

Primary Care Plan Update 2017

Millennium Care Collaborative

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’.

Index

Primary Care Plan Overall Strategic Updates	1
Fundamental 1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.....	2
Fundamental 2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?	5
Fundamental 3: What is the PPS’ strategy for how primary care will play a central role in an integrated delivery system?	8
Fundamental 4: What is the PPS’ strategy to enable primary care to participate effectively in value-based payments?.....	12
Fundamental 5: How does your PPS’ funds flow support your Primary Care strategies?	15
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)?	17
GLOSSARY OF TERMS	20

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.

Millennium's partner contract cycle followed the DY2 timeline of April 1, 2016 to March 31, 2017. The Primary Care Plan deliverables and implementation also aligned with this cycle. No impactful changes were made during this time as partner requirements were already in place.

In late February 2017, Millennium began its planning efforts for the following contract cycle. This new contract period was intended to be much more heavily weighted on performance metrics and outcomes; in contrast to the more project centric focus in DY2. From a PPS performance perspective, Millennium's strategy was to continue to build linkages and relationships across PPS partners based on need, deliver actionable reporting tied to dollars and outcomes, and provide care coordination support to practices without the resources to act upon PPS data.

This new strategy went in to effect in September 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:

During this time period, as per Millennium's primary care contract requirements, practices that had not yet achieved PCMH recognition were working on submitting for PCMH with a member of the Millennium primary care team. As described in the original primary care plan, each primary care practice has an assigned liaison from the Millennium team to support practice transformation and DSRIP deliverable completion.

Throughout the PCMH process, there is a heavy emphasis on ensuring that extended hours are in place, and ensuring that those extended hours are adequate. The Millennium team worked with 16 different PCP organizations to submit for PCMH 2014, which included provisions for extended hours. By March 31, 2017, only 6 organizations remained outstanding.

In addition to PCMH recognition, Millennium had also chosen the Patient Activation Measure (PAM) project, which promotes linkage of disconnected patients back to primary care. This strategy has taken two approaches: First, Millennium required all contracted primary care practices to accept Medicaid patients navigated to their offices from DSRIP projects. Secondly, as part of the PAM project and the ED Care Triage project, patient navigators were/are helping patients who need a primary care doctor find a primary care doctor. This effort includes scheduling a primary care appointment, helping patients with their insurance carrier, and following up to see if the primary care appointment was kept. These efforts were described in the original primary care plan and have not changed since that initial iteration.

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

A true capacity-building plan requires expanding primary care staff in Millennium's region. The PPS is not positioned to recruit new staff for its primary care practices, although practices are encouraged to use their earned DSRIP funding to fill staffing gaps.

Despite efforts to increase after hours availability through PCMH transformation, practices are still limited by the number of physicians, NPs, and PAs they have on staff. Several large primary care practices have had unfilled practitioner positions for a year or longer.

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?

No changes were made to the original strategy during this time period.

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

Millennium has increased the number of community-based primary care providers that received a contract and incentive funds in DY2. In addition to funds, Millennium offered practice transformation and PCMH support to these new partners.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	254
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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:	333
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	291
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	57 (all providers currently are PCMH 2014)

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:

Millennium offered support to primary care practices in achieving PCMH recognition in a few different ways. Training and practice transformation support for this effort has been ongoing, and was described extensively in the initial primary care plan. Dedicated primary care relationship managers worked with assigned practices to guide them through the PCMH submission process for renewals and first-time submissions. These relationship managers maintained project plans, led documentation and medical record reviews, and conducted extensive staff training.

In addition to the resource support, a portion of Millennium's contract funding for PCPs included dollars for achieving or working towards achieving PCMH. The intent of those dollars were to provide practices with funds to make EMR upgrades or add staff as needed.

During this period, additional strategic planning has occurred around strengthening the entire Millennium network's clinical integration, which included a stronger emphasis on bi-directional communication and care coordination. Plans were developed to hire an internal care coordination team to support practices with their practice transformation efforts. As of September 2017, those positions are posted to be filled. A more comprehensive update will be available in the next Primary Care Plan update.

Throughout DY2, the primary care team worked with 12 primary care practices to submit PCMH 2014. More practices were identified as needing support after March 31, and are actively engaged in PCMH.

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:

In April 2016, Millennium brought on several new primary care partners to participate in DSRIP. Some of these partners were small offices that had never gone through PCMH recognition in the past. Bringing these organizations up to speed with fundamentals such as team-based care, care coordination, and care management was very time-consuming. These smaller practices have moved forward at a much slower pace, and at least one will need the NCQA DSRIP extension.

There is a second challenge worth noting. Several of Millennium's primary care partners are hospital-owned or part of a large IPA. The leadership at the administrative levels of these organizations required their primary care providers to participate, but at the practice level there are many priorities competing for time and resources. Additionally, there are several examples of practices that require EMR upgrades to enhance reporting for PCMH, but these have not been prioritized over other system-wide initiatives.

