Primary Care Plan Update 2017

The New York and Presbyterian/Queens PPS

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.

The PPS has made great progress in DY2 on the implementation of the primary care plan. The PMO has held numerous training sessions for staff on care coordination, clinical best practices and will be launching VBP trainings in DY3. Additionally, the PPS has exceeded the goal of 36 providers becoming PCMH 2014 Level 3 certified and already has 42 that are certified and 3 undergoing the process. The PPS is continuing to utilize the strategy outlined in the primary care plan, but has made some notable additions to ensure success. These changes, which are detailed below, include the integration of Case Managers into the ED to improve care coordination and the utilization of the MAX series to connect high utilizers with primary care while reducing the number of ED and inpatient admissions. Additionally, the PPS has been preparing for VBP initiatives in DY3 surrounding training and education for partners. Finally, the PPS has been successful in exceeding the original goal of 38% of funds flow incentives to providers; to date the PPS has paid out 48% of funds flow to incentives. All of these strategic additions will help the PPS achieve the goal of an integrated delivery system with patient centered primary care at the center.

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 of August 2017, the PPS has 42 primary care providers certified for 2014 PCMH Level 3 standards, and 3 additional providers in the process of completing certification. This exceeds the speed and scale commitment of 36. Through the achievement of PCMH recognition, both access and capacity have been improved; these sites are utilizing team based care and care coordination to improve both workflow efficiency and patient experience. These sites have worked to extend hours and increase access through the implementation of open access scheduling, weekend and evening hours. Sites have implemented open access scheduling to ensure patients are able to receive primary care based on their scheduled needs. The PCMH sites across the network are exploring telemedicine options and looking at best practices, infrastructure and technology, and sustainability plans for such innovation. Finally, the PPS has 2 FQHC partners, both of which received PCMH certification, which are integrated for primary care and behavioral health. These sites are able to increase access to vulnerable and difficult to capture populations in behavioral health and ensure that their primary care needs are met while on site.

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

The PPS has faced several challenges to addressing wide spread primary care needs, including resources for obtaining PCMH certification, PCMH site physician champions, scheduling changes, and implementing open access scheduling. Although the PPS has surpassed the 36 providers committed for PCMH certification in project 2.a.ii, additional providers are continuing to work towards completing their certification. Many of these small community practices lack the capacity of staffing and infrastructure of EHRs to complete the certification process. The PPS is continuing to support the transformation of these community practices through the funds flow incentives, HANYS transformation support, and PPS funded trainings on care coordination and population health for staff. As part of the transformation process, each site chooses a PCMH physician champion. This clinician works closely with HANYS for the weekly check-ins on progress and is charged with helping the site through the PCMH culture change. This role has been at times challenging to fill, especially for small practices with limited resources. The PCMH champions have a big lift with the culture change and have to be dedicated to the PCMH process and commit to the needs of practice. Finally, PCMH sites are required to implement open access scheduling. This is a fundamental change in the ways providers have traditionally managed their schedules and requires a significant culture change for the practices.

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

In addition to the strategy outlined in the primary care plan, the PPS has added a new initiative to support primary care and care coordination. The PPS is working with NYP Queens hospital to recruit LTC Coordinators and patient navigators for the ED. These coordinators and navigators will do warm hand-offs to the primary care physicians and ensure care coordination from the hospital to the outpatient primary care setting.

The major challenges identified are within the PCP offices, however the PPS will implement the following strategies to help address these issues;

1) MD champion- strategy- utilize HANYs SME to provide education and onsite support. 2) open access scheduling- NYPQ is working with voluntary providers to understand and implement the importance of timely follow-up appointments post hospital discharge. When a patient is identified a high utilizer, the case managers, along with the SW identify the drivers of utilizations, secure needed services, and schedule a timely follow-up appointment with their PCP

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:	
The PPS utilizes several avenues to engage community-based providers including PPS committees, town hall meetings, PMO site visits, and HANYS transformation support. 31 of the 45 providers that are undergoing transformation are community-based including independent practices and FQHCs. In addition to the committee meetings, which review implementation strategy and best practices for the project, the PPS has conducted site visits to assist partners with creating patient registries, connecting to the RHIO, completing the PCMH applications, and implementing best practices. The PPS has also engaged HANYS as the PCMH vendor to assist practices with the transformation process and conduct weekly webinars and 1:1 meetings to ensure success. The PPS funds flow model incentivizes RHIO connectivity, engaged patient activity, and utilization of PMO resources for community-based providers to alleviate financial burdens of DSRIP changes.	
Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	33

