Primary Care Plan Update 2017

Leatherstocking Collaborative Health Partners

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.

LCHP PPS used the Patient Centered Medical Home transformation as a foundation to support the overall patient needs; thus also creating the infrastructure to support other DSRIP clinical projects. While there are shortages in the PCP practitioner and nursing arena, the primary care practices continued their work. Close to 70 primary care practices representing around 175 practitioners will have submitted their 2014 Level 3 applications to NCQA by the 9/30/2017 NCQA deadline. Below is a break down of the partner organizations overseeing the primary care practices.

*Bassett corporate includes 30 sites
*Bassett SBHC corporate includes 20 sites
Oneida Health Center (Bassett single site)
*AO Fox corporate includes 6 sites
*Little Falls Hospital includes 2 single sites
*Community Memorial Hospital corporate includes 4 sites
*Regional Primary Care Network includes 1 site
Oneida Healthcare corporate includes 3 sites
Verona Health Center (Oneida Healthcare) single site
Planned Parenthood Mohawk Hudson one site plans to pursue APC Model
Herkimer Nurse Practitioners one site plans to pursue NCQA 2017

LCHP contracted with PCDC (Primary Care Development Corporation) in mid-2015 to guide practices through the Patient Centered Medical Home transformation. The contract expenses with PCDC were covered by the LCHP PMO. Additonally, LCHP paid for key individuals in the primary care practices to attend NCQA training and to become a Certified Content Expert in PCMH.

*Some practices within these partner organizations are pursuing integration of behavioral health .

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 NCQA transformation, practices are required to look at their capacity and ensure same day access for both acute and routine appointments as well as extended hours. The LCHP region happens to have a majority of their primary care practitioners employed by hospital based systems. Due to the large geographic footprint, LCHP practices implemented extended hours in geographic regions where it may not be feasible or necessary to extend hours every day. This assists with the challenges identified in Fundamental 1 in the primary care plan, which were recruitment, burnout, and geography.

Due to the small number of community/independent primary care practices in the LCHP region, LCHP has done their best to identify and engage them. All were invited to the Patient Centered Medical Home clinical project meetings and focused PCMH Learning Collaboratives.

LCHP has led one FQHC (Federally Qualified Health Center) to submit for 2014 Level 3 recognition through NCQA with both the financial assistance and PCMH expertise.

One community practice is planning to pursue the APC model and one is planning to pursue NCQA 2017 model.

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

Challenge 1-Rural Geography: As mentioned earlier, the large rural geographic footprint of LCHP posed a challenge to primary care practices across the region. Again, the majority of primary care practitioners are employed by hopsital based systems, so it was natural for them to look at sharing primary care resources by region. RN Care Managers and non-clinical navigators cover geographic regions, which encompass several practices. By creating the patient care teams in the primary care practices, practitioners have increased support to address patient needs.

Challenge 2-PCP burnout: PCP practitioners continue to be frustrated with a system that incentivizes volume of patients in the fee for service model and look forward to a value based future model that values the quality of care for the overall patient. Integration of services such as behavioral health and navigation assist PCP practitioners with addressing the mental health and social determinant of health needs of their patient panel; thereby acting as collaborators. PCP fatigue continues to be an issue as primary care practices are subjected to initiatives and implementation of projects and programs.

Challenge 3-Recruitment: The compensation and benefits survey showed a 44% vacancy rate among primary care physicians and a 30% vacancy rate among primary care nurse practitioners. Programs such as SCRUBS club to expose high school students to health care fields, rural immersion programs that expose medical residents to rural communities and similar pilot programs have been implemented. Additionally, as LCHP conducts their DY3 compensation and benefits survey, there will be additional questions asked to determine true need versus only vacancy rate.

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?

The PPS is undergoing a dramatic transformation through project implementation in the DSRIP program. Through the process of achieving NCQA PCMH 2014 Level 3 recognition, close to 70 primary practices are developing strategies to increase capacity through new staffing models. For example, the introduction of care managers in the primary care setting has reduced the burden on primary care practitioners in ensuring routine follow up with their patients to address health and social needs prior to requiring acute intervention.

