

Primary Care Plan Update 2017

North Country Initiative

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.

The PPS Primary Care Plan strategy remains consistent with a stronger focus turning towards preparing partners for value-based contracting. The PPS will continue to support provider NCQA Level 3 PCMH 2014 implementation, invest in provider recruitment, contract for care management teams, facilitate standardization of policies and procedures, and maintain a governance structure led by clinicians. However, the PPS is looking toward value-based contracting as a sustainability mechanism for the infrastructure investments made possible through DSRIP funding.

The PPS is currently exploring options to become a contracting entity, engaging a consultant to help develop a strategy and build a contract that would work for the region. Value-based payment training for providers will be a priority, leveraging the existing training resources (NYS DOH, MCTAC, etc) as well as providing more targeted trainings to fit the needs of the region.

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:

Standards for PCMH 2014 Level 3 recognition require extended hours or after-hours availability. As of March 31, 2017, 6 of the 40 participating primary care sites had received their recognition with 1 additional site awaiting recognition. All sites have an individualized plan and timeline for submission, all on track to receive recognition by 3/31/2018.

The PPS is also supporting the development of a new Family Medicine Residency Tract for Graduate Medical Education which will provide an opportunity for medical graduates to train in a rural region, fostering collaboration between each of the 6 partner hospitals and 2 FQHCs.

Additionally, in an effort to support primary care performance, the PPS secured and awarded 4 Certified Diabetes Educators, a consulting psychiatrist, and a tobacco cessation expert to ensure primary care sites have interdisciplinary teams. These teams aim to improve primary care capacity by providing primary care providers with resources to improve workflow and patient outcomes.

Finally, the Provider Incentive Program has continued to close the gaps in primary care access. While the Regional Community needs Assessment identified a shortage of Primary Care Physicians, Nurse Practitioners, Physician Assistants, Psychiatrists and Psychologists who are positioned to provide care for Medicaid patients, the incentive program has filled a large need by resourcing recruitment dollars for 11 PCPs, 2 NPs, 3 PAs, 2 Dentists, 2 Psychologists, and 2 Psychiatrists. A third year of the program will run from April 1, 2017 – January 31, 2018 to continue to close the gaps in primary care access.

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

The primary care capacity continues to be a challenge for the region, many areas of which have been classified as Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSA) for primary care. The Provider Incentive Program for DY3 had significantly less funding than the program in DY1 (\$1,067,000) and DY2 (\$1,500,000). Therefore, the NCI Finance Committee and Board of Managers approved a 60% increase to the available funds to support the program in DY3 (\$800,000), which started taking applications on April 1, 2017.

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 continues to make progress towards the strategic approach to expand primary care capacity. Immediate impact has been recognized by the recruitment efforts possible through the PPS Provider Incentive Program. The 3-year PPS Provider Incentive Program was designed to grow primary care capacity and expand availability of vital services. Through DY2Q4, nearly \$2.4 million had been distributed to primary care providers.

Investment in the region's Graduate Medical Education as well as transformation to NCQA Level 3 PCMH 2014 remains the strategy to ensure sustainability of primary care capacity.

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

The PPS continues to keep community-based Primary Care Providers engaged despite the 5% non-safety net funding limitation. The PPS is committed to distributing incentive payments twice per year as well as finding opportunities to contract with and provide support to these providers. This includes support to build Compliance and Security plans, PCMH implementation, PPS training, and utilization of PPS-contracted care team members including Care Managers, Behavioral Health Peer Supports, Community Health Workers, and Certified Diabetes Educators.

Community-based Primary Care Providers see the value in participating in a clinically integrated network as the region looks to move towards value-based care and contracting.

<i>Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:</i>	22
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e. Additional Information

<i>Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:</i>	81
<i>Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:</i>	16
<i>Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:</i>	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 continues to provide each partner practice with PCMH coaches and Certified Content Experts (CCEs). All participating practices remain on track to transform, submit, and receive PCMH 2014 Level 3 recognition by the 3/31/18 deadline. The original projection of sites participating has decreased from 42 to 40 due to a primary care practice closure and another practice removing itself from Project 2.a.ii. As of March 31, 2017, 6 of the 40 participating primary care sites had received their recognition, 1 additional site was awaiting recognition and the remaining 33 sites were in implementation stages.

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:

NCQA PCMH 2014 standards are very robust and can be a tremendous amount of work for a practice depending on staff allocations, technical infrastructure, and the ability to promote transformation in a quick manner. Dealing with many different EHR platforms has proven to be difficult. The technical capabilities of some lesser used platforms create challenges around building and running reports. Smaller practices have had a hard time designating the necessary staff time to meeting the requirements given their additional responsibilities of daily practice activities.

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 remains committed to assisting all Project 2.a.ii partners in meeting Meaningful Use and NCQA Level 3 PCMH 2014 by the end of DY3 to ensure all Medicaid populations within the PPS have access to advanced primary care. The PPS has dedicated personnel and incentive dollars (\$1.325 million) to drive the success of this transformation.

