Primary Care Plan Update 2017

WMC Health

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.

WMCHealth PPS' Primary Care partners are committed to delivering comprehensive, integrated, culturally relevant primary care services to all patients. The PPS seeks to:
a) provide a structure for integrating a transformed primary care into comprehensive regional partner networks, and
b) build innovative models of delivery systems within these regional partner networks using the transformative momentum of DSRIP projects.
The PPS geography covers areas of high needs such as Health Professional Shortage Areas (HPSAs) across all 8 counties, and informs our strategy on the expansion of primary care capacity. We have addressed our expansion of Primary care in the following ways:
i) Prior to the network reopening in Aug 2016, we provided monetary and project management support to primary care providers who were increasing access to care via expanded hours and providing immediate care. We continue to fund and work with these providers and recruited additional practices to achieve NCQA's Patient Centered Medical Home (PCMH) Level 3 recognition status. We are supporting practices who are transforming to Advanced Primary Care (such as Institute for Family Health), and Comprehensive Primary Care Plus recognition (such as Poughkeepsie Medical Group and Bridge Street Medical).

ii) Partnering with regional Qualifying Entity (HealthlinkNY) to integrate community based providers by facilitating connections and providing informational sessions;

iii) Funding innovative pilot projects that partner Primary Care practices with local hospitals, health homes, and Tier I and II community based providers to address the care management needs of their high risk patients;

iv) Pursuing grant opportunities such as Doctors Across New York to place physicians-in-training into HPSA of the PPS, and Project ECHO that increases the primary care providers' access to subject matter experts in Behavioral Health related topics such as managing patients with depression, anxiety, medication management for BH patients etc.

v) Expanding the reach of the WMCHealth network's telepsychiatry to help integrate behavioral health and primary care.

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:

Primary Care is critical to building an integrated healthcare system. Building upon the capacity of our primary care providers, both institution-based and community-based, has been the priority for us. The Community Needs Assessment (CAN) had identified:
- gaps around access to same day appointments,
-need for alternate encounters that facilitate access to Primary care without an office visit,
-need for enhanced PCP connection with area hospitals for post-discharge followup care, and
-cultural competency & language barriers that hinder delivery of optimum care.
Based on these findings, WMCHealth PPS allocated significant resources to transform primary care practices and achieve NCQA's PCMH Level 3 recognition status. This was targeted especially towards providers in areas of high need, those caring for vulnerable population such as those patients with Intellectual and Developmental Delays (IDD), those with specific language barriers, and underinsured status. PPS also conducted several workforce trainings to community based providers addressing barriers around cultural competency and health literacy. Expanded hours and alternate encounters are part of PCMH standards' requirements, that have been implemented at many of the practices that are undergoing transformation, and those who have the recognition status.
We have also trained FQHCs and other community based providers in principles of Team Based Care, Trauma informed care, care coordination, etc. In order to enhance the connections between Primary Care and area hospitals, along with other secondary and tertiary service providers, we convened several Medical Neighborhood meetings across the PPS regions. The series of meetings in each region has focused on DSRIP projects deliverables by addressing Transitions of Care, Health Home Referrals and the role of CBOs in the medical neighborhoods.

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

Many challenges regarding Primary care capacity have been identified in the regional Medical Neighborhoods. In them we identified additional barriers that Primary Care providers face, such as lack of ongoing health insurance coverage that precludes & disincentivizes PCP access, lack of a common platform to share care plan type patient information, varying levels of infrastructure & human resource readiness of community based providers to participate effectively with area hospitals and other medical neighborhood participants, etc.

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?

Based on the information gathered form the PPS regional meetings, WMCHealth PPS convened several workgroups to address gaps identified by the community-based Primary Care providers. We are currently facilitating structural and multi-organizational process & workflow changes as well as EF trainings to address these barriers. WMCHealth PPS continues to educate the community based providers on the value of a PCMH recognized practice that can participate effectively in a VBP relationship with MCOs.

The Medical Neighborhood meetings have been refocused to bring smaller groups of providers within the region to address large scale outcome measures like Potentially Preventable Readmissions (PPRs. The Primary Care workgroup continues to focus attention on PCMH transformation. By preparing individual practices to transform, PPS hopes to build upon the capacity within the regional medical neighborhoods and address PPRs and avoidable ED utilization.