The integration of behavioral health in the primary care setting further increases capacity and reduces practitioner burnout through "warm hand-offs" to a behavioral health specialist who has become part of the primary care team.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
Most PCPs are hospital-employed and analysis did not yield many community based PCPs. LCHP engaged practices like Regional Primary Care Network (RPCN who is a Federally Qualified Health Center) to transform their Primary care practice and re-engaged Herkimer Nurse Practitioners (HNP);however, they are waiting for CMS to approve DOH's request to include NCQA 2017 standards. Planned Parenthood Mohawk Hudson (Cobleskill location) initially thought NCQA would be their model, but later verbally indicated they would pursue the APC model. Nonetheless, the community primary care providers have benefited from consultant arrangement with PCDC (Primary Care Development Corporation). **It should be noted that primary care practices receive the NCQA recognition and not the pracititioner.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	4 (from HNP and RPCN)

e. Additional Information

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:	67 practices (175 practitioners)
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	6 practices (12 practitioners)
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	1

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:

LCHP has contracted with PCDC (Primary Care Development Corporation) to provide training, guidance and expertise on transforming practices to Patient Centered Medical Homes while paying for NCQA training for key individuals within the practices to become PCMH Certified Content Experts. RN Care Managers have been hired to support the needs of the primary care practices and non-clinical navigators have started to embed within PCP practice locations. As practices have struggled to over come barriers to PCMH "buy in", conultants and other practices who have achieved PCMH 2014 Level 3 recognition have spoken to the benefits of the transformation.

LCHP, in collaboration with PCDC, intends to put sustainability plans in place for practices who achieve their recognition in order to maintain it.

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:

Provider and staff "buy in", competing priorities such as other DSRIP clinical projects and electronic record turnover, led to some initial delays in transforming practices. During the corporate and site specific NCQA applications and submissions, there were enormous amount of documentation that needed to be collected to meet submission requirements. Additional resources from LCHP PMO office were deployed to assist practices where needed.

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?

LCHP arranged to increase both PCDC and PMO resources to partners where needed. Development of PCMH Champions continues in order to sustain the recognitions, so LCHP has funded individuals identified by the partners to become CCEs. A strategic plan was outlined for the largest partner overseeing the majority of the PCP practices to ensure continued knowledge of NCQA guidleines for sustainability and to support smaller partner practices who may not have the staff available to attend training.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
LCHP's use of PCDC Consultants as PCMH experts and a Project Manager in the central PMO office becoming a CCE in order to provide guidance and expertise to all practices have been effective methods. It has increased the bandwidth of those who can answer questions and has allowed additional practices to join late and still be able to submit their applications by the 9/30/17 deadline.

e. Additional Questions:

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

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:	67 practices-175 practitioners
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:	1 (APC) and 57 (phytel)

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	175

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:

LCHP used Patient Centered Medical Home as the primary foundational clinical project necessary for the delivery system to change. The focus on access to primary care same day and through extended hours, creation of a patient-centered team, consistent systems to collect and record patient data in structured fields within the electronic record, identifying high risk patients and creating care plans, working with hospitals and emergency departments for the patients through transitions of care, managing lab/imaging orders and referrals, development and monitoring quality measures have become the foundation to the LCHP primary care practices. Additionally, collaboration with community navigators, home care agencies, long term care faciltiites and behavioral health providers have all emerged from this work.

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:

Inorder to create meaningful linkages essential for an integrated delivery system, interoperable systems are necessary. Utilizing the Bassett Healthcare Network (BHN) electronic record, Epic, which includes 5 of 7 PPS hospitals. Epic Care link has been rolled out for use with PCP practices and key partner organizations to have a central system for communication on common patients. Ther eis more work to do in this area and the PPS is considering additional educational sessions with RHIOs.
PPS continues to be challenged with incentivizing practitioners in hospital employed models who function under fee for service reimbursement from payers. Additionally PPS has been challenged with properly incentivizing CBOs and emergency medical services given the 5% cap in funds flow to non-safety net partners.