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?

No strategic changes were made to address Fundamental 2 during this time period. Millennium's partner contracts were already in place.

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

The most effective strategy to support PCMH was the availability of Millennium staff to facilitate PCMH recognition in primary care. The Millennium primary care team are experienced with PCMH and practice facilitation, and were able to help practices successfully navigate their PCMH submissions along with completion of other contract deliverables.

Overwhelmingly, practices did not have the staff to dedicate to managing a PCMH submission. Receiving help from the PPS expedited the process and allowed practices to take advantage of the enhanced PMPM.

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>	0
<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>	2

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

645

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 described in the original Primary Care Plan, Millennium has well positioned its PC partners as central players in IDS implementation. In the specified timeframe, much of the work in PC was focused on PCMH, DSRIP project milestones, and general DSRIP education. That included requirements to link with other partners for improved patient care. The PPS had really just begun work to create/improve linkages with secondary and tertiary services, in particular Behavioral Health. Through Millennium's PC engagements, it was discovered that practices without an integrated solution were struggling with BH referrals. Millennium facilitated growth/development of PCP/BH relationships with a "matchmaking" approach. Practices that expressed interest in a BH partner were linked with and introduced to an agency that was geographically appropriate. These organizations developed bi-directional communication workflows and processes to ensure patient consents were in place immediately for information sharing. Millennium also runs a Health Home initiative with lead regional HHs. A workgroup convenes biweekly, and a key deliverable is to create strong linkages between the HHs and primary care. The team is implementing a program where PCP offices commit to select one lead HH to work with. This approach supports a standardized communication pathway between the HH and PCP. The PCP can call their lead HH to assess patient's HH status (not in a HH, outreach, or enrollment), assigned case manager, and affiliated agency. Detailed workflows and patient tracker systems are available, serving as a baseline for best practices for HH integration with PCPs.

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:

Millennium has faced challenges implementing an IDS. The first challenge has been that the primary care partners are at very different stages of transformation, based on their leadership, staffing structure, and size. Many of the participating FQHCs already have a variety of services integrated in their organizations, robust care coordination staff, and community engagement staff. They have been somewhat reluctant to fully engage with the PPS because they are very self-sufficient.

On the opposite end of the spectrum, many of the hospital-owned and privately owned primary care clinics are understaffed. These organizations have limited resources to expand services within their organizations and to help their patients link to other services.

Data and IT are also key challenges. Disparate EMRs and levels of expertise are often barriers to bi-directional communication, which makes it difficult for providers at different sites of service to co-manage patients. The RHIO provides robust information, and while many primary care practices are using it in some capacity, there is still a learning curve in maximizing its functionality.

One of the biggest challenge has been a delay in the launch of Millennium's own population health tool, which is intended to provide actionable patient data to its partners regardless of payer. This has slowed down some opportunities for collaboration among PPS 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?

No strategic changes were made in this timeframe, although organizational planning occurred to address some of these challenges. Two key initiatives are intended to support primary care:

The first initiative is to have a small, centralized care coordination team at Millennium comprised of a care manager, a behavioral health care manager, and a pharmacy care manager. This group will be deployed to support primary care practices in connecting their patients to needed services, in hopes of addressing some of the staffing shortfalls occurring at some organizations.

The second initiative is to partner more closely with representatives at the RHIO to identify practices that have additional training and workflow needs around accessing patient information. HEALTHeLINK, the RHIO in Millennium's region, has a program where it can send real-time alerts for hospital and ED admissions, discharges, and transfers. Millennium included provisions in the next contract requiring practices to implement this program as a mechanism to do hospital and ED follow-ups.

To further support primary care as the central role in the IDS, Millennium collaborates regularly with HEALTHeLINK to identify opportunities for improvement within their system.

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:

Not applicable. All primary care partners had certified EMRs, and Millennium did not offer Meaningful Use support.

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):

Millennium included very specific deliverables around connecting to the RHIO and accessing various functionality within the DY2 contract. These deliverables included implementing a patient consent process, signing up for patient queuring, signing up to receive patient alerts, and initiating a CCD exchange between their EMR and the RHIO. Millennium tracked progress towards these deliverables using a dashboard created by the RHIO that was produced monthly.

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

100%

f. Additional Information

<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:</i>	26
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:</i>	6, 23%
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:</i>	20, 77%

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:

Within this specific period of time, there was little additional work done outside of what was described in the original primary care plan. The VBP Needs Assessment, which was distributed in September 2016, did require a second round of surveys in order to obtain additional responses, which was completed in early 2017.

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

Millennium has encountered challenges in working towards VBP readiness with its primary care providers. The single largest challenge is that the PPS does not have any integrated organizations that could enter into a VBP arrangement today. There is still a need for more relationship-building across healthcare organizations in order to get the right mix of partners and a large enough volume of patients to make VBP feasible.

