Primary Care Plan Update 2017

Staten Island 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.

Strategic changes related to the Primary Care Plan include:

1) Expanding engagement of community-based primary care practices:
   a) Engaged new practices in the Population Health Improvement Project
   b) Supported additional practices for PCMH transformation technical assistance
   c) Increased behavioral health detailing to primary care providers
   d) Provided on-site technical support for population health data extraction from EHR
2) Identifying new training needs
   a) Developed PCP medical home and population management training through xG Health Solutions
   b) Expanded Lean training opportunities for building efficiency and sustainability of transformation
   c) Planning borough-wide training/engagement symposiums
   d) Incorporating PCPs into the VBP Plan

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 indicated in the initial Primary Care Plan, the PPS and State DOH analyses did not identify any primary care capacity issues. Practices within and outside of the PPS network have continued to expand primary care services on Staten Island. Richmond University Medical Center has absorbed community-based PCPs and opened new primary care centers. Community Health Center of Richmond is continuing to expand its footprint. Project Hospitality is exploring FQHC status with NYU/Lutheran to expand its clinical scope. The PPS' support of PCMH transformation has ensured that primary care practices offer extended hours and make clinical advice available 24/7. In order to support PCMH transformation, the PPS contracted with two technical assistance vendors (HANYS and NYC REACH) to support 8 practices and supported the vendor cost for two additional practices for a total of 10 practices across the borough. The PPS has also begun to collect data on length of time to get an appointment with PCPs through its Care Transitions project and Patient Activation project in order to address any capacity issues identified.
The PPS is working with managed care plans in order to decrease credentialing burdens on primary care providers who seek entry into behavioral health settings.

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

PPS behavioral health partners have experienced regulatory challenges to integrating primary care. These challenges have limited their success in building primary care capacity in their organizations. See Fundamental 6, Section C for more details.

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

The PPS is expanding its support of Lean training. By training front line staff and managers on Lean, the primary care practices can be empowered to increase efficiency and subsequently increase capacity in their organizations and better meet the needs of patients.
In order to address performance, the PPS contracted with xG Health Solutions to develop PCP training focused on medical home concepts and chronic disease population health management. These online training modules are being rolled out to physicians and nurse practitioners in the network.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:	
The PPS and its various partners have engaged community-based PCPs through a variety of efforts including: 1) Inclusion of PCPs in project implementation and performance focused workgroups 2) Offering PCMH technical assistance 3) Providing training opportunities for PCPs and their practice staff 4) Funding and facilitating a nutrition education program and asthma home visit program 5) Incentivizing PCPs to adopt evidence based guidelines and focus on specific population health concerns like asthma, diabetes, cancer and share outcome data with the PPS through the PHIP program	
Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	71

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:	149
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	46
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 contracted directly with two PCMH technical assistance vendors for the primary care practices that have master service agreements.
1) HANYS was brought on to work with the nine partners participating in projects (3.a.i, 3.c.i) that require NCQA PCMH 2014 Level 3 recognition. Three practices chose not to use the vendor and three practices had already executed their own contracts with a technical assistance vendor. The remaining three practices received technical assistance from HANYS. As of March 31, 2017, five partners had achieved recognition and four practices were still in the process of PCMH transformation.
2) NYC REACH/PCIP was contracted to work with a subset of five community-based private practices that are participating in the Population Health Improvement Project (4.b.ii). As of March 31, 2017, the contract had just been executed with technical assistance set to begin in April. Two additional private practices contracted directly with alternative technical assistance vendors with PPS funding to off-set the cost.

Through its workforce transformation efforts, the PPS supported trainings in line with NCQA PCMH expectations. These trainings included motivational interviewing, care coordination, cultural awareness, and health literacy. The PPS also collaborated with NYC REACH/DOHMH to co-sponsor a Practice Transformation Symposium. The symposium, attended by 43 people,addressed PCMH, AIU and Meaningful Use, and the integration of primary care and behavioral health.

