# DSRIP Mid-Point Assessment – Primary Care Plan

**PPS Name:** Central New York Care Collaborative, Inc.

## Introduction:

The Central New York Care Collaborative, Inc. (CNYCC) is a performing provider system (PPS) that connects more than 1,400 health, behavioral healthcare and community-based service providers in six central New York counties: Cayuga, Lewis, Madison, Oneida, Onondaga, and Oswego. CNYCC aims to serve our target populations (Medicaid members and the low-income uninsured) by improving healthcare service coordination, enhancing the quality of performance outcomes, and creating an overall better system of care for patients throughout the community.

CNYCC's vision is *"to improve the health of our community by coordinating services and building partnerships through the healthcare system."* We aim to realize this vision by integrating services to improve patient outcomes, collaborating to improve on patient care coordination, improving healthcare quality, and ultimately reducing healthcare costs associated with potentially preventable hospitalizations and emergency services.

We are pleased to provide a comprehensive outline of CNYCC's Primary Care Practice (PCP) plan. The plan includes detailed information regarding our approach to PCP engagement, practice expansion, project implementation, and transition to value-based payment.

***Fundamental # 1 – Current Primary Care Assessment***
In an effort to develop the Primary Care Practice Plan, CNYCC reviewed data collected from the Community Needs Assessment (CNA) to gain an understanding of regional consumer demand for healthcare. The CNA included an analysis of PCP capacity throughout the community. Based on this analysis and other resource e measures, CNYCC was able to develop a strategy that builds on existing PCP capacity, and outlines various approaches to address gaps that could potentially impact the delivery of services and performance across PPS related projects.

***Fundamental # 2 – PCP Expansion/Transformation***
CNYCC has identified primary care expansion as both an opportunity and a challenge. CNYCC has employed a human resource and workforce development specialist who will focus on regional workforce issues including PCP talent shortages and resource availability. CNYCC is also working to develop a plan that will support the recruitment of clinicians in primary care. In terms of supporting our partner network to successfully achieve PCMH/APC standards, CNYCC is developing an enhanced comprehensive training strategy to support organizations working towards PCMH certification. Additionally, CNYCC has hired a PCMH Certified Content Expert to assist practices with the transition to a patient centered medical home model.

***Fundamental # 3 – Integrated Delivery System***
CNYCC has adopted a two-pronged approach to ensure primary care plays a significant role in an Integrated Delivery System. The first approach focuses on the expansion of PC capacity across the region (previously outlined above); the second approach involves working with primary care to encourage collaboration and necessary linkages to secondary and tertiary services. To achieve these outcomes, CNYCC is developing a comprehensive Population Health Management (PHM) platform that will expand the use of EMRs and RHIO services. The PHM platform will provide enhanced data analytics, facilitate care coordination, and drive focused care management services to patients who can achieve improved health outcomes. The development of the PHM system provides partner organizations the opportunity to align with the "Triple Aim" model to improve patient experience, population health, and reduce per capita cost.

***Fundamental # 4 – Value Based Payment***

CNYCC is working actively with partners across the PPS network to develop core resources that will enable a seamless transition from fee-for-service to a value-based model of care delivery. One of the major resources to facilitate this transition is CNYCC's investment in a Population Health Management (PHM) platform. The PHM system will provide four key areas required for successful VBP participation: Performance Management, Quality Improvement, Data Analytics, and Care Management & Care Coordination Programs. The PHM platform will significantly impact each of these functional areas and support the transition to VBP.

Additionally, CNYCC is working with PPS partners to develop self-assessment tools that will ascertain their VBP readiness from an operational, clinical and technical perspective. Findings from the assessment will enable CNYCC and its partners to systematically identify organizational deficiencies in each of the above functional areas, and implement change management strategies. The assessment tool will also provide an opportunity to identify training/continuing education needs for practices adapting to the VBP model.

***Fundamental # 5 – Funds Flow***

CNYCC is supporting our primary care practices through a number of payment models designed to incentivize activities associated with DSRIP project implementation. Several CNYCC projects include funds flow that support primary care partners with planning, implementation, meeting performance goals and actively engaging patients. CNYCC has also adopted a Centralized Investment funding mechanism, available to primary care practices, which will offset the cost of operational expansion to achieve DSRIP goals and requirements. Some examples of the Centralized Investment fund include; population health management system, employment of a PCMH Certified Content Expert, and future care management/care coordination services.

***Fundamental # 6 – Integration of Primary Care & Behavioral Health***

CNYCC's partner organizations are progressing toward integration of primary care and behavioral health and improving access to care through multiple DSRIP projects. In addition to facilitation through the Primary Care/Behavioral Health Integration Project (3ai), CNYCC is looking to expand access to community based crisis services that include mobile crisis, respite and other community based options through the work of the Behavioral Health/Crisis Stabilization project (3aii). Expansion of these services will be an important resource for primary care practices when a patient's needs exceed the capacity of behavioral services at an integrated site. CNYCC is also facilitating collaborations between medical, mental and substance use providers through the Behavioral Health Infrastructure Project (4aiii). The project features the creation of a "Collaborations for Health" RFP that will support providers to identify, plan and implement solutions for improving health outcomes related to community challenges such as rates of opioid addiction, suicide and serious mental illness.

***Primary Care Plan***

The following Primary Care Practice Plan outlines our proposed approach, working in conjunction with our PPS partners, to improve access, develop resources, and provide the appropriate level of support to PCP's across the region as they establish DSRIP projects and initiatives.