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:	55
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	28
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	0

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

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

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

The PPS has leveraged HANYS services to aid in NCQA PCMH 2014 Level 3 transformation. HANYS has provided practices with webinars, weekly calls, and educational sessions specific to requirements and policies, collaborative group learning, and health transformation. HANYS developed and customized a timeline with detailed expectations and action plans to engage each primary care practice throughout the entire transformation. The PPS continues to support education and training through partnerships to provide trainings on care coordination and population health. The PPS engages and informs providers through committee meetings, Town Halls, and email blasts. Throughout each quarter the PMO tracks project milestones and deliverables to ensure continued success of the project implementation and provide support and mitigation strategies for identified risks across partner sites. To date, this strategy has enabled 42 network providers to successfully obtain certification of PCMH Level 3 2014.

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 PPS has encountered several challenges with primary care including competing priorities at sites, staffing shortages, access to technology and data, and sustainability planning. Primary care sites have numerous initiatives that they are implementing aside from DSRIP, including payment reform (MACRA/VBP/MIPS), quality improvement projects, chronic disease management models, comprehensive primary care, and many more. The PPS has continued to work to ensure that providers see the value in PCMH transformation and are supported throughout the process both through financial incentives and resource support. Staffing shortages, especially at community-based practices, can be problematic, as they often do not have the bandwidth to support a full FTE for care coordination and therefore have begun to utilize MAs and receptionists as care coordinators for their patient population. Access to technology and data continues to be a struggle both for practitioners and the PPS. The cost of technology is a barrier, even with PPS support, and access to actionable data continues to be a struggle to obtain. The PPS is working with Healthix RHIO to connect partners and provide data exchanges in addition to the population health management tool and event notification provided by the PPS to partners to aid in patient management. Finally, sustainability planning continues to be essentially to the long term success of primary care as the center of the care continuum. The PPS provides education to providers on the enhanced reimbursements for PCMH certification and will begin to provide educational sessions on VBP in DY3.

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

The PPS has made no strategic changes specific to this fundamental.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
The PPS has utilized a dual strategy of funds flow incentives and transformation support to ensure providers have the resources required to meet the PCMH Level 3 2014 standards. Providers receive incentive payments from the PPS bi-annually based on engaged patient submissions and project requirement completion (quality is in the process of being incorporated into the funds flow model). Additionally, the PPS has provided resources through HANYS to assist with the transformation process including provider education and weekly webinars and 1:1 meetings. HANYS and the PPS have both worked to ensure that the PCMH sites each have a physician champion for the PCMH project to continue to gather support and ensure continued work towards the goal of continued health transformation.

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:	17
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:	28

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	203

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:

Primary Care is essential to the success of the care continuum and healthcare transformation and providing holistic care. The PPS is supporting primary care initiatives to ensure PCMH certification, RHIO connectivity, assistance with EHR selection, and best practices for referrals and managing patients in the primary setting as opposed to emergency care when clinically feasible. In addition to the infrastructure support provided to the PC providers, the PPS has engaged in several initiatives that compliment primary care, including trainings for partners on health home referrals, embedded health home navigators in the ED, and utilizing the MAX series to reduce high utilization of the ED and inpatient services. The PPS has also funded CBOs, QCCP Health Home, and ELMCOR OASAS provider to educate providers on health home services and assessing for and securing patient services for patients debilitated by substance abuse.Technology also plays a central role in the PPS strategy for primary care. The PPS is working with partners to connect to the RHIO and is in the process of rolling out a secure messaging system, Cureatr, so that partners can be notified when a patient is admitted to the NYP Queens hospital in real time. This will allow for better communication and improved care coordination between the hospital and primary care sites. Partners are also in the process of creating registries and trackers for patients based on the DSRIP project requirements and/or PCMH standards. These trackers allow providers to begin looking at quality measures for their patients and will help with the transition to VBP.

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:

Obstacles to the implementation of the integrated delivery system vary from required cultural changes to obtaining practitioner buy in. Queens County is the most diverse in NYS and therefore patients utilizing the partner services in the network hold diverse opinions and beliefs on the how the health care system factors into their care decisions and utilization of services. The PPS is working with partners to help educate patients on the importance of utilizing primary care as opposed to the ED for non-emergent services and helping to link vulnerable populations to the appropriate care providers. This education spans not only the care setting but also the types of care provided, such as palliative care discussions and the importance of home care, and health homes when referrals are made. The PPS is continuing to utilize and fund CBO partners, such as AIDS Center of Queens County and FQHCs to provide peer education and provider education to help patients better understand the role of the providers in their care. All of these are fundamental to the continuum of care of which primary care is central.