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 encountered few challenges in working with practices to achieve PCMH recognition. Practices with a diverse payer mix felt less of a financial incentive to participate in the intensive PCMH transformation process because few private insurance plans have incentive payments like Medicaid. One specific challenge is small practices, 1-3 providers, have limited bandwidth to champion PCMH and develop the necessary policies, processes, and workflows.
The PPS did not pursue APC for practices during this time period. Because of the delay in APC development, the PPS chose to guide practices toward NCQA recognition in order to meet State DOH milestones and deadlines.

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 is expanding its support of Lean training. By training front line staff and managers on Lean, the primary care practices can be empowered to increase efficiency and subsequently increase capacity in their organizations and better meet the needs of patients. A more efficient workforce and primary care practice can result in additional staff time to implement patient-centered medical home processes like staff meetings, proactive outreach to patients due for services, quality improvement initiatives, etc.
The PPS also enhanced its training offerings by collaborating with xG Health Solutions to create PCP focused population health management trainings. These trainings will contribute to the transformation of the medical workforce, a group that most trainings do not target. The trainings are web-based and can be completed by PCPs outside of practice hours so that it does not disrupt time with patients. The use of online trainings helps to address the bandwith issues that have been a challenge to date in engaging PCPs.
While staff time has been a challenge, the PCMH technical assistance will ultimately move the practices from paper-centric/phone-centric service to self-serve automated solutions. Practices are trained in the use of automated patient reminders, registry-assisted panel creation for population health initiatives as well as use of templates for documentation. Practices using Patient Portals have freed up staff time that normally would be on the phone addressing requests for appointments/prescriptions/referrals.
Lastly, the SI PPS data team has been creating Gaps in Care Reports to provide practices with actionable data on patient utilization, thus saving practices time in addressing hospital and ED utilization that they would not have otherwise had easy access to.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
The PPS used three strategies to support transformation, all of which were found to be effective: 1) Funding technical assistance vendors to manage the PCMH transformation and recognition process. Technical assistance vendors are able to provide content expertise, guidance, training, and application assistance. 2) Providing incentive payments to practices that achieved PCMH recognition. These PPS incentive payments help to off-set the cost of staff time involved in the transformation process and application development. 3) Offering trainings that align with PCMH transformation. The PPS funded local in-person and on-line trainings to support the fundamentals of being a patient-centered medical home (ie. xG Health Solutions, motivational interviewing, care coordination, etc.).

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:	54
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:	14

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	195

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:

Despite its exemption from creating an integrated delivery system, the Staten Island PPS has still made strides toward creating meaningful linkages between primary care and secondary and tertiary services. The PPS workgroups and committees have continued to be an interdisciplinary forum for all engaged partners to have a literal seat at the table and contribute to project implementation and performance improvement efforts. PPS trainings have brought together staff from various sectors of healthcare for an opportunity to learn from trainers and from each other. SI CARES (Health Home At-Risk, 2.a.iii) continues to play a significant role in coordinating patient care between primary care, hospital, behavioral health, etc. The majority of patients benefiting from SI CARES have been managed through Coordinated Behavioral Care which has allowed for the PPS to push for standardized processes and performance indicators. From an HIT perspective, the PPS has funded RHIO connectivity for primary care practices and skilled nursing facilities, thus enhancing the communication and data sharing capabilities of the providers. The PPS data analytics team has continued to enhance its reporting capabilities. New reports were developed to track the gaps in care for patients and performance of all partners serving those patients to identify opportunities for improvement. The continuing care element of the delivery system has been strengthened by the 3 projects in which they are participating, especially evidence based practices, reduction in ER and hospital utilization as well as home care continuum via the care transitions program.

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:

Due to the nature of the health system on Staten Island and potential anti-trust issues, the PPS cannot implement an integrated delivery system and was exempt from project 2.a.i.

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?