WMCHealth PPS PMO is looking outside DSRIP initiative to pursue grants and other project opportunities that could address Primary Care capacity: grants such as DANY that will place physicians-in-training in a large FQHC lookalike (Community Medical and Dental) in an area of need, and Project ECHO which we will begin to implement in DY3Q4; this will allow Primary Care providers in rural, MUA & HPSA areas to access clinical and BH experts to help manage patients with complex BH needs.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
The Hudson Valley CNA had identified lack of BH providers and a lack of comprehensive care management for high risk patients. In response, the PPS spent significant time and resources connecting Primary Care to experienced Care Management Agencies. We assessed the community-based primary care practices' organizational capacity & readiness to integrate care management resources into their existing structure, such as their use of registries, EMR based templates, risk stratification of patients as part of a population management strategy, etc. We selected a mix of practices for the pilot project based on the following criteria: -those with PCMH recognition & those currently undergoing PCMH transformation -those with practice locations across the PPS network, especially in high needs areas -pediatrics and internal medicine practices -those providing urgent care services, along with traditional hours The care management agencies funded to provide embedded care management support, were selected for their capacity to manage high risk patient case load with complex BH & medical needs. As part of furthering Project 2aiii focus, the CMs would assist in developing patient-centered care plans for the high risk patients at the practices; WMCHealth PPS provided the template for the careplans that both practices & CMAs were willing to adopt. The PPS provided recruitment & selection support, along with operational training for both Primary Care and CMAs. As we move further into the operationalization of this pilot project, we are confident that the support provided by the PPS will go a long way to sustaining the relationships and building capacity for new partnerships.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	745

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:	676
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	375
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	121

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:

WMCHealth has been committed to funding and providing program management support for the PCMH practice transformation efforts by contracting with a renowned transformational faculty vendor. MedAllies has years of experience working with practices towards transformation and their staff are recognized PCMH 2014 certified content experts; they have also proactively trained their transformational facilitators in the 2017 standards. PCMH 2017 standards have additional requirements around VBP contracting that is not required of the PCMH 2014; this knowledge is helpful as providers continue to build their organizational capacity to participate in VBC. The roster of primary care locations that took advantage of PPS funded transformation efforts grew from 25 practice locations in early April 2016 to 33 practice locations.
We have worked with the practices to take advantage of the PPS Learning Management System (LMS), our online platform that hosts training & educational materials on topics related to VBP, Cultural Competency, Health Literacy, HEDIS measures and other DSRIP projects related trainings. We continue to support our Primary Care providers via specialized workgroups that are formed within the regional Medical Neighborhoods to help address barriers encountered during transitions of care from area hospitals to post-acute care settings.

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:

WMCHealth PPS funded project management support provided by MedAllies includes biweekly calls and monthly on-site practice transformation guidance; despite such support, providers still lack the administrative and leadership capacity to engage in the required effort to meet the defined DSRIP timelines. Many of the small to medium primary care providers still operate with aging providers with ever expanding patient panels, and many find the burden of transformation challenging to keep up along with managing their practices.

Furthermore, there is a lack of standard communication from MCOs on financial and/or administrative support for the transformational efforts for achieving the several measures/metrics that are part of the PCMH standards. By not aligning the efforts of a transformed PCMH practice that is able to appropriately risk stratify their patient panel and thus manage their MCO assigned patient panel population health effectively, the MCOs almost disincentivize primary care providers to transform by expanding patient access hours or providing alternate type of patient encounters.

Additionally, because telehealth & telepsychiatry is still in the process of defining service reimbursement areas, many of our practices that serve population with complex needs, such as the medically frail IDD population, are not able to expand their primary care services to homebound patients, despite recent legislation that allows providers to bill for such services.

