
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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> | 150 |
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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> | 0 |
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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:

-Developed a structure for PPS-wide performance reporting and communication platform
-Contracted with a vendor to conduct network gap analysis of institutional systems and FQHCs
-Contracted with a PCMH consultant for on-site support, data collection and documentation to begin in DY3. The PCMH consultant will conduct a current state analysis of each site pursuing PCMH Level 3 Recognition and build a points plan for each practice, conduct chart reviews, identifying QI projects, assessing EMR capability and compiling practice application. The consultant will work with both Community Practices as well as practices submitting under multi-site application. Alliance expects to meet the DSRIP target commitment requirement of Primary Care sites reaching PCMH 2014 Level 3 recognition by 3/31/2018.
-Established a training and education fund to support partners in various transformation efforts necessary to achieve PCMH recognition. Partners are encouraged to apply for training support on an ongoing basis. Alliance has received eleven applications for training and education in DY2 from our partners, which has afforded opportunities to not only fund the requests, but enter into further dialogues about how to leverage some of those training and education ideas. Awards ranged in size from \$200-\$17,000 and covered the following trainings/topics: Meaningful Use (MU), patient-centered care, Health Literacy, Palliative Care, Community Health Workers, Social Determinates of Health and Quality measurement reporting.
-In addition to the training and education fund, Alliance implemented models of support for Primary Care sites predicated by status and need. Support resources include; internal staff, project managers (internal & vendors) as well as Transformation Coaches in effort to facilitate EHR adoption and MU, resource and workforce planning, and collecting documentation necessary to meet PCMH deadlines
-Alliance continues to support collaboration through PCP workgroups and cross training

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:

The primary challenge facing Alliance and network PCPs is the gap in data sharing across the PPS. The existing data sharing limitations with RHIO and SHIN-NY as well as slow user adoption and changing privacy standards has hindered the both Alliance and its partners from effectively exchanging data necessary to meet integration standards across the continuum of providers and services.

In addition, the delay in sharing data through the RHIO has placed a barrier on those providers intending to use the RHIO through the Patient Centered Medical Home model.

Aside from data sharing challenges, Alliance is challenged by lagging PCMH adoption. Partners are experiencing complications in meeting the milestones necessary to achieve recognition within the DSRIP timeline. Some specific examples of barriers faced by Practices as they transform to meet PCMH standards of care are:

- in DY2 some practices were still paper based,
- as of DY2 some Community Based Practices had been in process of transforming their practice into a Patient Centered Medical Home but faced resource constraints (human and financial capital),
- a number of Alliance partners lacked the expertise of NCQA standards which created a barrier when documenting various standards and elements
- some partners were in the process of updating and adopting EHRs, according the NCQA requirements a practice must be "live" in an EHR for 90 days before applying for PCMH recognition, as a result any provider/s updating and adopting EHRs were on hold for 3 months.

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?

Based on feedback from partners, Alliance initiated a plan to proactively increase internal capacity with intent to drive practice transformation and alignment with PCMH. Alliance's new resources dedicated to PCPs provide support in the areas of training and coaching, education and Behavioral Health. The PPS plan provides dedicated resources to PCP sites expressing additional needs.

In support of IT and communications, Alliance reviewed the PCP IT Population Health assessment and redefined a near term solution to the data sharing issue throughout the network. The planned near-term solution will be supported through a vendor with work planned to kick off in DY3. The PPS continued to improve the infrastructure of the network through a true population health tool that will incorporate various data sources including claims, EHR and census data as well as vital statistics and EMT data.

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

The two strategies initiated during DY2 that have been the most effective for Alliance and its partners are:

1.) Sponsoring resources that can meet face to face with providers. Alliance staff routinely meet providers in their offices and engage in strategy, education and support session. These one-on-one meetings have resulted in improved engagement with partners while increasing alignment with DSRIP goals.