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

Primary Care expansion has been identified as both an opportunity for the Central New York region and a challenge. The foundation of Central New York Care Collaborative (CNYCC) plan for primary care participation was developed based on the most recent data available on the current state of providers within the PPS. Several resources were used to establish a baseline assessment including: CNYCC's Community Needs Assessment, CNYCC Compensation and Benefits survey, CNYCC IT readiness surveys, PPS PCP Network Analysis/Regional Comparison data and the New York State Department of Health Performance and Quality Outcome Measures.

A key element of the plan is a current assessment of primary care capacity. Furthermore, CNYCC has identified the need to understand specific performance and patient access demand in order to address primary care capacity shortfalls, particularly for our target population. Feedback from partner organizations, as relayed to CNYCC staff, pertaining to their individual challenges related to the measurement of, and capacity for, patient access was also considered. Specifically, CNYCC has identified the need to further assess areas of patient access that create an imbalance between supply and demand in the primary care setting. Additionally, more information is needed to understand provider productivity which will aid in internal planning for primary care sites across the region.

Information provided to CNYCC in the PPS PCP Network Analysis/Regional Comparison, presented data that speaks to primary care capacity. CNYCC primary care practice providers work an average of 35 hours per week. While this is on par with other medium size Upstate PPS's, it is significantly below two PPS's to the west of us, both with much higher rates of patient-centered medical home recognitions. Additionally, the report indicated that only 20.7% of primary care providers offer extended hours. This is about the average of other medium-sized Upstate PPS's, where between 15.5%-31.9% of primary care providers offer extended hours to their patients. This would appear to be an area where primary care could grow capacity, given enough provider staff to meet the needs of patients for after-hour care. In terms of the capacity for serving the needs of our targeted Medicaid population, only 75.3% of CNYCC partners are accepting new Medicaid patients. This compares unfavorably with the medium-sized Upstate PPS where the range of providers accepting new Medicaid patients is between 89.3%-91.4%. One reason for this is the shortage of providers which results in full patient panels.

As a step in reaching the PCMH Level 3 (2014) requirement that is replicated across many of CNYCC's selected DSRIP projects, CNYCC created site-specific PCMH planning templates and provided an incentive payment to our partner organizations to complete a template for each of their primary care sites seeking recognition. Part of the template collected baseline data regarding the number of providers associated with the practice site at baseline (summer 2016). Partner response data is summarized in the table below:

| | Hospital-based | | | FQHC | | | Private Practice | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MD/DO | PAs | NPs | MD/DO | PAs | NPs | MD/DO | PAs | NPs | MD/DO | PAs | NPs |
| TOTAL | 166.7 | 25.9 | 51 | 27.25 | 9 | 24 | 59 | 12.6 | 25 | 252.95 | 47.5 | 101 |

The data indicate that vast majority of primary care providers within the CNYCC PPS are hospital-based.

In 2014, CNYCC conducted a community needs assessment to understand the consumer demand for healthcare, including primary care. CNYCC also contracted with Iroquois Health Alliance in December of 2015, to complete a compensation and benefits survey of all facility types, to understand the current supply of primary care providers. CNYCC contracted partners were surveyed and asked to provide total rewards and the current vacancy rates across titles. Primary care providers were isolated and reported on as a distinct category to assess average wage and benefit ratios.

| Job Title | Number of New Hires | CNYCC Current Vacancies | CNYCC Vacancy Rate | 6 PPS Vacancy Rate | CNYCC Compensation Rate | 6 PPS Compensation Rate |
|---|---|---|---|---|---|---|
| Physician Assistant Primary Care | 69 | 1 | 1.69% | 8.64% | $50.16 | $51.34 |
| RN Care Coordinators/Case Managers/Care Transitions | 54 | 60 | 14.18% | 14.77% | $29.84 | $29.30 |
| Office Clerks | 51 | 8 | 1.72% | -- | $14.48 | $14.28 |
| LPNs | 47 | 118 | 7.4% | 7.37% | $18.63 | $18.33 |
| Licensed Clinical Social Workers | 41 | 6 | 3.88% | -- | $29.10 | $30.11 |
| Care or Patient Navigator | 41 | 19 | 11.73% | 11.11% | $24.00 | $25.31 |
| Coders/Billers | 21 | 9 | 2.49% | -- | $17.45 | $17.96 |
| Medical Assistants | 17 | 6 | 2.93% | -- | $14.97 | $14.63 |
| Nurse Practitioner Primary Care | 15 | 10 | 7.72% | 11.34% | $45.89 | $46.97 |
| Nurse Managers/Supervisors | 15 | 36 | 6.91% | -- | $34.10 | $34.08 |
| Bachelor's Social Work | 26 | 4 | 8.00% | -- | $21.72 | $21.38 |
| Secretaries and Administrative Assistants | 15 | 20 | 3.43% | -- | $16.76 | $16.94 |
| Primary Care Physician | 14 | 9 | 3.45% | 10.34% | $104.08 | $103.59 |
| Staff Registered Nurses | 14 | 352 | 6.56% | -- | $27.85 | $28.33 |
| Nurse Aides/Assistants | 14 | 246 | 8.67% | 10.09% | $13.20 | $12.69 |
| Psychiatric Nurse Practitioner | 12 | 7 | 15.91% | 18.79% | $62.96 | $60.41 |
| Technical Support | 12 | 7 | 7.87% | -- | $22.67 | $22.33 |
| Other Mental Health/ Substance Abuse Titles Requiring Certification | 32 | 16 | 6.02% | -- | $23.43 | $24.92 |
| LPN Care Coordinators/ Case Managers | 6 | 3 | 10.00% | 15.93% | $20.70 | $19.31 |
| Licensed Master's Social Workers | 6 | 9 | 4.71% | -- | $24.87 | $25.67 |
| Care Manager/Coordinator Bachelor's Degree required | 6 | 64 | 10.29% | 7.50% | $22.32 | $24.03 |
| Health Educators | 6 | 10 | 9.50% | -- | $22.88 | $23.48 |
| Psychiatrists | 5 | 4 | 6.45% | 11.35% | $132.49 | $130.96 |
| Janitors and Cleaners | 5 | 44 | 4.53% | -- | $11.95 | $12.43 |
| Nutritionists/Dieticians | 5 | 0 | 0.00% | -- | $26.34 | $27.66 |
| Social Worker Care Coordinators/ Case Managers/Care Transition | 3 | 16 | 13.01% | 8.72% | $23.07 | $22.45 |
| Psychologists | 2 | 2 | 2.41% | -- | $51.22 | $49.01 |
| Health Coaches | 2 | 1 | 11.11% | -- | -- | $23.19 |
| Patient Service Representatives | 2 | 14 | 8.14% | -- | $16.35 | $16.16 |