Secondly, partners do not have a way to monitor their performance and costs in a VBP. Millennium is implementing a population health platform that will offer some of these analytics, but the implementation has taken longer than expected. Organizations need sophisticated tools and technology in order to manage participation in VBP arrangements.

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?

The strategies outlined in the original Primary Care Plan are still the main strategies of the PPS. Millennium has continued to focus on providing implementation and training support utilizing a VBP Sub-Committee. The Physician Steering Committee is also leveraged as advisory to the VBP Sub-Committee.

The PPS still intends to use its population health solution to provide a comprehensive view of Medicaid members to support organizations in their ability to budget and manage risk. As mentioned in previous sections, the timeline for this solution being available has shifted considerably due to a cyber attack on Millennium's lead entity in April 2017. It is anticipated to go live in Q4 2017.

Beyond these ongoing activities, Millennium identified other strategies that are currently being put in place. These new strategies include the planning of a regional VBP conference; a program designed to improve primary care access for low- and non-utilizers; a clinical integration bonus program that will require PCPs, FQHCs, regional hospital systems, and behavioral health providers to partner together to meet value-driven metrics; and contract provisions to support the progression to a Medical neighborhood.

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:

No actions were taken during this timeframe, however Millennium has ongoing monthly meetings with MCOs. A chief objective of these meetings is to standardize sharing of partner performance data, which supports migration towards VBP.

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):

Not applicable.

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: Millennium is actively participating in ongoing activities around the support and development of IPAs, ACOs, and other clinically integrated partnerships. Millennium intends to make available administrative resources and expertise associated with these efforts. Some of these efforts include becoming an affiliated member of Value Network LLC, a regional behavioral health IPA that is being developed as part of the NYS Value-Based Behavioral Health Readiness Program, where a Letter of Intent is being finalized. Additionally, Millennium is facilitating and supporting current NYS VBP pilots (GBUACO and YourCare), and supporting FQHC evaluation of available legal structures and contracting vehicles.

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:

Funds are flowed to primary care and other partner types through the issuance of a Master Participation Agreement (MPA). The funds are awarded upon completion of contract deliverables that align with PPS milestones and deliverables. Currently they are paid out twice a year.

Primary care receives the largest percentage of available partner funds due to the large impact it has on quality measures and overall PPS performance.

All funds flow strategies and methodologies are vetted through Millennium's internal leadership, its lead entity, the Finance Committee, and the Board of Managers, which represents a wide range of partners. Funds flow is categorized by provider type.

<i>b. Funds Flow</i>	<i>Total Dollars Through DY2Q4</i>	<i>Percentage of Total Funds Flowed</i>
Total Funds Distributed	\$24,045,948.79	100%
Primary Care Provider	\$5,955,074	21.51%
Hospital-Ambulatory Care	\$822,724	2.97%
Federally Qualified Health Centers (FQHCs)	\$822,724	2.97%
Primary Care Practitioners	\$1,789,767	6.46%
PMO Spending to support Primary Care	\$2,519,859	9.10%

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?*

During that time Millennium planned for an increase in percentage of funds flowed to primary care from 35% of total funding to 43% of total funding.

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):

As part of Millennium's practice transformation strategy, primary care practices without integrated behavioral health were linked with an area behavioral health provider to strengthen referral relationships and assess co-location opportunities. Primary care offices and their linked behavioral health providers began to develop collaborative workflows to improve bi-directional communication. Organizations were encouraged to identify a point of contact to coordinate and track mutual patients. This has resulted in unexpected partnerships between healthcare facilities that have not worked together in the past.

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

While the new partnerships have been beneficial to primary care practices, some practices have been unable to implement a true collaborative solution as described in Model 1. One of the biggest challenges is a shortage of licensed behavioral health providers in this region.

In some cases, there has also been a lack of a sustainable business model to support adding behavioral health staff. Practices are not confident in the ability to maintain a behavioral health practitioner post-DSRIP when funding disappears. These organizations are waiting to see if a VBP model bridges the gap financially for adding critical staff.

Practices are also challenged with the system-sharing piece of behavioral health integration if they identify a partner that is not part of the primary care organization. It has been difficult to move beyond a referral relationship to true system integration when primary care and behavioral health are not able to share an EMR. Millennium is evaluating the use of its population health solution as a shared system option for both behavioral health and primary care partners. It has a care management module that could be accessed by both parties.

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

From a regulatory perspective, mental health provider billing limitations are an ongoing issue. Regional payers limit reimbursement to LCSW-Rs, who are in high demand and difficult to find. To date, there has not been further guidance from the Managed Care Organizations on whether other provider types will be considered for reimbursement.

In addition, the Federal requirement to have separate waiting rooms for primary care and behavioral health contributes to the stigma around mental health treatment and continues to be a barrier to reaching true integration.

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?

N/A

<i>e. Model</i>	<i>Number of Sites Planned</i>	<i>Number In Progress</i>	<i>Number Complete</i>
Model 1	6	1	5
Model 2	14	9	5
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
- 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