Primary Care Plan Update 2017
Suffolk Care Collaborative
September 29, 2017

Introduction

The New York State (NYS) Delivery System Reform Incentive Payment (DSRIP) Program´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent by 2020. To transform the system, the DSRIP Program focuses on the provision of high quality, integrated primary, specialty, and behavioral health care in the community setting, with hospitals used primarily for emergent and tertiary levels of service. The integration of services and the path to value-based care puts primary care at the center of the health care delivery system. Primary care is the cornerstone of the DSRIP Program and is critical to NY State's success in the overall improvement and coordination of health care.

Instructions

The DSRIP Primary Care Plan Update is an opportunity for each PPS to highlight, and inform the New York State Department of Health (the Department) and the DSRIP Project Approval and Oversight Panel (PAOP) of, progress towards and challenges to the improvement of Primary Care under the DSRIP program.

For each fundamental, the PPS is asked to provide a series of brief updates in the space provided (approximately 250 words) to questions under each fundamental in its final Primary Care Plan submitted in 2016. The PPS should reference its previously submitted Primary Care Plan when completing this Update. Completion of the Primary Care Plan Update includes the progress the PPS has made within a fundamental, an outline of any challenges related to implementing the Primary Care Plan strategies, an explanation of any changes that need to be made to the Primary Care Plan, and other related questions where applicable. The Department requests that the PPS be as concise as possible in its responses; where elements are not relevant to their Primary Care Plan, 'N/A' should be written. Under fundamentals where no strategic changes have been made, please describe how the PPS' initial strategies continue to support that fundamental. Throughout the Update, some fields have been auto-populated for the PPS' convenience based on figures available to the DSRIP team. The Department requests that the PPS review these fields for accuracy and make revisions where necessary. The completed template is **due September 29, 2017** to the DSRIP Team at dsrip@health.ny.gov with subject line: 'Primary Care Plan Update'.

Index

Primary Care Plan Overall Strategic Updates ... 1

Fundamental 1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs ... 2

Fundamental 2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance? ... 5

Fundamental 3: What is the PPS' strategy for how primary care will play a central role in an integrated delivery system? ... 8

Fundamental 4: What is the PPS' strategy to enable primary care to participate effectively in value-based payments? ... 12

Fundamental 5: How does your PPS' funds flow support your Primary Care strategies? ... 15

Fundamental 6: How is the PPS progressing toward integrating Primary Care and Behavioral Health (BH) (building beyond what is reported for Project 3.a.i. within the quarterly report)? ... 17

GLOSSARY OF TERMS ... 20

Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

a. From April 1, 2016 to March 31, 2017, describe any overall strategic changes the PPS has made and the impact of these changes on the PPS' final Primary Care Plan submitted in 2016.

Since the initial submission of the Primary Care Plan in 2016, the SCC has expanded its primary care practice transformation plan to include the Advance Primary Care (APC) model. For several of the SCC's primary care practices the APC model is better designed to enable their success. The support provided through the practice transformation technical assistance advisors is assisting practices to meet gate specific milestones.

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:

The SCC has made significant efforts to engage primary care providers in PCMH transformation activities during this period. Standard 1A recognizes the importance of Patient Centered Appointment Access which is a "Must Pass" element for achieving PCMH recognition. The primary care providers demonstrate how they are providing same day appointments for routine and urgent care as well as providing routine and urgent care appointments outside regular business hours. On a regular basis, the SCC continues to gather information from the Hubs on the primary care provider practice sites' ability to offer access outside of regular business hours.

Standard 2D addresses the Team based care model. This standard has empowered the primary care provider practice teams to reevaluate team member roles and workflows so that staff at their sites are able to work at the highest level of their license/certification. This has enabled primary care providers to focus on & address provider level clinical patient care needs, particularly for high risk populations identified in their PCMH process for care management and performance and improvement.