Red indicates CNYCC compensation below the 6-PPS average; Green indicates high-compensation positions.

The survey results showed that the region currently lacks adequate primary care providers including physicians and mid-level staff, nurses, and other clinical workers for primary care. This has been further supported with anecdotal evidence shared by our partners. While compensation for primary care providers in the area is above average, the vacancy rate suggests the need for more providers across the spectrum of care givers in primary care practices.

Salaries for Primary Care Physicians averages over $215k per year which is about 20% above the national average. While over 260 Primary Care Physicians are active in the region, there remain over 150 openings for Primary Care Physicians. The survey also stated that Nurse Practitioners and Physicians Assistants in Primary Care account for 190 providers regionally, while 375 openings are posted as of this writing, which again demonstrates a shortage of labor.

As the demand for qualified primary care providers continues to increase in an area with constrained supply, practices must expand their talent searches nationally. To be competitive for this type of talent, employers have pushed compensation rates above the national average, but only to a point of minimal competitiveness. The realities of the Central New York labor market include the perception of a lack of the cultural and quality-of-life elements available Downstate, compensation rates that compares unfavorably to the higher rates historically paid in the North Country, and significant pay parity issues that have led to stagnation in compensation rates in most primary care titles other than mid-level. Data indicates that our region would greatly benefit from increased availability to Nurse Practitioners and Physicians Assistants. Due to continual demand for mid-levels in non-traditional retail settings, the compensation rates in these job categories have increased by roughly 20% over the past two years, creating recruitment challenges in more traditional settings such as primary care practices.

CNYCC recently developed and gained Workforce Governing Body approval for a multi-faceted plan, the PPS Workforce Transition Roadmap, to increase provider capacity in the region. Once the final details of its various strategies are determined, funding for approved strategies will be included in CNYCC's 2017 budget proposal. The Roadmap includes approaches expected to positively impact recruitment & retention, training, and deployment. Failure to secure funding plan will delay the initiatives proposed throughout this plan, which will negatively impact both the PPS's ability to reach its DSRIP goals and the improvements in patient access this plan would create.

CNYCC has employed a human resource and workforce development specialist to focus on workforce issues across the region, including talent shortages and the lack of readily available training. In considering the services needed most by partners, CNYCC's Workforce Transitions Roadmap includes a number of proposed strategies to support securing clinicians in Primary Care. The Workforce Transitions Roadmap was informed by the Gap Analysis and target Future State of the PPS workforce. Strategies will be especially focused on creating interest in recruitment for the placement of providers, mid-levels, and clinicians in rural and urban underserved areas. The proposed strategies that pertain to primary care practitioners and other supportive titles are included in Appendix B.

CNYCC developed the Workforce Transition Roadmap with the substantial input of its formal Workforce Committee, comprised of representatives from partner organizations. The committee includes subject matter experts from across the spectrum of Human Resource/Workforce Development including talent acquisition, total rewards, employee relations, instructional designers and training delivery. The committee is comprised of individuals from all partner segmentation areas including outpatient (primary) care. One of the opportunities and goals of this committee is to discover and share best practices that support collaboration and results in both greater efficiencies as well higher volume of practitioners and support staff at the practice level.

The long term needs of the primary care labor market can only be truly addressed by encouraging more young people to enter healthcare professions as well as developing retention tools and employment models that keep talent in this market. Engaging and informing potential candidates early on in their academic life of career opportunities in healthcare drives greater numbers of people into the industry, including high need positions in primary care. CNYCC can impact this with both community and school based mentoring programs between students and practitioners. One of our academic partners has developed a network of over 400 rural b practitioners throughout the State that have agreed to mentor students and emerging professionals. In the coming year, CNYCC will work with this partner to establish additional mentor relationships, focusing in particular upon students interested in primary care.

In the coming months, CNYCC work with the members of our Workforce Committee to determine the details of a program to provide incentives to partners to recruit new providers to fill specified gaps. This effort will be aided by CNYCC sharing job opportunities across the PPS partner network, acting as a candidate direct sourcing service, and encouraging practices and providers to expand access to care. To meet the needs of the engaged and newly activated patients resulting from CNYCC project implementation, the volume of available service must increase. Opportunities can be maximized by expanding average number of hours worked per week, offering innovative service delivery options as well as extending office hours. To that end, opportunities that CNYCC is pursuing to meet the

increased demand include physician/provider extenders and payment mechanisms to support additional providers servicing new Medicaid patients.