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 benefit of having MedAllies conduct monthly onsite practice transformation was the timely identification of training and resource needs for the staff, especially those in clinical and administrative leadership positions. PPS was able to deploy appropriate trainings such as Primary Care Asthma Preceptorship that connected pediatricians with trained pediatric pulmonologists to learn techniques of assessing, diagnosing and treating children with Asthma; primary care providers in both FQHC and medium practice sites were trained via this preceptorship opportunity. We were also able to provide much needed Team Based Care trainings for frontline workers and clinical staff at Mount Vernon Neighborhood Health Center, a large FQHC with 3 locations. WMCHealth PPS workforce team has deployed numerous trainings in Care coordination for front line workers in hospitals, Primary Care practices and CBOs. These trainings have been helpful especially for the small to medium primary care practices where human capital is limited in both number and the skillset needed for participation in a VBC world. WMCHealth PPS is also collaborating with Healthify, a vendor that provides a common platform for care teams to manage social determinants of health for the vulnerable population. The PPS has prioritized this resource for care management teams at all the network hospitals and with the receiving Primary Care practices that have the technology infrastructure and capacity to utilize the resource effectively. The PPS hopes to expand upon the current collaboration with Healthify to help track the high risk patients as they move from the hospital inpatient setting to the post-acute care and help the primary care providers sustain the 30 day Transition of Care plan of care for these patients in the community.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
Having a PCMH transformation faculty conduct an organizational assessment, gap analysis and an action plan was highly impactful in initially engaging practice leadership. In addition, having a dedicated on site facilitator was instrumental in engaging the practice workforce to the level that was needed to initiate and sustain the workflow changes needed for transformation. This has been especially helpful for those small practices that do not have dedicated resources for developing and maintaining policies or who have not had any formal training on quality improvement. While we have been developing trainings on Population Health, having someone explain the principles and the practical ways to utilize their patient registries have been helpful for not only the PCMH recognition process, but also for the practice to understand their strategic role in the larger Medical Neighborhoods. Currently, we are projecting all 11 organizations (across 31 sites) that PPS had provided transformation resources via PCMH vendor, to achieve PCMH 2014 Level 3 recognition for their sites. WMCHealth PPS has utilized Medical Neighborhoods to engage hospitals and post-acute care providers to collaborate on transitions of care. HealthlinkNY has been invited to meetings to discuss workflows and processes related to post-discharge notifications. In instances where notifications via the QE was not possible, several meetings focused on alternate means of direct exchange. The PP has spent time and resources assessing organizational needs and readiness around Team based Care, building a strong Practice Team, incorporating care management into practice priorities; once the needs were identified and strategies discussed with each organization, PPS teams provided vendor-led, practice-specific trainings. In many cases, the Workforce teams had developed both online and in person trainings; the online training format was instrumental in helping develop new means of training for the practice workforce, many of whom had not participated in any formally structured online trainings to date.

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:	220
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:	NA

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	745

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:

WMCHealth PPS has invested significant time and resources convening regional Medical Neighborhood meetings towards implementing an integrated delivery system. These series of meetings conducted in the south, west and north regions of the PPS have included area hospitals, primary care including FQHC and community based providers, and agencies that provide social determinants support services. Having key patient-facing staff from each of these provider types was instrumental in cataloguing the barriers faced by patients as they move through the system. Each of the Medical Neighborhoods have developed at their own pace as they come together to prioritize areas of need, and identify solutions to the barriers. We have facilitated connections with the regional QE (HLNY) and providers in each of the Medical Neighborhoods to improve connectivity and collaboration. Providers in large FQHCs and smaller practices are approaching CBPs to partner more effectively.

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 broad geography of the PPS regions has proven to be a major challenge in integrating the delivery system. In a network that did not have any focused forum for addressing common issues such as PPRs, the regional Medical Neighborhoods have become instrumental in bringing key community based providers together in a continued effort to address the issues. However, progress has been varied across the regions. For instance the Middletown area Medical Neighborhood is much more advanced than the other regional medical neighborhoods because of several reasons such as strong collaborative coalitions of organizations already in existence in Orange county. Their incentive to work together has been further enhanced by the DSRIP initiative. There have not been any recommendations or best practices established on exchanging discharge data between hospitals and post-acute care provider types such as Nursing Homes.
Another major challenge has been the varied organizational capacities of the primary care provider organizations across the PPS network. We have been diligently working to address some of the barriers.