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?

Community navigators from both the lead agency and contracted agencies have been embedded in the hospital emegency departments and are now starting to embed in primary care provider offices. Epic Care link has been rolled out to partners from lead agency for better patient care.
The largest strategic shift that the PPS has made is focused on connecting PCPs who are safety net with CBOs who are non-safety net to develop meaningful linkages to align with the future of VBP.

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:

Although this was not in the scope of our DSRIP 2aii work, the practitioners and their practices who were planning to pursue PCMH recognition already had implemented EHRs and reached MU stage 2.

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):

Although not in our Primary Care Plan scope, over 90% of LCHP PCPs are employed by hospitals that already participate with RHIOs. That said, LCHP still recognized the need for PCP's to more effectively use RHIO's. To address the increased utilization of RHIOs for partner PCP's who are already contracted and to increase the number of non-hospital employed PCP's contracted with RHIO's LCHP has held a number of HIXNY information sessions for partners of all types. Two of these sessions were held on February 23rd and March 1st, 2016.

We have also promoted existing incentives for partners to contract with RHIO's, thus reducing the up-front cost for joining the RHIO, effectively reducing the barriers to entry. In addition to promotion to Primary Care Providers, LCHP recognizes that Community Based Organizations, both health care and human service providers, must also be contracted with RHIO's in order to best utilize the technology and its ability to promote data sharing across the PPS.

PPS continues to learn about partners and Primary Care practices that are effectively using their RHIOs

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	175

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	3
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	3
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	0

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:

Phase 1 of VBP Education scheduled by end of DY3. Phase 2 includes provider-specific education.

Bassett is actively engaged in establishing VBP Agreements with Excellus BCBS and Fidelis Care New York. These two health plans represent over 90% of the Medicaid managed care enrollment in our primary counties.

The impetus for entering into value based payment agreements is multi-layered. Initially, since AO Fox Hospital is actively engaged in a VBP QIP program, we have engaged with Excellus BCBS and secured the initial Level 1 agreements required under this program. The QIP work has been underway and meeting QIP milestones for some time. However, Excellus does not represent a majority of Medicaid membership and we therefore must also secure an agreement with Fidelis (NYS Catholic Health Plan) in order to meet the progressive VBP QIP engagement targets.

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

A major challenge in engaging with MCOs is that MCO goals for DSRIP are not aligned to those of the PPS. As example, the MCO is challenged to secure Level 1 Agreements by a specified date. Those agreements specify quality outcome requirements and a level of risk sharing, but do not define specific programs to achieve those outcomes. The DSRIP is challenged to engage MCOs in very specific coverage concerns, i.e. "engage the MCO in providing coverage for palliative care". There is a large gap between these 2 related goals. Convergence of these like-goals when the health plan is not required to provide this extra-contractual coverage is a major challenge. Particularly in the Medicaid arena, where the health plans feel constricted by legislated benefits and reimbursement amounts.

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?

Notably, the Bassett Healthcare Network currently has a Medicare MSSP ACO representing approximately 14,000 attributed patients. Bassett Healthcare Network also has a Commercial ACO through the Excellus Accountable Cost and Quality Agreement that represents approximately 19,000 attributed patients. The proposed Fidelis agreement will establish a comprehensive ACO program for a major percentage of Bassett patients enrolled in Medicaid. In addition to these contracting initiatives, Bassett is partnering with Catskill Area Hospice in an appeal to Excellus and Fidelis to expand coverage guidelines for Palliative Care. There is much research to support the Triple Aim value of palliative care in advance of and separate from a hospice designation. Discussions are active with initial phone calls leading to in person meetings and documentation of a proposed coverage program. We are hopeful to secure contractual support for this service on at least a pilot basis and continue those efforts in earnest.

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:

We also understand Fidelis' need to engage providers in VBP arrangements in order to meet the MCO DSRIP goals. With 77% of our regional Medicaid Managed care patients enrolled, we see an obligation to support this Fidelis initiative not just for AO Fox, but on behalf of the entire clinically integrated Bassett Healthcare Network. To this end, Bassett has applied and awaits certification as a NYS ACO. The NYS ACO designation will provide the contracting vehicle for both the Fox VIP QIP and Bassett Network-wide VBP programs for this population.