In addition to recruiting new primary care practice clinicians, CNYCC expects to see expanded capacity resulting from transformative work being done as practices seek National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) 2014 Level 3 recognition. Less than 30% of CNYCC's primary care providers are currently recognized with any of NCQA's patient-centered medical home programs. While working towards transformation to a patient-centered medical home, primary care practices will be required to compile data and assess where opportunities exist to improve patient access. In addition to their EMR, CNYCC's Population Health Management System, once implemented, will support partners in measuring patient access.

CNYCC expects to see expanded primary care capacity and improved patient access resulting from transformative work being done in the integration of primary care into behavioral health settings. Specifically, through project activities in the Primary Care Behavioral Health Integration project (3ai) providing access to primary care services for individuals receiving outpatient behavioral health services. The integration of these two services as a single health host site will greatly expand access and allow patients to receive care. CNYCC is supporting this through payment mechanisms and relationship building.

***How is the PPS working with community-based PCPs as well as institution-based PCPs?***

CNYCC is currently working with community & institution-based primary care practices in various ways to help strengthen primary care practice participation in DSRIP related activities. As part of a regional strategy for engagement across the PPS network, primary care practices (both community and institution-based) play a significant part in building relationships across the care continuum and providing coordinated services for the region. To that end, very early in the DSRIP process, CNYCC identified primary care practices (both community & institution based) in the local region and began building relationships through several engagement activities. Working closely with organizations like Regional Medical Societies, CNYCC conducted educational/awareness presentations to provide information on PPS related activities.

CNYCC has also been very active in meeting with primary care practices individually to outline potential opportunities for partnership. As a result of these efforts, CNYCC has been able to execute contracts with several community based primary care practices (ex. FQHC's; private practices etc.) and institution-based primary care practices (hospital-operated Article 28s), for the delivery of DSRIP projects.

Additionally, CNYCC project managers have developed relationships with primary care practices across the region through project planning/implementation and feedback on project delivery. Primary care practices also play a key role in CNYCC's governance structure (outlined in Fundamental # 3), with significant representation on the Board of Directors and several Board committees. As CNYCC looks to continue primary care practice engagement, one area of importance to note is the impact of CNYCC's recent recruitment of a Chief Medical Officer (CMO). The CMO position will play a lead role in practitioner and clinical staff relations. The CMO will help develop strategies to keep practitioners (including primary care practices) fully engaged and support project implementation efforts. The delay in hiring a CMO has deferred the development of these key relationships with providers; however, with an incumbent slated to begin work in mid-November, CNYCC expects efforts in this area to accelerate.

Department of Health

**Fundamental 2: What are your PPS's plans for working with Primary Care at the practice level, and how are you supporting them to successfully achieve PCMH/APC?**

CNYCC is committed to providing technical assistance in the form of training primary care practice staff to facilitate process improvement. CNYCC has hired a PCMH Certified Content Expert (CCE) who will be working with practices to understand their performance in multiple areas of patient access including; same day (open) access, availability of after-hours care, wait times for appointments and no-show rates. Partner organizations will also be able to gain insight into the innovative ways that our region's primary care has expanded capacity through alternative types of appointments, such as group visits, telemedicine, and combined patient appointments. Through CNYCC's Learning Collaborative sessions and work with CNYCC's PCMH CCE, participating partners will be able to share best practices in expanding access to meet patient demand.

Team based care and enhanced care coordination teams, a foundational component of PCMH, will be enhanced as practices move through their transformation journey. It is expected that mid-level providers and nurses will be able to work at the top of their licensure, taking some burden off the providers and allowing practices to increase capacity. CNYCC has taken a multi-faceted approach to encouraging team based care and enhanced care coordination and care management services. First, CNYCC has offered multiple training programs on team-based care to facilitate transformation. Supplementary training on care coordination is planned as part of several DSRIP projects. Also, CNYCC has facilitated partnerships between primary care and the Health Home community, supporting care coordination services in the primary care setting. CNYCC is currently trying to secure funding for a service provider that will bring short term care management services to the primary care setting. Enhanced care management and care coordination services improve practice efficiency which should positively affect capacity. Lastly, as part of the Population Health Management System installation, CNYCC and its partners will consider opportunities for efficiencies to enhance primary care capacity. Examples of these are care management, telemedicine, patient population outreach and use of mobile devices.

CNYCC is considering funding opportunities to offer patient experience measurement to partners, utilizing a standardized tool, in order to obtain more timely data and identify opportunities for process improvement for patient access. This would allow CNYCC to better monitor patient experience in adult and children's access to timely appointments or clinical advice and care continuity. According to the Department of Health performance measurements for the period between July 2014 and June 2015, adult patients, insured by Medicaid, used primary care as their usual source of care less than 75% of the time. Providing higher levels of care continuity as well as educating patients on the importance of a primary care provider and the appropriate use of other methods of care delivery (i.e. Emergency Department use) generally leads to lower no-show rates and increased capacity.

CNYCC is developing an enhanced comprehensive training schedule/strategy to further meet the needs of Primary Care Practices with an emphasis on practice transformation. CNYCC has offered partners free training on Patient Centered Medical Home (PCMH) fundamentals and National Committee for Quality Assurance (NCQA) standards. In addition, CNYCC has offered trainings on various topics on a monthly basis. In the coming months we will be offering training at greater frequency that will cover topics such as Lean or Six Sigma Change Management, policy and procedure development, and understanding synergies between PCMH standards. CNYCC has also engaged the National Committee for Quality Assurance as a prime content provider for PCMH training and have purchased several "Live Webinar" programs and offered this training for free to PPS partners. We expect to use additional content from NCQA's "Strategies for Success" program and offer additional Live and Web on Demand programs, free to partners. Please see Appendix A for a schedule of previously offered and future scheduled training opportunities.