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?

The PPS is continuing with the strategic plan outlined in the primary care plan and is working to tailor educational series and trainings for both providers and patients based on the qualitative focus groups from the community needs assessment. These education initiatives include training providers on palliative care through EPEC and the use of the eMOLST tool. These sessions include training on how to speak to patients about palliative care and the cultural and/or faith based beliefs patients may have that impact these types of discussions. The goal of the primary care strategy is to create an integrated delivery system with patient focused primary care at the center. In addition to the educational initiatives, the PPS is collaborating with the hospital to focus on reducing high utilizers and readmissions through the MAX series and integrating health home staff into the ED to enroll patients, clinical providers to implement PPS projects across the disease states including HIV, pediatric asthma, and cardiology, and working to connect partners with CBOs in the network to ensure seamless care transitions from the hospital to outpatient to home settings.

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:

The PPS has partnered with NYC Reach to identify partners that do not have a MU certified EHR and provide education and support on implementing an appropriate vendor. The PPS is providing onsite IT project management to support partners with IT interconnectivity required for MU. It has also been the intermediary between the PPS partners and the regional RHIO. Through its onsite support, the partners have been able to gain knowledge about MU and develop strategies.

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):

The PPS supports RHIO connectivity across the PPS network. The PPS chose RHIO connectivity as an EIP measure and utilizes those earned dollars to cover RHIO connectivity costs. Additionally, the PPS PMO has a resource that does site visits to partners and helps navigate the process of connecting to the RHIO in collaboration with a Healthix representative. The funds flow model of the PPS provides financial incentives for all providers who have signed agreements with QE's in order to offset start-up costs of health exchange processes.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	42

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	93%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	27%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	73%

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:

The PPS conducted a VBP readiness and needs survey of the network to identify needs for training. The PPS is in the process of creating a VBP training curriculum that will be rolled out in DY3. Based on the results of the survey, the PPS anticipates providing training to partners on VBP 101 and Assessment and planning including metrics and analytics. Additionally the PPS plans to leverage the GNYHA VBP curriculum that is in development, the NYS DOH VBP University tools and boot camps, and MTAC/CTAC behavioral health trainings. The PPS aims to create a resource center and document repository on the NYP Queens PPS website to provide partners a central source to access VBP materials. The PPS also aims to host a VBP learning collaborative in the later years of DSRIP to share best practices, barriers to success, measures and analytics, and other topics requested by the partners and participants.

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

Challenges for the PPS VBP readiness include ensuring alignment with the NYP system for the hospital and well as the legal regulatory limitations of the PPS role in VBP discussions. The NYP Queens PPS is collaborating with NYP PPS to ensure that the DSRIP VBP strategy is aligned with the system strategy for payment reform. Additionally, as a collaborative contracting model the PPS has limitations in terms of the role it can play in helping partners to negotiate and contract with MCOs. The PPS plans to be an educational hub for network partners to meet the needs discovered in the VBP readiness survey.

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 PPS has made no strategic changes to date for this fundamental, but will be evaluating the strategy based on partner feedback of the VBP trainings implemented in DY3.

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:

The PPS will be providing training for partners for VBP beginning in DY3 and aims to provide data to partners to enable them to engage MCOs. The PPS is a collaborative contracting model and therefore is limited in the role that it can play regarding VBP and MCO negotiations and contracting. Therefore the PPS aims to provide education and act as an expert and resource to partners and provide data from DSRIP that partners can utilize in these individualized discussions.

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 PPS is supporting the integration of CBOs into the PPS framework and helping to foster new connections between partners and CBO organizations. Partner CBOs are a critical part of the PPS governance process and are members and chairs of the project committees they participate in. The integration of the CBOs into the PPS has enable relationships to develop between CBOs and partners that did not previously exist; examples include the Asthma Coalition of Queens (ACQ) working closely with St. Mary's Home Care to address pediatric asthma needs through training on asthma and patient and family education on the important role home care plays. These relationships are foundational to moving towards financial and quality relationships through VBP. The PPS will continue to bring collaborators together for both quality improvement and project implementation and the VBP education process. The PPS will be launching its VBP training program, based on survey needs, in DY3. The training schedule includes trainings specific to CBOs and behavioral health providers and will provide information for providers to help understand the shift to VBP from fee for service and the progress of moving from level 0 arrangements to advanced arrangements in levels 2 and 3.

f. Additional Questions

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

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

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

…If yes, describe: Click or tap here to enter text.