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?

Unlike the large scale Medical Neighborhood meetings that were convened earlier in the year, some of the more advanced medical neighborhoods have since shifted to smaller regional workgroups that focus on addressing structural and process flow barriers identified in the larger meetings, such as hospital ED requiring a point person for area Primary Care to contact, for hospitals to develop better communication flow with post-acute care providers, for Primary Care to proactively outreach patients who have been recently discharged from hospital ED or Inpatient, etc. We are also working with network hospitals to address best practices on exchange of post-discharge data and Transitions of Care processes as part of their post-acute care strategy.

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:

In assisting Primary Care practices with PCMH transformation, WMCHealth PPS via MedAllies has addressed several related Meaningful Use (MU) Stage 2 items. For smaller practices that do not have dedicated resources, PPS has also facilitated meetings with practices and their respective EHR vendors in order to redesign clinical modules to capture appropriate data for DSRIP projects, include new report building critieria and other aspects of implementing MU Stage 2 & PCMH in the systems. We have facilitated negotiations for Superuser trainings for large FQHCs with the same EHR that addressed elements of MU Stage 2 and PCMH.

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):

WMCHealth PPS is continuting to collaborate with Qualified Entity-HealthlinkNY (HLNY) to identify priority organizations in a phased approach to facilitate increased connection to HealthlinkNY. We are ensuring that those practices who are currently recognized as PCMH 2014 Level 3, and those who are undergoing transformation, are prioritized to be connected with HLNY. We have also prioritized those organizations that provide BH and care management services to patients who are connected to care. This builds agency for primary care providers to be able to interact meaningfully with the area hospitals and other community based organizations. We have facilitated in HLNY providing trainings on consent process for all providers, especially pediatricians.

The PPS has also been facilitating workgroup meetings with hospitals, pediatricians and HLNY to educate providers on direct secure messaging, utilizing next day alerts for admissions and discharge, and best practices on followup by community-based providers post-discharge.

PPS is planning to host sessions with our partners to understand the impediments to connecting to HLNY. We hope to highlight these barriers during our monthly meetings with the QE in order to increase connectivity amongst our partners.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	406

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	421; 56%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	62; 14%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	359; 85%

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:

WMCHealth PPS assessed the needs of our provider network via the Financial Sustainability Survey to ascertain organizational readiness. The VBP assessment included:
- current state of contracting
-current resources dedicated for care management and care coordination
-organizational technology infrastructure and analytics
-existing knowledge base regarding VBP
The VBP Needs Asssesment highlighted key areas for PPS intervention. These include technical assistance for analytics & data mining, operational costs review, contracts management process with MCOs and additional educational training to implement VBP.
As a followup to the assessment survey, we conducted several onsite assessments at practices to further examine the responses to the survey. This was used to help us further develop a detailed VBP workplan for Primary Care partners.

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

Primary care providers-especially those in small and medium practices, struggle to integrate VBP practices into their workflow. Lack of timely, actionable data and information sharing are challenges that concern many primary care providers about their ability to manage financial risk. Larger organizations with multi-disciplinary teams encounter difficulties in driving sustainable, organization-wide adoption to standardize best practices and integrate necessary changes.
Small to medium PCPs who are not part of larger organized IPA or ACO management structures find it challenging to communicate with MCOs about their high risk patients.

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?

Based on the VBP Needs assessment, the PPS is collaborating with our partners to provide eduction and training opportunities. Our phased, educational and training approach customized for primary care providers, BH providers and CBOs; this two-year training plan will be aligned with the VBP roadmap such that we are continually expanding the knowledge base of our providers, and helping them prepare to meet the DSRIP milestones by 2020.

Much of the feedback that the PPS receives from its engaged providers via PPS governance, DSRIP project work, Primary care workgroup meetings and numerous on-site meetings, PPS has redoubled its efforts to align & educate our partners on all the different initiatives that have been spearheaded throughout the network, within the larger context of VBP transformation. To that end, WMCHealth PPS has restructured its internal Project Management Office resources to now provide customized levels of support and education around practices :
-understanding individual performance measures,
-setting targets to improve performance
-implementing change packages within the organizations to achieve the improvement targets

By providing the intensive project managmenet support that is needed to align the transformational work that practices are undergoing to meet PCMH requirements and the DSRIP performance measures improvement work, with building the capacity needed to engage in a risk sharing relationship with the MCOs, the PPS hope to effectively support primary care practices.