CNYCC has also engaged potential Learning Management System (LMS) platform vendors to deliver best-in-class training from blended methods which can all be sourced, delivered, and reported from one system. This blended approach will be used to offer resources to providers in the most efficient manner, while also reducing any burden on their patient care time. These toolsets will help drive standardization across our Primary Care Practices and reduce the burden of coordinating and managing training.

Training to primary care providers to meet the DSRIP project requirements outside the scope of PCMH will also be made available to all practice members via the Learning Management System. This will provide both ease of access and reporting capabilities to partners. A comprehensive syllabus of trainings that support Primary Care practices will also be made available to the partners. This approach will complement existing resources and continuing clinical education plans with content focused on the goals of DSRIP including: evidence based medicine, best practices for comprehensive and collaborative care, cultural competency, patient engagement and health literacy.

On an ongoing basis CNYCC will track staffing levels and training program engagement of PPS partners quarterly. If trending indicates that extra resources are required for certain partners, CNYCC will strive to fill the identified gaps as needed. For those partners that are identified as high achievers with consistently positive trending, CNYCC plans to celebrate their success and share best practices.
As primary care practices move towards practice transformation specific to developing team based care and enhanced care coordination teams, it is expected that mid-level providers and nurses will be able to work at the top of their licensure, taking some burden off the providers and allowing them to optimize patient panel size. Recognizing the transformative process and financial lift of care management to primary care practices, CNYCC anticipates a multi-tiered technical assistance program. First, primary care partners were given a presentation on Health Homes including how the use of Health Homes would benefit primary care practice patients and supplement care coordination services within the primary care setting. CNYCC, through the DSRIP Care Management (2aiii) project has been active in building awareness and facilitating partnerships between primary care and the Health Home community. The DSRIP Care Management project will bring care coordination resources into the primary care setting to supplement management resources, for targeted patients with one chronic condition. Secondly, CNYCC has been engaged with a service provider that will bring short term care management services, as well as training to current primary care staff to fulfill care management and care coordination needs. Lastly, CNYCC is the final stages of licensing a Population Health Management system, which will provide enhanced analytics and care management capabilities to primary care offices.

CNYCC also has employed a PCMH Certified Content Expert (PCMH CCE) on staff to assist practices in transformation to a patient centered medical home. Those practices new to the model are offered the opportunity to work with the PCMH CCE in a baseline assessment of their readiness and recommendation of next steps. In addition, each primary care partner has been asked to supply an implementation plan on how they will achieve PCMH, which will be managed and supported by the PCMH CCE. The PCMH CCE will also be available to answer questions that may arise in implementing new processes and/or compiling documentation for NCQA submission. To help promote collaboration between partners, CNYCC is in the process of transitioning the existing Project Implementation Collaborative into a Learning Collaborative model. These collaboratives will provide opportunities for partners to disseminate best practices and lessons learned during project implementation. Additionally, the Learning Collaboratives will focus on rapid cycle improvement techniques to help primary care participants both identify and overcome challenges that are impeding their progress toward PCMH recognition.

At the onset of the DSRIP program, the PPS also formed a strategic partnership with our local RHIO, HealtheConnections, which also serves as the local Regional Extension Center. As part of this collaboration, the RHIO provided PPS-wide webinars, highlighting their technical assistance services for the Eligible Provider 2 initiative, as well the NYeC Data Exchange incentive program. PPS partner lists were also shared with the RHIO, so that they could identify and perform proactive outreach and education to primary care providers eligible for these statewide programs.

**Fundamental 3: What is the PPS Strategy for how primary care will play a central role in an integrated delivery system?**

CNYCC's strategy to strengthen the continuum of primary care and ensure meaningful linkages to necessary secondary and tertiary services will be instituted through a two part approach. The first step is to strengthen and expand primary care as a key component of the integrated delivery system. The second step is to work with primary care partners through the implementation of DSRIP projects and encourage collaboration with necessary linkages to secondary and tertiary services. These projects include 2ai Integrated Delivery System, 2aiii: Health Home At-Risk Intervention Program (CNYCC has rebranded this as DSRIP Care Management), 2biii: ED Care Triage, 3ai: Primary Care/Behavioral Health Integration, 3bi: Cardiovascular Disease Management, and 3gi: Palliative Care/PCMH Integration.

***Integrated Delivery System-Population Health Management System and Patient-Centered Medical Home***

To ensure continuum of services with primary, secondary and tertiary services across the CNYCC region, and to maximize incentives to move towards a value-based system, CNYCC must develop a high performing integrated care delivery system. Providers in primary care, specialty care and secondary and tertiary services must work together across the community to provide a seamless continuum of coordinated, person-centered services that are population health focused. CNYCC identified the need for an HIT/HIE infrastructure that allows for informed, data driven decisions and accessibility to pertinent clinical information. By introducing the capabilities of a Population Health Management (PHM) platform and expanding the existing use of EMRs and RHIO services, this vision is achievable. The PHM system will improve data analytics, facilitate care coordination across the healthcare delivery system, and drive focused care management services to patients who can achieve improved health outcomes.

In addition, this robust HIT and HIE infrastructure will allow all CNYCC providers to align with the "Triple Aim" model to improve the patient experience of care, improve population health, and reduce per capita cost. The PHM system will also ensure that CNYCC can proactively react to the evolving needs of the Medicaid and uninsured populations it serves to maximize the reach and efficacy of the DSRIP projects. In order to achieve these goals and strengthen the continuum of care, CNYCC is purchasing and implementing an integrated PHM infrastructure. CNYCC is in final stages of contract negotiations with the vendor with preliminary plans to have the system available for partner use in the second quarter of 2017.