The Advanced Primary Care (APC) model was not fully implemented during this period; however, discussions have begun with technical assistant advisers to support the practices which may not have been ready for PCMH transformation activities.

As noted in section 1e, as of March 31 2017 160 PCPs have already achieved PCMH 2014 Level 3 recognition in partial fulfillment of our commitment of 511 PCPs achieving PCMH or APC designation by March 31 2018. The SCC monitors PCPs engaged in PCMH Level 3 and APC Gate 2 transformation and we are on track to fulfill our commitment.

b. Describe the PPS' challenges from April 1, 2016 to March 31, 2017 with addressing primary care capacity needs:
The SCC, fortunately, has not encountered challenges with addressing primary care capacity during this period.

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 SCC's progress has been consistent with the Primary Care Plan submitted in 2016. The release of the State's Advanced Primary Care (APC) model for practice transformation and the identification of technical assistant advisors has enabled SCC to engage large practices and more importantly, some smaller practices that could benefit from this transformative model. The extension of the PCMH application submission to January 2018 has provided the opportunity for practices who would have missed the September 2017 deadline to engage in PCMH transformation.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:	
The SCC continues to engage community-based primary care providers. Though there may be different approaches by Hub, the overarching strategy is consistent and all three Hubs continue to make progress. The comprehensive partner onboarding program created a standardized process and education materials across the PPS (available on the SCC website https://suffolkcare.org/forpartners/onboarding). One of the phases of engagement that has proven to be beneficial is providing community-based providers with information and resources that are available to support the practice transformation efforts including PCMH, Care Management, Behavioral Health Integration and Information Technology.	
Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	291

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:	685
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	160
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	7

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 SCC has made significant progress as demonstrated in Fundamental 1e – the number of primary care practitioners who are recognized for NCQA PCMH 2014 Level 3 or pursuing APC as of March 31, 2017.

The SCC has different approaches in working with primary care practices to meet NCQA level 3 or APC by Hub, however, the overarching strategy is consistent. All three Hubs have dedicated staff to work with practices to achieve recognition through these models. In addition, the development of excellent relationships with our vendors who have been engaged to support our primary care provider partners in PCMH transformation has been consistent. These same vendors are also involved in existing statewide initiatives including APC technical assistance. The SCC is leveraging these PCMH vendor relationships that have already been established to support our primary care providers in APC practice transformation.

On a monthly basis the SCC Director leads the Practice Transformation Workgroup (formerly named PCMH Certification Workgroup). The workgroup is comprised of key stakeholders across the PPS, including PCMH specialists, subject matter experts, and practice staff engaged in PCMH / APC transformation activities. Worth mentioning is the participation of primary care practices in this workgroup who, by their choice, have opted out of PPS vendor support, and are sharing their experiences and best practices with our group.

SCC provides education to primary care practitioners using SCC website & statewide resources available to support their PCMH transformation activities, including documentation resources that can be used to meet requirements.

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:

A major challenge when working with primary care practices to meet PCMH has been the reporting capabilities. Some partners have EMRs that are unable to run reports for PCMH. Our primary care providers have overcome these challenges working with their EMR vendors, SCC provider relations teams and practice transformation teams.
The SCC found there was a lack of awareness about the PCMH or APC models of care among many practices, particularly for smaller practices. Primary care provider sites were also challenged with the time commitment to transformation activities and need for less redundancy. The SCC offered onsite as well as web-based and one-on-one sessions to educate primary care providers and their teams. In addition, primary care providers experienced being overwhelmed with the PCMH requirements. Although some providers had workflows already in place, others needed to adopt changes to be more efficient. Lastly, balancing the simultaneous implementation of two initiatives, the DSRIP requirements with PCMH requirements, was an overall challenge for primary care providers, especially to new adopters of the PCMH model of care.
The delayed release of APC model and technical assistant support details presented a challenge particularly to those practices that had been identified by the PPS as best fit for this model. Another challenge aligned to the APC model is that currently there is no defined associated value-based payment arrangement (or financial incentive) when APC is achieved. The PPS is aware that active discussions are in progress to mitigate this challenge.