Towards the end of DY2, the PPS began efforts to improve communication between PCPs and other providers in the medical neighborhood. One area of work has been to develop relationships with the urgent care centers on Staten Island. With so many PCPs working in small practices with limited hours, the urgent care centers are a critical part of the care continuum and communication between urgent care centers and PCPs can be very limited. In December 2016, the PPS began to explore how best to partner with the urgent care centers and facilitate relationship building. Also during this period, the PPS began an effort to have community-based PCPs approved for emergency department notifications from the two hospitals. The hospitals have sophisticated notification systems for when patients present at the ED but these systems are not accessibly by all PCPs. The PPS anticipates that this focus on communication will assist in the creation of meaningful linkages even if the PPS cannot create an integrated delivery 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:

This is not applicable. Implementation of EHRs was a requirement for primary care practices to enter into a master services agreement with the PPS. The PPS has not been supporting practices in reaching Meaningful Use Stage 2. All practices that participate in projects requiring MU certified EHR systems already had certified EHRs in place or contracts in place to implement certified systems.

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 funded the connection to Healthix, the local RHIO, for the three required primary care practices that were not already connected. In addition, the PPS has collaborated with both Healthix and partners to implement the new community consent process. By achieving the production environment for its HIT platform the PPS can now share with the RHIO roster data to facilitate event notification and care plan exchange.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	89

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	21, 14.1%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	6, 28.6%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	15, 71.4%

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 engaged consultants to facilitate the creation, distribution, and analysis of its second VBP needs assessment (commonly knowns as the SI PPS VBP Survey) which is considered foundational to the PPS VBP strategy. Further to the survey distribution (in electronic format), the PPS and its consultants conducted a series of in depth field interviews with a cross-section of the SI PPS collaborating partner network. The field interviews specifically targeted, among other constituencies, independent physician practices and CBOs. The PPS felt it was important to speak with providers and CBO leadership at their sites of constituent interaction to better understand providers' needs as VBP payment systems roll out. The PPS VBP Support Plan, inclusive of its VBP Education Schedule, will include training and education sessions directed toward PCPs after it builds a common understanding about VBP for its entire collaborating partner network. The PPS wants to be sure that its collaborating partners understand that the evolution of VBP means that financial opportunity is directly linked to accepting, identifying, and effectively adjudicating risk at the population level. Beyond introductory material, or "VBP 101," the PPS will offer trainings on VBP mechanics and metrics against which transformational efforts will be measured. This will be followed by the need for and importance of data analytics capacity. Finally, the roles of PCPs in Population Health will be explored (as well as CBO and Behavioral Health) through training/education sessions specifically targeted to such providers. VBP education sessions will be offered every quarter, alternating between in-person and webinar sessions:
VBP 101: 2017 Q4 – 2020 Q1, VBP Mechanics: 2018 Q1 – 2020 Q1, Data Analytics: 2018 Q2 – 2020 Q1, Role of PCPs in Population Health: 2018 Q3 – 2020 Q1, Role of Behavioral Health in Population Health: 2018 Q3 – 2020 Q1
Role of CBOs in Population Health: 2018 Q3 – 2020 Q1
The schedule will begin with VBP 101 with additional programs rolled out in a staggered formation.

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

The VBP needs identified in the PPS VBP Survey are as follows:
1. There is a lack of common definition for "Value Based Payment" and "Population Health".
2. There is a lack of common understanding about VBP mechanics and the metrics against which transformational efforts will be measured.
3. There is a lack of consistently articulated Population Health goals and Quality Measures.
4. The survey recipients told us that there are an array of quality measures – none of which have consistent reporting requirements. This causes confusion and, most importantly, heretofore unrealized costs to the providers as these overlapping Federal, State, and PPS driven quality requirements converge on providers.

The first three needs are of no surprise and appear to be of equal need for all PPS partners. The last need, however, relative to the array of quality measures associated with reporting requirements is especially burdensome for the PPS primary care providers. Many PCPs in the PPS network do not have the capacity to analyze population health data in general. Thus data analytics capacity is the greatest challenge, especially for small practices. In small practices, the required behavior change to adopt new data practices is significant. Hence the reason the PPS will spend so much time on delivering a strong arguments for WHY population health is so important. Further exhausting the challenge that is data analytics capacity, is the wide range of EMR platforms and MCO requirments. To this end, the PPS has created Gaps in Care reports that reveal opportunities to improve on population health measures for each partner, including PCPs. As mentioned in the previous Primary Care Plan, the small scale of many PCP practices hamper engagement with MCO's. This will be discussed in more detail in the next section (4.c).