CNYCC is also working with partners to transform their primary care practices into patient-centered medical homes. Through the course of this transformation, primary care partners will be working towards enhanced coordination with secondary and tertiary services and important community resources while systematically coordinating patients' care, based on their need. CNYCC is supporting the practices through training and other technical assistance. In meeting the requirements for recognition by the National Committee for Quality Assurance PCMH 2014 Level 3, primary care practices are providing coordinated care across specialty care, facility-based care and community organizations. Effective transitions of care between primary care and specialist providers, between facilities and institutional settings ensure that patients' needs are met efficiently and safely and quality care is provided.

***DSRIP Care Management***

Through the DSRIP Care Management project (2aiii), CNYCC is assisting in building awareness on the benefits of care coordination across the healthcare delivery system and through community linkages and partnerships with Health Home care management services. This partnership is designed to educate and inform Primary Care providers and their staff on community resources that are available to meet the social and behavioral needs of their patient panel. In addition, DSRIP Care Coordinators will be trained and located within the primary care setting serving patients that do not qualify for Health Homes due to only having one chronic condition. DSRIP Care Management will strengthen the continuum of care, including those to secondary and tertiary services, coordinated through the primary care setting and provide essential services to patients in order to improve their experience and health outcomes.

*ED Care Triage*

Within the ED Care Triage project (2biii), patient navigators are reinforcing the importance and establishing the connection from the hospital emergency department (ED) back to the primary care provider. In order to strengthen the continuum of care, the program is designed for hospitals and primary care to form meaningful linkages that allow ED's to redirect patients to primary care settings. Another important aspect of the project is to educate patients on the appropriateness and benefit of care provided by the primary care clinician.

*Care Transitions*

Effective care transitions designed to reduce unnecessary hospital readmissions rely on the strength of the relationships between the inpatient hospitals, primary care, specialty care and the supportive services of the community based organizations. The Care Transitions (2biv) project strategy for strengthening the care continuum, is the formation of community coalitions. The coalitions serve to improve communication and foster relationships among providers in primary, secondary and tertiary care and create improved systems of care for patients as they transition from the hospital setting to another provider, particularly their primary care provider. Each coalition seeks to find solutions for identified, community specific gaps in service and any systems issues that create barriers to effective care transitions throughout the medical neighborhood. As a result of these coalitions, primary care practices learn more about the resources available for patients in their community and build important collaborative relationships with secondary and tertiary service providers.

*Behavioral Health Integration*

The Primary Care/Behavioral Health Integration project (3ai) creates a central role for primary care in the integrated delivery system. Through the framework of the Patient Centered Medical Home, patients' needs are identified and met with the addition of skilled behavioral health providers who are available onsite at the practice. New external partnerships between primary care and behavioral health specialists, such as outpatient mental health and substance abuse services, are forming to strengthen the continuum of care and to address the needs of patients that cannot be met onsite. As the primary coordinator of patient care, primary care practices will play a critical role in whole-person care, supporting seamless transitions of care and preventing avoidable hospital admissions.

*Cardiovascular Disease Management*

The goal of the Cardiovascular Disease Management (Project 3bi) is to support implementation of evidence-based guidelines and best practices for management of adult patients' cardiovascular disease and/or its risk factors within the primary care setting. Strategies to improve both individual patient care and outcomes in the patient population include all elements of the chronic care model. Primary care providers will be coordinating patients' care across the care continuum to include specialty care, pharmacy, nutrition services and behavioral healthcare. Primary care practices will also be focusing on post hospitalization patient care follow-up and any necessary care coordination in order to avoid unnecessary hospital readmissions. In addition, CNYCC expects to work with the local IMPACT group that is advancing health system interventions and community-clinical linkages for priority populations, one of which is patients with identified disparities and uncontrolled hypertension.

*Palliative Care Integration*

Palliative Care is an extension of the patient centered medical home model which aims to respect the ability of patients with severe or chronic illness to participate in and choose the direction of their own care. Services will center on Advanced Care Planning, pain and symptom management, and caregiver support. To ensure a continuum of patient centered care, this project seeks to develop partnerships with community and provider resources, including Hospice, to bring palliative care supports and services into the practice. Additionally, linkages to community-based service providers outside of the primary care practice ensures comprehensive care to address the emotional, spiritual and socio-economic needs specific to each patient.

CNYCC is working with primary care in their important role in the integrated delivery system through several projects. Care coordination is central to continuity of care and assuring care is provided at the right time, at the right place and by the right practitioner. In addition, many of the projects encourage, if not require, co-location of services including Health Home care

management, behavioral health, and palliative care, yielding patient-centered care for patients. These additional resources and facilitated partnerships will strengthen primary care and ensure meaningful linkages to necessary secondary and tertiary services as well as community based resources.