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):
Through facilitated county hub discussions, PPS is increasing their level of understanding on how CBOs can assist with DSRIP goals and alignment with VBP arrangements. LCHP is challenged with determining value on CBOs addressing social determinents of health.

f. Additional Questions

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

…If yes, has it been granted? ☐Yes ☐x No

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

…If yes, describe: Worked on Interoperability with Epic/Epic Care Link for Bassett PCP practices. There is a financial risk to understanding and preparing for this.

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:

LCHP has pro-actively engaged and paid for PCDC consultant services on behalf of partners actively pursuing PCMH recognition through NCQA. Partners who are engaged in the PCMH clinical project also receive funds for reporting actively engaged patients. Additionally, partners received funds for being engaged by attending project committee meetings and providing requested information to the PPS.

**LCHP has the majority of their PCP practices (and primary care practitioners) working in hospital-employed models. We have very few community PCP practices in our PPS area.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$12,263,661.65	**100%**
Primary Care Provider	0	0%
Hospital-Ambulatory Care	$5,270,089	43.0%
Federally Qualified Health Centers (FQHCs)	$50,661	0.4%
Primary Care Practitioners	$45,330	0.4%
PMO Spending to support Primary Care	$272,397	2.2%

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?
LCHP has taken the financial responsibility to assist with providing consultant services to assist in PCMH recognition work. In addition, PPS financed the training of champions within the partner practices involved in the project. The PPS has also taken the initial financing of training providers in behavioral health screening. Two fold changes have been made to our funds flow. Firstly, the process to request funds has been modified to be more comprehensive and clear for partners. Secondly, a portion of funds will be used to incentivize for outcomes.

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):

We have done quite a bit in the past year and a half. We have co-located therapists into approximately 30 primary care clinics, where they are able to work collaboratively with primary care teams to meet the comprehensive needs of our patients. We have collaborated with care management to make care for behavioral health needs as efficient and accessible as possible, including asking our care managers to help encourage patients with new diagnoses of major depressive disorder and a prescribed anti-depressant to follow their treatment plans and to get patients with diagnoses of serious mental illness who are on anti-psychotic medications screened annually for diabetes. We have made great progress with integrating records, and now have a fully intergrated psychologist in one of our clinics who has bi-directionally shared records with the rest of the primary care team. Finally, we have collaborated with our withdrawal management DSRIP team, and have helped to bring evidence-based care for opioid addiction into our primary care clinics in a model that has received national recognition. In this vein, we hosted an opioid addiction stakeholders summit (headlined by keynote speaker Dr. Andrew Kolodny), which focused on providing evidence-based information about addiction and its treatment to stakeholders in the community. Included in the audience for this event were local law enforcement leaders, who have since stated that participating in this summit helped change they way that they viewed addiction and the efforts of the medical community to stem the opiod epidemic.

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

-Lack of PCPs to integrate into Model 2 sites

-Culture change (mental health clinics reluctant to facilitate primary care services on site)

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 mental health hygiene law has made it challenging to get clinics able to share records with one another. The rules around article requirements for billing (i.e., primary care clinics must also have article 31 license for LCSWs to be able to bill for services) has made it hard for mental health providers to be financially viable in some clinics, and has contributed to the continued financial and cultural separation between mental and physical health.

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?

We are now able to have PCPs view behavioral health progress notes for their patients through change in culture and removing myths that it was restricted by regulations.

As a part of MAX series Community Memorial Hospital has worked on a warm hand-off process. They have also created BH and PCP consult on patient treatment plans, monitoring and tracking progress. Warm hand-off processes have been implemented in practices of other partners as well.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	37	7	30

Model 2	2	1	0
Model 3 IMPACT	0	0	0

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
☐x 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): part of comprehensive health assessment
☒ Other Substance Use screening (please specify): part of comprehensive health assessment
☐ 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