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

The most effective strategy has been to deploy PCMH Coaches and CCEs to be on the same level as the practice to help promote transformation yet allow them to own the change. These coaches have assisted with not only the technical challenges but have shown the practices the benefits that transformation has on overall patient care. Creating an individualized plan and timeline for each site was also very successful, yet challenging, requiring constant communication among all involved.

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>	9
<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>	0

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

89

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:

NCI continues to be a hospital capitalized, physician led organization operating with a Delegated Model of governance. The PPS, its governance committees, and its partners have placed a large emphasis on care coordination. NCI has signed 18, 3-year contracts to resource care managers in the primary care setting for a total investment of \$2.25 million. To ensure meaningful linkages to secondary and tertiary services, the PPS has contracted to expand the care teams to include care management from the hospital setting, Behavioral Health Peer Supports, Community Health Workers, and Certified Diabetes Educators. In addition, all Project 2.b.iv participating partners have adopted standardized 30-day care transition protocols by 3/31/17. Finally, the PPS promotes strengthening the continuum by hosting two monthly collaboratives to drive networking and education among those involved in patient care.

Further, the integration of primary care and behavioral health has been central to bridging gaps in the PPS' healthcare spectrum and effectively creating an integrated delivery system. Of the 40 primary care sites, 31 have pursued the integration of primary care and behavioral health through Project 3.a.i. By March 31, 2017, 26 primary care sites successfully streamlined care through integration and are now providing behavioral health services on site.

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

The rural population in the PPS region proves challenging for implementing an integrated delivery system as the rural landscape has led many areas of the PPS to be labeled as Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSA). Additionally, existing resources within primary care practices were leveraged to build a care coordination model to fit the rural community it serves.

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 strategy continues to be strengthening the region's care coordination as well as fulfilling DSRIP projects that impact integrated care across the healthcare spectrum, including the Medical Village and the Integration of Behavioral Health and Primary Care projects. Using the platform that has been built, the PPS will develop goals to use care management to improve on select DSRIP performance measures.

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 assisted 65 providers attest for Meaningful Use Stage 2 for the 2015 year and an additional 14 providers attested for Meaningful Use for the 2016 year. EHR implementation has been completed for partners prior to DSRIP. However, assistance has been provided in the form of connecting EHR's to the PPS funded Population Health Tool, Lightbeam®. As of March 31, 2017, 32 sites were in production and 7 were in validation stages of connecting to Lightbeam®.

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 has promoted connection to the RHIO, HealtheConnections (HeC). The PPS acts as a liaison between practices and HeC and educates partners on functionalities of the RHIO which can increase efficiencies and effectiveness of the practices. 100% of the PPS primary care partners have signed participation agreements with HeC, over 80% of the partners who are capable are sharing data and 85% are receiving data through their EHR interfaces and portal access.

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

89

f. Additional Information

<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:</i>	10, 43.5%
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:</i>	4, 17.4%
<i>Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:</i>	6, 26.1%

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:

Technical assistance on contracting and data analysis: The Value-based Payment Baseline Assessment was based on responses from two partners surveys. To follow-up the 2016 survey completed by all partners, a 2017 survey was conducted specifically for primary care and behavioral health partners. This survey further expanded the baseline to understand current state of managed care contracting to determine which payers, by plan type, were establishing or interested in establishing value-based arrangements with PPS partners. These two surveys were then used to develop the NCI Board approved VBP Support Implementation Plan that was due 6/30/2017. The PPS enhanced it's VBP Committee from 8 members to 12, including a community-based primary care provider. The committee conducted a roundtable session in January 2017 from which, the PPS was tasked with identifying a subject matter expert around VBP strategy and contracting.

Creating transition plans: All partners participating in Project 2.b.iv have adopted and implemented 30-day Care Transition Protocols. In addition, Care Collaboratives have been formed as a mechanism for networking, education, and the review of case studies.

Addressing workforce needs: NCI began accepting applications for their Licensed Clinical Social Worker (LCSW) Transition and Recruitment Program October 1, 2016. This program awarded \$235,000 to partners in recruiting and growing their own LCSW-R. The DY3 Provider Incentive Program was funded at 60% more than originally budgeted and the program started accepting applications on April 1, 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:

Technical assistance on contracting and data analysis: The PPS continues to implement the Population Health Management Tool, Lightbeam®, for aggregate real-time clinical data. As of March 31, 2017, the tool anticipated a "Go Live" date in April 2017.

Creating transition plans: Care transition will continue to be a focus among the PPS and its' partners. A current state analysis was done to gain a baseline of how transition of care was being performed, identifying gaps in care. The PPS will continue to evaluate transition of care processes to compare to the baseline and look for areas of improvement.

Addressing workforce needs/Behavioral Health integration: The DY3 Provider Incentive Program will begin accepting application on April 1, 2017 for awardees to recruit providers by 1/31/18. Applications submitted to address integration of primary care and behavioral health will be prioritized due to the current challenge among Model 2 sites to resource a primary care physician.