***Primary Care Representation in PPS Governance and Structure***

Primary care provider organizations are well-represented in CNYCC's governance structure. Representatives from several PCPs, both community and institutional based are members of CNYCC's Board of Directors. The composition of the Board of Directors is dictated by CNYCC's bylaws, which designates a seat for each of the four corporate members of CNYCC, up to seven representatives from the other non-member hospitals, four representatives from FQHCs, and up to seven additional representatives including one representative from either a County Health Department or Mental Health Department, one representative from an OMH or OPWDD-licensed provider, one representative from an OASAS-licensed provider or Health Home, one representative from a licensed skilled nursing facility or home care agency, and three at-large representatives affiliated with other partner organizations. These representatives are chosen by their organizations and typically hold senior leadership positions. As a result, few are active primary care practitioners; however, three (14%) are physicians and fifteen (68%) represent organizations that provide primary care, either community-based, hospital-based, or integrated into behavioral health settings.

| CNYCC Board of Directors | | | |
|---|---|---|---|
| Kimberly Townsend | Laura Eannace# | John McCabe, MD^ | Pat Roach^ |
| Gene Morreale^ | Sean Fadale^ | Patricia McMahon* | Leola Rodgers* |
| Scott Berlucchi^ | Chuck Gijanto^ | Mark Murphy^ | Christa Serafin |
| Mark Cattalani, MD# | Seth Kronenberg, MD# | Liz Nolan | (Vacancy) |
| Teisha Cook | Michael Leary* | Scott Perra^ | (Vacancy) |
| Diane Cooper-Currier | David Lundquist^ | | |
| * Primary care, community-based | ^ Primary care, hospital-based | # Behavioral health integration | |

Primary care practices also have representation on several CNYCC Board Committees and workgroups including the Clinical Governance Committee, which is involved in overseeing & monitoring clinical quality aspects of CNYCC's 11 projects and approving the practitioner training plan. The membership of the Committee is guided by CNYCC's bylaws, which requires representation from a diversity of professional disciplines and care settings. In nominating & appointing members to the committee, a premium was also placed on geographic diversity and balancing community-based and institution-based organizations. Four of the Committee's twelve members (33%) are physicians and four of whom (three physicians and a PA) (33%) are primary care practitioners.

| CNYCC Clinical Governance Committee | | |
|---|---|---|
| Seth Kronenberg, MD | John Epling, MD, MSEd^ | Liz Nolan, MSW |
| Amanda Beattie, MS, RPA-C* | Renato Mandanas, MD^ | Michele Prince, MT |
| Sherry Buglione, MS, RN | Stephen McLaughlin, MS CASAC | Mat Roosa, ACSW, LCSW-R |
| Deborah Donahue, MA | Diane Nanno, MS, CNS, RN | Mark Warfel, DO^ |
| * Primary care practitioner, community-based | ^ Primary care practitioner, hospital-associated | |

Additionally, primary care practices have actively participated in other organizational work streams such as Clinical Integration, Population Health Management, Financial Sustainability, Cultural Competency and Health Literacy, IT Systems and Processes, Performance Reporting, and Funds Flow. Several projects have active clinical workgroups with a diversity of primary care representation, including a Clinical Workgroup that has developed standards for cardiovascular disease management and a multi-disciplinary workgroup that developed the PPS's screening standards for primary care & behavioral health integration.

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

Payment reform and the transition from fee-for-service to a Value-Based-Payment (VBP) model provides a catalyst for CNYCC's participating primary care providers and practices to assume clinical and financial accountability for the populations they serve. To assist our partners with this paradigm shift, CNYCC is developing an HIT/HIE infrastructure platform that will allow for informed, data driven decisions, and accessibility to pertinent clinical information. By introducing the capabilities of a Population Health Management (PHM) platform, CNYCC will provide access to information that will impact four key areas required for successful VBP participation:

1) Performance Management
2) Quality Improvement
3) Data Analytics
4) Care Management & Care Coordination Programs

The implementation and utilization of a PHM platform will significantly affect each of these key areas during and beyond the life of the DSRIP program. Following is a summary of how each of these functional areas will support a transition toward VBP (Table 1).

**Table 1.** VBP required organizational/collaborative capacities enhanced by PHM platform utilization

| VBP Functional Requirement | PHM Platform Impact |
|---|---|
| Performance Management | • Aggregation of clinical and claims data to generate a comprehensive data for accurate and timely performance monitoring<br>• Ability to generate quality/outcome measures of interest to our participating primary care providers and track the performance of those measures for their attributed populations |
| Quality Improvement | • Monitoring patient and provider/partner adherence to quality improvement protocols<br>• Facilitation of Rapid Cycle Improvement (RCI) processes to gain insight into the effectiveness of particular interventions, or programming efforts<br>• Proactive identification of patients at risk of falling out of compliance with prescribed treatment protocols<br>• Registry functionality to enable the tracking of all key metrics of interest for target patient cohorts |
| Data Analytics | • Access to centralized risk assessment and scoring capabilities across a partner network allow for standardization of protocols to address high risk patient cohorts<br>• Simultaneous analysis of clinical, financial, social and behavioral data allows for enhanced patient targeting and more effective use of resources to mitigate potentially high cost adverse outcomes<br>• Assignment of value to individual collaborating partner contributions based on performance and outcomes |
| Care Management and Care Coordination Programs | • Ability to manage transitions across care settings and complete the longitudinal patient care record Knowledge of other care team members and their interactions with shared patient populations<br>• Patient engagement tools assist with outreach and enrollment activities<br>• Care management/coordination strategy and program design can be informed and prioritized based on the supporting analytics that identify high risk patient cohorts<br>• Supporting the administration of standard assessment criteria, toolsets and processes to ensure consistent measurement and mitigation of a patient's level of risk |

These functional capabilities will also empower CNYCC's primary care providers to make informed, data driven decisions as they move toward value based contracting with regional MCOs, by allowing them to understand the risk and outcomes associated with their attributed populations. It is only through the simultaneous analysis of claims, clinical, and social/behavioral determinants data, that a patient's true risk can be accurately assessed. Assumption of financial and clinical accountability through VBP arrangements requires that participating primary care providers are able to both understand and manage these risk factors. CNYCC's PHM platform will support prospective and predictive modeling to inform decision making and to ensure that current and potentially high-risk, high-utilizing, and rising risk patients can be proactively managed, which can help prevent avoidable hospital and ED utilization and unnecessary costs. Data will be organized and reportable at the provider, practice and population levels, providing the flexibility for VBP contracting entities to understand performance and risk among their collaborating partners.