2.) Alliance's Provider Assessment and network analysis received tremendous feedback from partners, this data was instrumental in the development of a robust IT component of the Practice Transformation strategy. The network analysis helped gain a better understanding of provider network capabilities necessary for PCMH and MU requirements.

e. Additional Questions:

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

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| <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> | 30 |
| <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> | 167 |

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

507

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:

Alliance's commitment to the "MAX (Medicaid Accelerated eXchange)" to redesign the way care is delivered for New York State's most vulnerable individuals supported its progress towards implementing an integrated delivery system with Primary Care playing a central role. The interdisciplinary cross continuum PPS MAX action team participated in the series focused on transitions of care, care management, primary care integration and emergency room triage efforts. The action teams systematically pursued the "driver of utilization" (DOU), or root cause, for High Utilizers resulting in more timely linkages to appropriate services outside the hospital, identifying and developing community partnerships, and with primary care. The organization's on-going commitment to these efforts are reviewed and monitored through data outcomes to ensure sustainability.

Alliance continues to provide an innovative solution that connects Primary Care with the continuum of services available throughout the PPS network. During DY2 Alliance spent significant time and resources working with HIXNY on a population health strategy for its partners that would improve care integration through an electronic referral process. While the solution develops from concept to application Alliance continues to make investments in care coordinators and community navigators and provide these resources at Primary care sites where necessary. The coordinators are essential in creating linkages between Primary care and support services provided by our community resources such as health education and advocacy, food pantries, supportive housing, child care and behavioral health services.

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:

The tactical approach taken during DY2 was the supported development, education and promotion of HIE specifically through HIXNY to all Primary Care Sites. Alliance worked to educate primary care practices on the value of RHIO data specifically as related to integrating care across the partner network. Alliance recognized lagging uptake and use of RHIO data once connected resulted in limiting the value of alerts, clinical data exchange between specialty, ED providers with the PCP. Alliance IT and privacy team has worked with stakeholders at the state and local level to create a roadmap that supports Primary Care adoption of the RHIO throughout the network of providers.

Data sharing and privacy has been a challenging in executing the HIE plan. Changes to data sharing requirements between PPS and partners and the RHIO have required Alliance to pivot on the strategy that focused primarily on the RHIO to a more inclusive HIE strategy.

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?

Due to the limitations of data sharing, Alliance initiated a strategy to bring Primary Care, hospitals and community based providers together to build a mechanism for data sharing, making referrals and integrating care throughout the network. Alliance created a plan to recruit and hire a vendor to support data sharing, population health tools and performance reporting. As mentioned in Fundamental #2, Alliance expects to execute a contract with a vendor in DY3.

In addition to refining the HIE strategy Alliance developed an Incentive Program to launch April 2017. The program was designed to function as a platform for partners in which innovation, testing and assessment are encouraged. Alliance engaged partners such as Primary Care, Hospital and Community-Based to participate in programs that result in substantiation. Partners that applied to the Incentive Program were asked to consider preventive care quality metrics they could impact. Partners considered workflow adjustments, referrals and integration strategies that could be implemented in effort to transform their practice and align with DSRIP goals. Preventive Care quality metrics in the program include; annual and well child reminders, open access scheduling and referral to community based organizations for social supports. Alliance and its partners are working collaboratively towards the development of quality programs that are sustainable and support Primary Care as the central role of the network.

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:

During DY2, Alliance actively engaged partners in a Network and IT assessment. The purpose of the assessment was to understand any system gaps that would present as a barrier for MU Stage 2 achievement including EHR system, or lack thereof. The survey results indicated over 40 different types of EHRs with varying degrees of reporting and network capacity. Alliance created a plan to support EHRs connection to the RHIO and provide EHR analysis and education for practices using EHRs that would not meet MU standards in current state. Additionally, Alliance began actively seeking vendors with solutions that would increase electronic referrals throughout the network, Alliance plans to begin vendor selection in June 2017.

Alliance proactively worked to both sponsor and coordinate the connection of providers to the RHIO and provide access to a population health platform. The intent of these two connections allows for providers to meet the health information exchange requirements and care coordination efforts outlined by CMS specifically targeting care transitions, referrals and coordination, transmission of care plan summaries and developing a rigorous HIE.

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):

Alliance is actively engaging with partners and has committed to financially supporting the associated costs of primary care practitioners' connectivity to HIXNY. Additionally, Alliance has been providing consulting services on HIXNY product integration and workflow support to increasing active engagement with HIXNY offerings.