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

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

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

The NYP/Q PPS funds flow model supports primary care physicians with a multi-faceted approach to ensure engagement, alignment with project implementation, and focus to quality based outcomes. The funding to primary care providers for the following categories account for 30% of the total funds paid to network partners (not including the cost of implementation expense).

Non-Covered Services – Primary care providers are included in the non-covered service funding metric to compensate for clinical processes that have been implemented but currently have no form of Medicaid reimbursement. Patient access to blood-pressure (BP) checks without a designated appointment, to identify acute hyper/hypotensive issues is an example.

Incentives: Project Requirements - Project requirement milestones are an incentive based funds flow metric that are paid to primary care providers based on the achievement of pre-defined DSRIP standards. Each project milestone is communicated to committed providers and clinical committees who work with providers to ensure full implementation of the requirements. Primary care providers receive incentive funding within this category based on their individual achievement of outlined milestones.

Cost of Implementation: Project Requirements – Understanding the need for support with large strategic initiatives, the PPS designated funds to support primary care providers by engaging HANYS to implement the 2.a.ii. Requirements for PCMH certification.

Incentives: Quality Outcomes – The PPS funds flow model incentivize primary care providers to achieve quality based outcomes, similar to that of a value-based payment arrangement for primary care providers related to ambulatory and facility based indicators. Providers are paid based on target achievements.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$1,586,919.70	**100%**
Primary Care Provider	$313,874.00	20%
Hospital-Ambulatory Care	$245,767.00	15%
Federally Qualified Health Centers (FQHCs)	$22,062.00	1%
Primary Care Practitioners	$46,045.00	3%
PMO Spending to support Primary Care	$254,000.00	16%

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?
The PPS in the process of making 2 strategic changes to the way in which providers are incentivized. The first change is to incorporate quality into the funds flow distribution process. The PPS is working to build a mechanism for distributing funds to partners who meet the quality measures for the PPS. The PPS aims to have this integrated into the funds flow model by the end of DY3, Q3. Additionally, the PPS has been setting aside funds from each payment that it has received for project requirements. The PPS will begin to distribute these dollars to providers as they complete their requirements, such as achieving PCMH certification, in DY3.

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):

In addition to the project committee meetings for the 3.a.i project with partners, the PPS is working on agreements to contract with partners to provide sessions at co-located sites. NYP Queens hospital is working on a business plan to ensure sustainability of the integrated ambulatory care clinics for the hospital. While the dynamics of integration and implementation are being worked through, the PPS project committee has been approving best practices for these integrated sites and provided training materials on best practices including PHQ-2/9, post-partum depression screenings, SUD screening, cholesterol and lipid screenings and more. The PPS is preparing partners to ensure staff are trained and workflows in place for when the integration of care is implemented. Additionally, partners are in the process of recruiting staff which will take time as there is a shortage, specifically of behavioral health providers, across the state.

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 PPS is in the process of implementing co-located services at primary care and behavioral health sites. The PPS continues to face challenges with the recruitment of behavioral health practitioners to provide sessions in the Article 28 primary care sites. The PPS strives to ensure sustainability and is looking at both billable and non-billable providers to ensure that the practitioners that will be co-located can continue to sustain their sessions post DSRIP.

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 PPS faces several issues specific to regulatory limitations for this project. The PPS is in the process of evaluating the regulations for partners at Article 31 sites to integrate with Article 28 providers. The regulations require specific space needs that may require capital costs (DSRIP funding is not able to be used for capital costs) and many providers did not receive capital funding from the DOH RFP process for these projects. In addition to capital needs, the PPS is evaluating the billing regulations for having integrated care including what licensure types are billable for which populations and the dynamics to ensure that the providers are both reimbursed at 100% for services rendered.

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?

The PPS is in the process of reevaluating the staff recruitment strategy for the integrated sites (project 3.a.i). There is a known behavioral health provider shortage across NYS and the PPS is evaluating what provider types are needed to successfully create integrated care sites within the PPS and create a sustainable model. The PPS originally was interested in recruiting LCSWs for the primary care sites but is currently revisiting this strategy. The PPS is now considering hiring billable providers, including psychiatrists and behavioral health NPs, for the adult ambulatory PCMH clinics. These licensed providers are billable and therefore ensure a sustainable business model as the dynamics of VBP and post DSRIP waiver are worked out. The PPS continues to look to hire or partner with LCSWs for the pediatric and OB sites as they are able to bill for these services

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	3	0	0

Model 2	3	0	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