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 SCC identified opportunities to enhance the transformation vendors as well as PPS support to mitigate challenges through more frequent contacts and a higher touch level including on-site sessions/support; EMR vendor selection resource guidance; and collaborative meetings between EMR vendors and practice champions to achieve reporting needs.
In addition, the SCC made some strategic changes to messaging when engaging primary care providers in the APC model without the financial incentive program which focuses on the evolving changes in health care payments to align with emerging and existing quality/performance payment programs.
Upon achieving PCMH Level 3 recognition, the SCC as well as the primary care provider partners understand that the sustainability of the PCMH requirements would be integral to the ongoing progress. The SCC explored opportunities to provide education beyond the vendors and support teams. During this period the SCC along with other New York PPSs, vendors and organizations initiated a sustainability plan for primary care providers and/or their practice site PCMH champions to receive NCQA PCMH 2017 training.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
The SCC's early collaboration across the three Hub PCMH leads, early engagement of PCMH transformation specialists, and building "trust" relationships with primary care providers and their team have been the most effective strategies to supporting transformation activities. In addition, notably, the strategies outlined below have contributed to support transformation across the PPS: •Transformation vendor support and flexibility in the engagements with the primary care practice team– onsite, web-based, cohort, and one-on-one. •Developing dedicated internal practice transformation teams across the Hubs; several team members are PCMH Certified Content Experts. •Multidisciplinary team engagement to support practices with performance reporting, measurement and quality improvement including education. •Care management support across the Hubs. •Renaming our PCMH Certification Workgroup to Practice Transformation Workgroup - aligning the name to the multiple transformation models available. •A robust Practice Transformation workgroup and subgroups which meet regularly to share information and best practices. •Highlighting primary care providers' best practices and accomplishments during their transformation journey in Synergy, the SCC eNewsletter. •Frequent access/support from SCC practice transformation leads. •Educational opportunities – onsite, virtual, and through our Project Advisory Council (PAC) meetings.

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:	147
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:	7

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	465

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:
The Suffolk Care Collaborative recognizes the key role that Primary Care Providers play in a truly integrated delivery system and we continue to engage and support our PCPs. Key highlights of this effort include: PPS wide facilitated transformation of Primary Care Practices to Patient Centered Medical Homes or Advanced Primary Care, Integration of behavioral health services in Primary Care Practices, PPS sponsored IT connectivity from practice to PPS Enterprise Data Warehouse to monitor performance at the PPS and practice level and Risk stratification of cohorts of patients that may require intensive care management support. Care management resources in all three hubs support primary care providers and their patients during transitions of care from acute inpatient care back to community based care through the transitions of care program. Care Managers support Care Coordination and linkages to Health Homes, Managed Care Organizations as well as other Community Based Organizations and resources. The Suffolk Care Collaborative's structure includes several workgroups, committees and a governance structure that include Primary Care representation. In each of the workgroups and committees, the SCC has medical providers whose serve as experts in Primary Care and inform decisions being made to ensure accurate reflection of the work done in Primary Care sites. Topics of these workgroups and committees include but are not limited to, development of training around cultural competency and health literacy, work being done to achieve PCMH recognition at provider sites, development and implementation of clinical guidelines, and the creation of an integrated delivery system through successful clinical integration and population health management approaches.

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 SCC recognizes that Primary Care Providers are challenged to effectively and efficiently coordinate and communicate with other providers and specialists. This is a global issue that is regularly discussed at the above mentioned workgroups and committees. The creation of work flows that support and encourage increased communication across disciplines, including transition from acute level care, is informed through the workgroups and committees. IT interoperability represents a significant challenge in the ability to gather, store and share information in order to support care planning across the continuum of care as well perform concurrent performance management. In lieu of concurrent data, the SCC is using State data for directional purposes in performance management.