To appropriately respond to the immense workstream of connecting Alliance partners to the Regional HIE, Alliance initiated recruitment of a full time Hixny Coordinator. This resource will be responsible for overseeing and spearheading the effort and coordination of connecting partners. A process was established to respond to the vast coordination effort necessary to achieve these connections. The process begins with a varying degree of education within the practice. During this activity, infrastructure metrics will be collected, including EHR information, to assure sufficiency in standing up and maintaining a connection. Alliance's Hixny Coordinator then contact the practices EHR vendor and establishes a kick-off discussion with the vendor and Hixny. The EHR development cost will be conveyed to and covered by Alliance. Ongoing project management activities will be overseen by Alliance's Hixny Coordinator and in concert with Hixny and the given EHR, a project plan was drafted and will be implemented once the Hixny Coordinator is hired. The expected timeframe for hiring the coordinator and implementing the process is April 2017.

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

390

f. Additional Information

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| <i>Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:</i> | 6/15 – 40% |
| <i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:</i> | 5/15 – 33.3% |
| <i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:</i> | 1/15 – 6.67% |

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:

Alliance used the State provided value-based payment needs assessment template to survey partners on the status of VBP in March 2017. Approximately 45% of the partners that responded to the assessment have primary care physicians in their organizations. Based on the results of the assessment, several needs were identified such as education, data, and technical assistance. The identified needs were used to develop an education and implementation plan to ensure that partners are prepared to transition to a VBP environment. An education schedule was created in collaboration with Adirondack Health Institute (AHI) and Better Health for Northeastern New York (BHNNY) to ensure that meaningful education sessions were provided while not overburdening the three PPS' partners. Education topics identified include readiness, payment arrangements, contracting, working with MCOs, and technology and data. Pre- and post-tests are used to measure the effectiveness of the sessions.

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

Provider education and training remains a challenge. Creating a strategy to ensure that PCPs are provided the resources and education to be successful in outcomes based care is a priority. Education sessions have delivered more than a roadmap to VBP contracting; these sessions engage in topics such as measuring quality, data/analytics and technology. With few Medicaid VBP contract options available in the capital region, the PPS has developed an education platform within the Incentive Program. Alliance has also supported piloting innovation programs that enhance community involvement and focus on sustainability and integration.

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?

Alliance developed an Incentive Program that aligns with VBP goals. PCPs engaged in this program will work collaboratively with community partners on improving quality measures for a defined set of DSRIP metrics. Participation in the program encourages network partners to work collaboratively towards the development of sustainable quality programs that align with quality and efficiency goals.

As of March 2017, 16 partners have applied to participate in one or more project focused on the following areas: Asthma, Potentially Preventable Readmissions, Potentially Preventable ED Visits, Well Child Visits, Follow up to Inpatient Mental Health. Partners will be required to submit data reports on defined quality metrics such as open slots, visit reminders, successful PC visit post discharge for MH Inpatient. Partners will be encouraged to implement any workflow change that will remain sustainable once the fast start program is over. The program expects to begin in April 2017. This will be part one of a three-part program where part two will provide seed money for innovative programs that include a sustainability plan, integration and measurability. Part three is a long term integrated delivery system with a focus on improving the health of our community.

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:

1) Alliance will continue to work with partners through the Incentive Program to develop programs that offer practices real participation in risk & value sharing. The Incentive Program is designed to focus on Quality Measures generally included in total cost general population "on menu" options. The quality measures rates will be reported from partners to Alliance monthly throughout the term of the program. The activities are designed to support PCPs as they ready to engage with MCOs.

2.) Alliance will continue to work closely with Innovative Health Alliance of New York (IHANY). IHANY is an ACO partner of Alliance that is working on a VBP contract with Fidelis for Medicaid Shared Savings.

3.) Alliance plans on partnering with area PPS on VBP learning sessions throughout DY3. These sessions will provide partners the opportunity to learn best practices from providers and payers.

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):

The Incentive Program was designed to work with PCPs and CBOs to design programs that encourage evaluating delivery of care through quality measurements with the goal of reducing PPR/PPVs. Establishing a platform for care integration has provided PCPs the avenue for engaging CBO partners with the expertise and capacity to address social determinants of health (SDH). In turn CBOs are provided an opportunity to gain experience measuring quality of care and in turn develop value propositions. The Program was Implemented April 1, 2017.