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?

While the strategy remains consistent to provide technical assistance, create transition plans, address workforce needs, and integrate behavioral health with primary care, the PPS is strongly pursuing the formation of an IPA. The IPA would enable primary care partners to participate effectively in value-based payment arrangements.

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:

As outlined in the NCI Board approved VBP Support Implementation Plan, the PPS continues to invest in the infrastructure required to support value-based contracting including a care management platform, PCMH coaches to assist practices in reaching NCQA Level 3 PCMH 2014, and a Population Health Tool. In addition, the PPS is moving forward to form an IPA, engaging with a consultant around VBP strategy and contracting. Furthermore, trainings will be conducted around DSRIP quality measure data and performance, indicating value not only based on DSRIP performance dollars but also on potential for value-based contracting.

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):

Based on the 2017 value-based payment survey, no PPS primary care providers are in level 2 & 3 arrangements however, over 40% indicated engagement with Tier 1 Community-Based Organizations. In addition, the Care Collaboratives have brought primary care practice care managers together with partner CBOs to address social determinants of health. Finally, the PPS plans to offer training opportunities regarding the Bridges out of Poverty framework, effectively creating champions for change in PPS entities. The PPS plans to send a select group of partners to become Train-the-Trainers in December 2017.

f. Additional Questions

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

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

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

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

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

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

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

The PPS Phase 2 Funds Flow Procedure is a multifaceted approach to distribute incentive funding to each active PPS partner. It takes into consideration each participating site, DSRIP project participation, site type (i.e. primary care practice), the impact that site type has on project outcomes, and impact of Medicaid population (measured by billable visits for safety-net partners and number of full-time employees for non-safety net partners). Partners are paid two times per year for reaching performance measures and achieving patient engagement targets. In addition, primary care sites participating in project 2.a.ii will receive a lump sum payment for reaching NCQA Level 3 PCMH 2014. Safety net sites will receive \$50,000 for the first site and \$25,000 for additional sites. Non-safety net sites will receive \$25,000 for each site.

Outside of the incentive funding, primary care sites are eligible to receive direct funding for provider recruitment. The 3-year PPS Provider Incentive Program was designed to grow primary care capacity and expand availability of vital services. Through DY2Q4, nearly \$2.4 million had been distributed to primary care providers.

Tier 2 funding to primary care providers through PPS contracting for care management has brought an additional \$684K to primary care providers in the PPS through DY2Q4. Additional PMO spending has benefited primary care providers including PCMH support, compliance and security support, care team members (Behavioral Health Peer Supports, Community Health Workers, Certified Diabetes Educators), Psychiatric consultation, and workforce training.

<i>b. Funds Flow</i>	<i>Total Dollars Through DY2Q4</i>	<i>Percentage of Total Funds Flowed</i>
Total Funds Distributed	\$9,413,727.66	100%
Primary Care Provider	\$4,020,215.27	42.7%
Hospital-Ambulatory Care	\$2,710,918.04	28.8%
Federally Qualified Health Centers (FQHCs)	\$929,535.82	9.9%
Primary Care Practitioners	\$379,761.41	4.0%
PMO Spending to support Primary Care	\$684,000.00	7.3%

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 funds flow model adopted by the PPS has remained consistent and is approved through the remainder of the DSRIP program. The current model directly rewards performance for both patient engagement as well as performance measures.

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):

Of the 40 primary care sites, 31 have pursued the integration of primary care and behavioral health through 3.a.i. Models 1 and 3. By March 31, 2017, 26 primary care sites successfully brought behavioral health services on site. The PPS supported this initiative with investment of \$235K in LCSW-R recruitment and growth. Currently all of the PPS's DSRIP 3.a.i Model 1 sites have obtained a Behavioral health provider to complete integration.

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

3.a.i Model 2 sites have found it challenging to recruit and contract primary care providers, a challenge for the region as a whole. The DY3 Provider Incentive Program will focus on the needs of these sites and prioritize awards to address this challenge.

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 DOH and OMH have raised Licensure Thresholds as a result of DSRIP Project 3.a.i permitting our providers to integrate primary care and behavioral health services under a single license or certification as long as the service added is no more than 49% of the provider's total annual visits. While this is currently not a regulatory issue due to the approved waiver, the PPS is concerned at the sustainability of integration post-DSRIP should these thresholds not maintain current levels allowed under the waiver.

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?

Overall, the strategic components to expand providers, provide access to care, train/educate, streamline clinical standards, and analyze behavioral health needs of the region continues to be the strategy of the PPS. However, much of the focus is now on analyzing and planning. With most partners integrated, the PPS and partners are analyzing the DSRIP performance measures and working together to optimize their workflow to make a positive impact on performance and care for their patients.

<i>e. Model</i>	<i>Number of Sites Planned</i>	<i>Number In Progress</i>	<i>Number Complete</i>
Model 1	25	0	25
Model 2	3	3	0
Model 3 IMPACT	5	0	5

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