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 has moved forward in implementing the work flows and work groups indicated in the Primary Care Plan submitted April 2016. The role of a Patient Navigator has been developed in order to support PCPs to address and close identified Gaps in Care. This role is in addition to other Care Management / Care Coordination support.

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 PCMH 2014 Standards align with the Meaningful Use Stage 2 Core and Menu Objectives. As SCC supports the practice transformation journey, primary care providers are also simultaneously implementing many of the core and menu objectives into their workflows. A core objective alignment is met in Standard 3D, the Use of Data for Population Health by the practice's ability to generate lists of patients – this is a Must Pass element for PCMH recognition. The APC Model aligns with Meaningful Use and is anticipated to well position primary care providers for future federal delivery and payment models. In Gate 2 in the APC Model, the sub milestone 6.2 aligns MU & HIE- providers will demonstrate certified health information: common clinical data set, demographics, vital signs, body mass index, growth charts, and problem list.

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):
SCC assists its primary care practice network in connecting with a RHIO through education as well as coordination and facilitating contracting and information exchange. RHIO education is embedded in SCC's on-boarding process of a primary care practice as a coalition partner. Throughout the on-boarding process, the SCC initiates contracting efforts between primary care practices with the regional QEs in the PPS, New York Care Information Gateway (NYCIG) and Healthix. In addition to facilitating contracting between the PCP network and the QEs, the SCC has also supported IT onboarding engagement between practices and the IT PMO as needed. Supporting IT onboarding efforts is significant for data to be exchanged through the RHIO and SHIN-NY. The SCC's RHIO workgroup, consisting of stakeholders from the Catholic Health Services, Northwell and Stony Brook hub, also monitors the continued growth and adoption of the RHIO community. Best practices are shared between stakeholders to collectively address challenges and effectively communicate the benefits of participating in a RHIO to SCC's network of providers.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	288

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	18%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	16%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	3%

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 results of the SCC Value Based Needs Assessment (VNA) Surveys have been utilized to inform content for VBP education for the SCC provider/partner community. Responses to the survey indicated an opportunity to inform understanding of VBP programmatic goals, provide specific details of programs, especially for VBP arrangements present. This observation is supported by a low level of current VBP payor arrangements reported across all lines of business, modest working knowledge of VBP contracting levels and current VBP contracts weighted toward the lower levels (i.e., 0, 1). These findings, coupled with the high percentage of respondents interested or planning to initiate or expand upon VBP arrangements in the future, highlight a significant opportunity between current provider VBP participation and intentions for VBP contracting.
The training and education program to assist partners for VBP readiness is being developed during DY3 (April 1, 2017 through March 31, 3018) with planned implementation in DY3Q4.

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:

1) Achieving PCMH designation addressed in 2b
2) IT interoperability addressed in 3b
3) Quality reporting requirement addressed in 3b

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?

In order to address practice transformation challenges, the SCC initiated APC strategies in 2017.
Progress has been made with developing specific business rules for pay-for-performance (P4P) payment to SCC partners for the domain 2 and 3 performance measures. In February of 2017, the SCC formally initiated a Pay-for-Performance Business Rules Workgroup with representation from all three HUBS to prepare the business rules for P4P payment for the domain 2 and 3 performance measures. The SCC developed three guiding principles which provided the framework for this work effort. The guiding principles include "only incentivizing what you can measure", "align the right measures to the right providers" and "organize metrics by categories to make it easier for providers to understand".

The workgroup settled on choosing 31 of the Domain 2 and 3 performance measures for incentive payments which map to one or more of the following provider types: Hospitals, Skilled Nursing Facilities, Behavioral Health Providers and Primary Care Providers. Twenty eight of the thirty one measures are aligned to primary care providers. In addition, attribution rules were developed for all four provider types to identify the accountable provider and a specific algorithm has been initiated to determine the accountable primary care provider.