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 previous Primary Care Plan update outlined a three-pronged strategy to provide (i) infrastructure in data management, (ii) quality outcome standards and (iii) eventual contracting facilitation. Progress towards the first two are evident in the PPS VBP Support Plan, specifically relative to the VBP Education Schedule as described above briefly. With respect to the later, engaging MCO's has been the single greatest challenge in PPS VBP readiness efforts overall. The PPS has made strides in engaging MCO's, but much of the progress to report has occurred after March 2017. However, during the period January through March 2017 the PPS made concerted efforts to engage MCO's for the sake of managing population health measures by identifying gaps in care via reports targeted to each MCO. As these relationships grow, it is our hope that the PPS relationship with MCOs will facilitate VBP contracting for PCPs in the future. In terms of evaluating a Medicaid ACO program, the PPS has tapered efforts towards such a goal and widened the potential future state scope to become a data surveillance organization in general. This includes the potential to become a Medicaid ACO – at the far or high end of the spectrum – but also includes becoming a population health support organization at a minimum – similar to an MSO. As the Department continues to communicate the future direction of VBP statewide the PPS will be abe to adopt the most suitable and sustainable future state business model.

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 mentioned above, it has been challenging for the PPS to engage MCOs. During the period January through March 2017, the PPS reached out to each MCO to set-up in person meetings. The PPS was able to engage several MCOs and provide a presentation of data analytics capabilities and gaps in care reports specific to each MCO patient population associated with the PPS collaborating partner network. As a result, a handful of MCOs have further engaged. The PPS will report on such progress in the next Primary Care Plan Update relative to the time period after March 2017. Ultimately, the PPS acts as a convener and educator to support PCP engagement for VBP contracting. The VBP education strategy will include the following modules: VBP 101, VBP Mechanics, Data Analytics, Role of PCPs in Population Health, Role of Behavioral Health in Population Health, and Role of CBOs in Population Health. The schedule will begin with VBP 101 with additional programs rolled out in a staggered formation. SI PPS is aiming to release this training module in early 2018. Partners would be cross-trained on the role of various provider types. For example, PCP's would be provided with training for their role in Population Health and VBP, but also trained on the importance of CBOs and Behavioral Health organizations. This cross-training will help to promote a more collaborative, knowledgeable partner network.

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 has not yet focused its efforts on supporting Primary Care providers in moving toward levels 2 & 3 VBP arrangements. The PPS has been more focused during this time period on the small community-based primary care practices who are in the most need of support to achieve level 1 VBP arrangements. In terms of engaging Tier 1 CBO's, the PPS VBP Support Plan and Education Schedule has an emphasis on social determinants of health and two Tier 1 CBO partners were invited to participate – and subsequently joined – in the PPS's VBP Workgroup to help shape the PPS social determinants of health strategy.

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 has expended over more than $41 million to its collaborating partners for performance and reporting through the period ended DY2Q4 (note: this includes the payment relative to the second half of DY2 that was executed during the first half fo DY3). Nearly 30% or $11.5 million of the total funds flowed to PPS collaborating partners have been associated with Primary Care Providers. More specifically, approximately $6.6 million or 16% has flowed to Hospital-Ambulatory Care providers. The hospitals play an integral role in the PPS ambulatory projects (i.e. 2.a.iii, 2.d.i, 3.a.i, and 3.c.i), impacting a larger portion of Actively Engaged targets and/or Medicaid patients in such projects. Approximately $2.4 million or 6% of total funds flowed to collaborating partners has flowed to FQHC partners. As mentioned in previous Primary Care Plan updates, FQHCs Community Health Center of Richmond and Brightpoint have expanded access to primary care capacity on the North Shore, an area designated to have both Healthcare Professional Shortage Areas and Medically Underserved Areas. Lastly, approximately $2.5 or 6% of total funds flowed to collaborating partners has flowed to Primary Care Providers ranging from large practices with over 20 PCPs to small individual practitioners.

An additional $162K has been expended as part of PMO Project Implementation in support of Primary Care initiatives. These funds are not directly flowed to collaborating partners, rather vendors who are facilitating PCMH recognition, for example. The majority of these funds are associated with the Healthcare Association of New York State, Inc.