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:

WMCHealth PPS participates in monthly calls with regional MCOs to discuss NYS contracting requirements as it relates to VBP QIP. Using this foundational knowledge, the PPS has developed a more comprehensive workplan as part of Financial Sustainability (Milestone 5). Additionally, the PPS has facilitated face to face meeting with principals of a regional MCO and the senior leadership of FQHC to discuss VBP levels.

WMC Health PPS has provided supportive services to Primary Care Providers for engaging MCOs in VBP contracting. These supportive services have been in the form of educational training that are provided periodically. One such example was the training opportunity provided at the November Summit where PCP's, CBO's and BH organizations attended an hour long interactive VBP workshop.

The PPS's role around VBP QIP has been to provide support (non–financial) and guidance to participating facilities. The PPS also acts as administrator of the VBP QIP funds and acts to flow funds from the paired MCO to the respective VBP QIP facility. The MCO is responsible for validating and documenting related VBP related measures that have been reported by the facility, communicating its satisfaction while collaborating with both the PPS and the paired facility. To date paired facilities are also in a process of negotiating VBP like contracts with MCO's that account for 80% of its managed Medicaid revenues.

As mentioned above, the PPS has participated in monthly calls between MCOs and a paired VBP QIP facility. The objective of these calls has been to document via call minutes the performance data and provide a timeline on the anticipated funds that are to flow to the facility.

The MCO's are expected to:
- Validate reporting
- Communicate with the facility and PPS
- Collaborate
- Oversee program

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):
WMC Health PPS has utilized the April 2016-March 2017 period to engage its Tier 1 CBOs (the non-profit, non-medicaid billing, community based social and human service organizations) via numerous community engagements such as SOUPS, community coalition building & trainings aimed at building the VBP related knowledge base of the organizations. The PPS has also been planning an innovative collaborative pilot with twoTier 1 CBO (peer group agencies) to partner with a Tier II CBO, the BH provider group (CBHS) and PPS network hospitals (MidHudson Regional Hospital and Bon Secours Community Hospital), along with area Primary Care providers to address Transition of Care event for patients with Inpatient Behavioral Health discharges. This pilot will utilize the unique capacity of peer agencies to provide the exclusive patient-centered care prior to and at time of discharge from hospital, engage the patient with the BH provider group via mobile services to assess & provide any intervention to the patient for BH related in the transitory period between hospital discharge and the next scheduled BH/PCP appointment.

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:

WMCHealth PPS funds flow is reflected in different waves of provider contracts:
Wave 1: Implementation contracts were sent to provider organizations with leading roles in DSRIP project implementation activities, milestones and deliverables. Payments are variable based on NPI attribution and number of projects. Wave 2: Contracts were sent to Primary care providers who participate in DSRIP project beyond baseline activities; enhanced engagement on projects and cross-cutting workstream activities. Wave 3: BH providers who support DSRIP implementation as applicable to their reporting roles were targeted. Wave 4 & 6: Contracts targeted all essential providers including Skilled Nursing facilities, Assisted Living, Long term Care, Specialty DD services, Home Health care, Substance Use providers etc.
Wave 5: Care Management Agencies (CMA) in this category received additional funds to establish care coordination model for Primary Care providers supporting referrals of high risk patients to social services and Health Homes; CMAs receive 0.5 to 2 FTEs based on PPS evaluation of provider's capacity to perform the services. Wave 7: Providers in this category receive funding to perform clinical integration & coordination activities that will facilitate BH community crisis stabilization. Wave 8: Providers in this pilot funding category receive innovation funds for use in areas related to DSRIP High Performance measures, particularly for PPV and PPRs. WMC Health PPS does not break out Hospital Flow of Fund into Inpatient/Ed and Ambulatory. Additionally, this PPS is in the process of implementing the Modified PIT template, which will provide greater detail on the breakout for primary care funding.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$55,476,189.20	**100%**
Primary Care Provider	$3,586,885.29	6.47%
Hospital-Ambulatory Care	NA*	NA*
Federally Qualified Health Centers (FQHCs)	$2,247,643.29	62.67%
Primary Care Practitioners	$1,339,242.00	37.33%
PMO Spending to support Primary Care	$2,257,357.54 (This is only PMO Workforce spend related to PC)	4.07%