By managing the SCC's primary care providers against this incentive based model, they will be better positioned to effectively participate in similar payment models that are outcomes based.

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 continues to support PCPs to position themselves to be able to engage MCOs for VBP contracting. To be successful, we engaged our aligned PCPs in SCC's performance management and improvement program within the PCMH / APC construct. As the DSRIP program has evolved the initial presumption of being able to readily generate contracts directly between the PPS and MCOs has proven to be challenging. Currently we have not been able to operationalize this with the MCOs and barriers encountered have been escalated to the State. We continue to work with each of our 5 MCO partners to explore contracting opportunities.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers in levels 2 & 3 VBP arrangements to address social determinants of health and engage Tier 1 Community-Based Organizations (CBOs):
Through PCMH transformation activities Primary care providers are addressing the social determinants of health. PCMH Standard 4 recognizes the importance of care management and support. Primary care providers are developing processes to identify patients as well as workflows to address the social determinants of health. In element 4E the practice site maintains a resource list of key community service areas that are of importance to their patient population. To support the connection to community based services, the SCC has partnered with the Greater New York Hospital Association (GNYHA) to sponsor their Health Information Tool for Empowerment (HITE) on the SCC website (https://suffolkcare.org/community/resources/hite) on the Community Engagement webpage. The HITE resource is a web-based directory offering information on health and social services. This resource supports our primary care providers to meet this PCMH requirement as well as to connect the primary care provider and patients to local services or resources to improve their care. In addition, GNYHA and SCC are collaborating to form a HITE Advisory Workgroup in Suffolk County. This workgroup will engage SCC partners, including primary care providers and community based organization, to have a voice in the ongoing development and efficacy of this resource.

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 funds flow model for contracted PCPs provides two sources of funding. One comes from the cost incurred by the PPS on behalf of the PCP to help in providing foundational elements including costs of vendors to transform aligned PCPs practices to NCQA 2014 Level 3 PCMH; provide resources and cover vendor costs for technical on-boarding and RHIO connectivity; provide Behavioral Health Primary Care Integration support (model 1, 2 or 3 as applicable); provide Care Management resources; and provide support through the development of toolkits and support specialists to implement specific project requirements. The second source of funding to PCPs comes from a Performance Payment Pool. PCPs have five performance factors (engagement, technical on-boarding, clinical improvement programs – domain 3, PCMH certification/ APC, and domain 2 and 3 clinical outcome measures). Once a performance factor is achieved, the PCP will receive a recurring payment twice a year throughout the term of the DSRIP program contract based on contract anniversary dates.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$23,212,008.82	**100%**
Primary Care Provider	$2,795,118.04	12.04%
Hospital-Ambulatory Care	$448,362.98	1.93%
Federally Qualified Health Centers (FQHCs)	$294,354.50	1.27%
Primary Care Practitioners	$2,052,400.56	8.84%
PMO Spending to support Primary Care	$3,119,801.76	13.44%

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?
Progress has been made with developing specific business rules for pay-for-performance (P4P) payment to SCC partners for the domain 2 and 3 performance measures. In February of 2017, the SCC formally initiated a Pay-for-Performance Business Rules Workgroup with representation from all three HUBS to prepare the business rules for P4P payment for the domain 2 and 3 performance measures. The SCC developed three guiding principles which provided the framework for this work effort. The guiding principles include "only incentivizing what you can measure", "align the right measures to the right providers" and "organize metrics by categories to make it easier for providers to understand". The workgroup settled on choosing 31 of the Domain 2 and 3 performance measures for incentive payments which map to one or more of the following provider types: Hospitals, Skilled Nursing Facilities, Behavioral Health Providers and Primary Care Providers. Twenty eight of the thirty one measures are aligned to primary care providers. In addition, attribution rules were developed for all four provider types to identify the accountable provider and a specific algorithm has been initiated to determine the accountable primary care provider. By managing the SCC's primary care providers against this incentive based model, they will be better positioned to effectively participate in similar payment models that are outcomes based.