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:

Alliance's Fund Flow strategy initially focused on the implementation of projects and completion of DOH milestones (the Alliance Project Fund). Collaborative teams were formed by Alliance's partners, along naturally occurring patient service areas lines (hubs). Alliance Payments to primary care providers for this project implementation activity are performance based, focusing on meeting targets including partner and patient engagement, and activities that specifically reflect the role of PCPs in completing project milestones. Project Fund contracts to PCPs and other providers have now been extended through the end of DY3.

Additionally, in recognition of the shift of DOH funding from reporting to performance on outcome measures, our focus has shifted as well. First, our analytics team identified a set of near-term opportunities through the balance of the measurement year that ended June 30, 2017. With the help of a provider led Incentive Plan Working Group of clinicians, quality, and financial personnel, we incorporated into a Incentive Program. Our Board approved Long Term Incentive Program focuses on both Innovation and Transformation, and we are in the process of working with an expanded group of providers to develop an implementation strategy that maximizes the impact of PCPs and others on gap-to-goal performance as an indicator of improved population health.

| <i>b. Funds Flow</i> | <i>Total Dollars Through DY2Q4</i> | <i>Percentage of Total Funds Flowed</i> |
|--|------------------------------------|---|
| Total Funds Distributed | 29,917,758 | 100% |
| Primary Care Provider | 11,381,829 | 38.0% |
| Hospital-Ambulatory Care | 5,965,224 | 19.9% |
| Federally Qualified Health Centers (FQHCs) | 4,178,090 | 14.0% |
| Primary Care Practitioners | 1,238,515 | 4.1% |
| PMO Spending to support Primary Care | 2,232,570 | 7.5% |

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?*

Alliance's Fund Flow strategy has shifted from a 100% focus on project milestone implementation through March 31, 2017, to a DY3 Funds Flow Plan that budgets 50% of potential DY3 DSRIP earnings to Incentive Plan payments based on outcome measures P4P, and 15% of potential DY3 DSRIP earnings to Project milestone implementation.

Increased emphasis has been placed on direct involvement of PCPs and other providers in the development of our funds flow plan through the involvement of our provider led Incentive Plan Working Group. As opposed to a focus on project milestones, the working groups' focus is on maximizing the impact of PCPs and others on gap-to-goal performance as an indicator of improved population health.

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):

Alliance developed evidence based standards of care and has started to work with practice sites in the adoption of standards into care plans. Evidence based standards of care are built upon outcome and quality measurements and have been established as best practice. These standards of care include new process for administering depression screenings, warm hand-offs and titrating care based on a patient's individual needs. The care plans are vital for co-located PCPs and Behavioral Health providers.

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 primary barrier facing integration of primary and behavioral health is workforce and access to licensed Behavioral Health providers.

Based on the education and training needs from participating providers there are gaps in internal Alliance resources with Behavioral Health expertise.

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 three most common regulatory challenges for sites participating in 3.a.i are:

1. Co-location & Shared Space: ex: regulations around sharing address while maintaining distinct spaces, equipment requirements, examination room regulations and approved shared hours of operation
2. PCMH and Billing: Billing authority and financial/administrative controls particularly within Hospitals and freestanding entities. Codes for APG rates were not clearly defined at the beginning of DY2, many provider groups were experiencing challenges with multiple integrated services and then required to submit a claims adjustment. The process was creating a bottle neck in claims, reimbursements and tracking.
3. Licensing: Sites pursuing integration are looking to bridge the Behavioral Health workforce gaps through tele-health (telepsychiatry and tele-medicine). Providers are seeking further clarification around telemedicine regulations for substance use treatment.

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?

Alliance is committed to expanding internal resources dedicated to Behavioral Health integration at participating sites. Internal resource will work with partners in developing workplans for integration, assessing needs, barriers and capacity. Alliance will review the needs of the partners and network to provide ongoing education and support. Alliance will continue to work with Local Governmental Units in providing guidance and education as practice implement integrated care.

Alliance will continue to work with DOH OMH and partners to adopt the Collaborative Care Model.

Alliance is actively recruiting Behavioral Health director with an expected hire date of November 2017.

| <i>e. Model</i> | <i>Number of Sites Planned</i> | <i>Number In Progress</i> | <i>Number Complete</i> |
|-----------------|--------------------------------|---------------------------|------------------------|
| Model 1 | 53 | 33 | 25 |
| Model 2 | 11 | 2 | 0 |
| Model 3 IMPACT | N/A | N/A | N/A |

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:

[Click or tap here to enter text.](#)

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