Lastly, resources relative to Population Health Analytics have been expended, but are not summarized here.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$41,035,222.60	**100%**
Primary Care Provider	$11,503,000.00	28%
Hospital-Ambulatory Care	$6,572,990.00	16%
Federally Qualified Health Centers (FQHCs)	$2,376,202.00	6%
Primary Care Practitioners	$2,553,808.00	6%
PMO Spending to support Primary Care	$162,345.04	0.4%

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?
No changes have been made to the funds flow model through March 2017. There is ongoing work to restructure the payment model relative to 4.b.ii that will be reported on during the next Primary Care Plan Update.

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):

Through the Behavioral Health Infrastructure Project (4.a.iii), the PPS launched additional initiatives to further the integration of primary care and behavioral health. At the end of DY2, the lead organization for BHIP, Staten Island Partnership for Community Wellness (SIPCW), hired a director of BHIP and a senior coordinator for clinical outreach and education. Updates on workgroups:
Community Norms: Launched two social media campaigns on Holiday Blues and New Year's Resolutions
Behavioral Health Training: Partnered with PPS on behavioral heatlh educational forum, CAP-PC training, and planning for alcohol and cancer forum.
Creating Linkages to Behavioral Health: Developed Staten Island behavioral health resource guide and referral guide.
Data Sharing: Evaluation staff member hired in DY3.
Moving Toward Collaborative Care: Created two detailing toolkits: one to educate PCPs about the building blocks of collaborative care and the other to educate physicians and NPs about prescribing buprenorphine. Before March 31st, eleven practices on Staten Island were detailed as part of an effort to promote both collaborative care and the NYC Department of Health and Mental Hygiene's Mental Health Service Corps (MHSC). Assisted 12 practices with completed MHSC application.

The PPS also worked with Project TEACH/Columbia University to bring the Child and Adolescent Psychiatry for Primary Care (CAP-PC) training program to Staten Island. Through the two part series, 41 clinicians working in pediatric practices received training on depression, ADHD, anxiety, and aggression.

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

Model 1
1) Staff turnover is high resulting in temporary lack of co-located services and disruption of continuity
2) Lack of reimbursement for services provided by social workers has resulted in a need to outsource behavioral health specialists through the Mental Health Service Corps

Model 2
1) Recruitment of a medical provider (physician or Nurse Practitioner) to work in a behavioral health site for 8 or more hours per week has been challenging due to limited availability of this workforce
2) The credentialing process with MCOs has been a barrier, specifically adding medical providers to MCO networks that are contracted with behavioral health providers. Several providers have expressed issues about closed networks, lengthy credentialing process, etc.
3) Reimbursement for same day co-located services are sometimes denied or delayed

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 challenges related to regulatory issues have been encountered with Model 2 providers who are integrating primary care into behavioral health clinics. The issues include:
1) Physician space requirements to deliver primary care services are difficult to achieve for some behavioral health clinics.
2) Navigating through different licensure requirements, regulations, billing methodology, and agency oversight for primary care, mental health and/or substance use disorder services is difficult for providers.
3) Unclear sustainability model for providing and expanding primary care services in behavioral health site. Reimbursement rates for managed Medicaid for primary care services make it difficult to encourage physicians to work in Behavioral Health settings.
4) Credentialing of providers through the plans has been cumbersome and slow in developing.

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 and SIPCW increased their promotion of the Mental Health Service Corps resulting in the placement of behavioral health specialists at thirteen primary care practices across Staten Island. In a move toward sustainability of integration, the PPS has been exploring how to better support the training and licensure of social workers. SIPCW staff who support the Behavioral Health Infrastructure Project attended SBIRT train-the-trainer which provides sustainability for local training opportunities. The PPS has also begun to explore how to facilitate collaboration between primary care practices and OASAS providers who can now offer off-site services.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	12	1	11
Model 2	12	1	8
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:

Motivational Interviewing, Care Coordination, Mental Health in Pediatric Primary Care – Project TEACH/CAP-PC, Island-Wide Primary Care Event: Continuum of Substance Use Health Services for Primary Care and Treatment of Opioid Use Disorder

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