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):

During DY2 the Suffolk Care Collaborative completed readiness assessments for integration for all of our primary care and behavioral health partners. The Fourth Edition of the Primary and Behavioral Health Integrated Care Implementation Manual was also released during this time frame.
Additionally, during this time the SCC partnered with Family Service League, a community based organization, to contract with coalition partners of the SCC who are providing primary care services in the community to locate behavioral health providers in those sites. In DY2 the SCC and FSL successfully embedded a behavioral health provider in two primary care sites.
The SCC also renewed the contract with North Carolina Centers of Excellence for Integrated Care in order to assist efforts for this project. Together we offered Primary Care and Behavioral Health partners the opportunity to participate in an informative and interactive learning collaborative series. We offered bimonthly Learning Collaboratives to discuss pertinent topics in integrated care. During each one hour live webinar a 20 minute "quickinar" on a specific topic is presented, followed by a question and answer session. Based on the topic of discussion, recommendations and strategies for participating sites is presented.
On March 24, 2017 the SCC hosted a half day program entitled "The New Face of Healthcare: Building an Integrated System of Care in Suffolk County." Over 120 primary care providers, behavioral health providers, hospital and health home representatives came together to facilitate a collaborative discussion about bridging referral gaps, peer navigation, integrated care success stories, SBIRT in the ED and community and collaborative workshopping to help better serve population health in Suffolk County. The interactive event featured timely and informative presentations as well as guided workshops during which participants connected with other providers in their region.

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 breadth of this project, combined with the need to shift the cultural paradigm in medicine in a limited amount of time with a large number of partners, proved to be the most challenging part during DY2. A great deal of provider education and the establishment of relationships with those providers had to take place in order to position the SCC for the implementation of integrated care. Much time was also spent collaborating with other PPSs across the state to interpret ambiguity in particular tasks and metrics in order to ensure a common understanding for the success of this program.

c. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health specific to regulatory issues:
Some of the greatest barriers to integrated care lie in difficulty of putting in place a value based model of care in a fee-for-service world. Additionally, regulations regarding shared space, and billing requirements proved to be very limiting to the work that could be done. While the SCC is very progressive in wanting to put in place innovative practices in Telemedicine, regulations regarding the "hub and spoke" have made this a very difficult practice. These regulatory barriers also make it quite difficult to routinely utilize telemedicine, more specifically telepsychiatry, in a non-rural area such as Suffolk County. Another difficulty that the SCC has encountered is in regard to 42 CFR Part 2. Because of the restrictions on sharing information from OASAS providers the SCC has had to find ways to engage our SUD providers without violating the strict confidentiality rules. This has proven to be quite difficult for the SCC to gather data, drive change and move forward in the project given the number of OASAS providers that are partnered with the SCC. The SCC has a respresentative, as a non-voting member, at the Regional Planning Committee (RPC), who participates with the subgroups in order to help further the goal of primary care and behavioral health integration.

d. Based on the PPS' progress and challenges addressing Fundamental 6 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 6 outlined in the final Primary Care Plan submitted in 2016?
During DY2 the SCC participated in the MAX Train-the-Trainer program in order to help efficiently and effectively address site specific PDSA rapid cycle change management with its partners. By having the Director of Behavioral Health Integration prepared to implement a MAX series in Suffolk County the SCC has positioned itself well to effectuate change across the county. Additionally, the SCC is actively involved in the RPC in Suffolk County to help collaboratively address needed change across the region. These strategic initiatives have allowed the SCC to scale its efforts to further the goals of the project.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	127	79	33
Model 2	43	30	10
Model 3 IMPACT	1	0	1

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): PSC-Y/PSC-17/GAD
☒ Other Substance Use screening (please specify): CRAFFT/DAST
☐ 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