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?
WMCHealth PPS has been responsive to our partners who are able to participate in DSRIP projects and performance measures beyond performing the baseline activities. Based on the challenges that we faced in engaging CBOs, we quickly pivoted to planning innovative pilot projects that enhanced collaboration between different provider types. The Wave 5 funding category was developed to support Primary Care, enhance collaboration between provider types that focus on integration, and help CMA produce new service lines. The Wave 8 funding category was planned for pilot services that: a) do not yet currently exist in the PPS, b) target high risk patient population related to performance measures, and c) have a defined delivery model that enhances integration and is capable of being tracked. There has been a positive response to this change in engagement strategy and we hope to produce more innovative pilots.

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):

WMCHealth PPS has continued to work with our BH partners and Primary Care partners to enhance integration work. Partners have participated in Medical Neighborhood meetings that have addressed the integration of BH with Primary Care. All key Primary and FQHC partners have been educated on all BH performance measures, and we are currently working with them in identifying and realigning workflows to meet the measures, with ongoing monitoring and support.

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

While all provider types including the CBPs understand that the overall goal of reducing hospital readmissions and avoidable ED utilization requires an integrated community approach, the logistics of the integration and their respective roles within is not always entirely clear. Additionally, the success of DSRIP requires some CBPs to essentially transform how they have been functioning till now, it has been challenging to get all providers to the same functional capacity for the ideal integration. For instance,
assisting Local Governmental Units (LGUs) and CBOs in understanding compliance issues around Stark laws and fair market value trends, such that they are able to contract effectively with providers is one issue that that has been of particular note.
Thus, lack of community infrastructure linking the organizations, and lack of financial resources & technical know-how to invest in re-evaluating and redesigning their current business model to new performance-based model is a major 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:

Despite the national crisis around the shortage of licensed behavioral health providers-a need that is keenly felt in many regions of our PPS-there still seems to be a reluctance to embrace mainstreaming telehealth services to address the needs of those patients. A number of states have cleared the way to allow telehealth to be a main component of treatment delivery especially in light of NCQA's recent inclusion for billing telehealth codes for Behavioral Health Hedis Measures. Anecdotally, it has been reporrted that New York psychiatrists at state facilities have been resigning their positions to pursue more lucrative practices & better lifestyle, by remaining in NY while providing telepsychiatry to patients in other states.
In the effort to integrate BH services, the Article 28 clinics are willing to provide the services, yet the regulatons around reimbursement for these services disincentivize them from fully participating.

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?

PPS is engaged in developing integrated collaborative practices between LGU such as Orange County Department of Mental Health and hospital ambulatory care such as Bon Secours Charity Health System's Medical group. In Dutchess county, we have been facilitating discussions around collaborations between Dutchess county Mental Health department and Planned Parenthood of Mid Hudson region. Beyond the 3ai project, WMCHealth PPS is planning a hybrid model of integration where all embedded collaborative clinicians are certified in Primary Behavioral Health care delivery through the University of Massachussets medical school certification program.
To help address the gaps in regulatory guidance, we have encouraged partners to appy for the DSRIP waiver which would allow them bill for the BH visits; this item is not covered under the current regulatory stipulations. We are also encouraging our BH partners to engage with MCOs to develop mobile hybrid services which could impact the delivery of BH services within primary care.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	1	3	49

Model 2	NA	NA	NA
Model 3 IMPACT	NA	NA	NA

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:

WMC Health PPS is planning on conducting training BH providers on Lean Six Sigma principles to address process improvement in Addiction Treatment. The Critical Time Intervention trainings were conducted by the PPS CBO partner agencies as well (summer 2017)

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