CNYCC's PHM platform will aggregate clinical data from across the care continuum, including data provided by our regional hospital and behavioral health partners. This will provide our primary care centers with a much broader perspective and more timely and granular understanding of the care delivered outside of their offices, that wouldn't be possible through a claims driven approach. In addition, the data that is shared through the platform will exceed what is currently available through standards based exchange mechanisms propagated by Meaningful Use and will therefore provide additional value to current data exchange practices. Most importantly however, aggregated data will be transformed into meaningful insights that can also be acted on from within the PHM platform. Collectively, these capabilities will enhance transitions of care, and allow care team members to have a common understanding of the patient's status. Newly acquired data will also be incorporated into risk calculations, allowing for the continuous monitoring of the patient as their health status changes and is informed by new encounters.

Gaining an understanding of a patient's social and behavioral determinants of health and coordinating with regional CBOs to address those determinants will also be enabled through CNYCC's PHM platform. Health and needs assessments that can be administered through the tool will be used to capture discrete social and behavioral risk data that will be used to inform a plan of care that CBOs serving as members of a care team, will have direct access to. These functional capabilities will help coordination of services outside of care delivery and decrease barriers to collaboration with essential community services.

To further assist with the transition to VBP, CNYCC has developed a self-assessment tool aimed to support primary care partners ascertain their VBP readiness from an operational, clinical and technical perspective. Findings from the assessment will enable CNYCC and its partners to systematically identify organizational deficiencies in each of the above functional areas. CNYCC will use this information to develop a tiered population health roadmap to highlight how the centralized PHM platform can be utilized to support practices at varying levels of technical sophistication and readiness, ensuring that the adoption and application of toolsets are specific to each partner's current state.

Clinical integration is another area that CNYCC will assist primary care partners with VBP readiness. The strategy includes analysis of the data that is required to facilitate transitions of care across the continuum from the perspective of each member of a patient's care team. As such, primary care providers will be engaged to verify which transitions are most important to them, as well as identification of pertinent data sets that are critical components of those transitions. CNYCC will then work with the PPS partners (PCP and others) engaged in those transitional activities to make sure that data capture is prioritized at the point of care and that mechanisms exist to support the sharing of data.

Securely connecting stakeholders to allow access to real-time patient data and enable information sharing will be accomplished through CNYCC's relationship with HealtheConnections (RHIO). Direct protocols will be utilized for point-to-point connections for the exchange of clinical documentation in support of transitions of care. The HealtheConnections' web-based, secure messaging portal that supports Direct protocols, will be made available to partners without EMRs to facilitate the secure exchange of information among all applicable CNYCC partner organizations. Additionally, the PHM platform will be used to capture and expose additional data of interest that may not currently be available in the standards based exchange mechanisms supported by EMR vendors and the RHIO.

CNYCC also recognizes that in order for our primary care partners to be successful in a VBP environment, they must develop effective collaborations across the continuum of care to assure that will ensure the patient's clinical, social and behavioral needs are met. Through the work of the Primary Care/Behavioral Health project (3ai), primary care practices are developing integrated service and shifting to an expanded focus on behavioral health conditions and outcome-based frameworks. Primary care practices will not be successful unless they establish formal partnerships with community based organizations and outpatient mental health and substance use providers. To support relationship development, CNYCC has taken the following steps:

- Facilitated "meet and greets" between primary care and community behavioral health providers
- Promoted knowledge of existing coalitions as a mechanism of connection for primary care practices
- Facilitated individual relationships based on articulated practice needs
- Supported partner contracting through sharing of contracting best practices identified by partners
- Facilitated information sharing to support implementation and relationship building

The MAX Series has allowed a primary care practice within the PPS to rapidly implement elements of integrated care specifically in the areas of data collection, workflow, and rapid cycle change with a focus on quality. In turn, this practice has served as a model, resource, and catalyst to other providers working toward similar integration.

Another aspect of VBP readiness that CNYCC has begun to address is in the area of education. In order for our primary care partners to effectively participate in VBP models, they must first understand the structure and concepts underlying these initiatives. As such, CNYCC worked with a well-renowned VBP expert to develop a series of educational whitepapers and presentations, which were made available to partners across the PPS. Additionally, CNYCC has been highlighting the State sponsored VBP boot camp series and will continue to point our partners toward all available VBP resources.

As part of the VBP readiness strategy, CNYCC will assist partners in preparing for the shift in workforce to accommodate the transition. CNYCC will provide resources from training on efficient best practices, working with the academic community to ensure that the available labor pool is capable and available, tracking and sharing trends on total rewards to keep partners competitive in labor recruitment, and by supporting sourcing, selection, and retention best practices for talent acquisition. The PPS has the capability of "leveling-the-playing-field" for PCP's by sharing information used by the other facility types to inform their management of labor. By ensuring that the labor market is prepared with the appropriate level of skills needed and set expectations, the risk of losing incumbent talent at the PCP due to change is mitigated. The PPS is preparing for that now by comparing the current state of labor readiness and availability and what may/will be needed in the future. Understanding this gap will inform the actions of the PPS going forward to ensure continual readiness.

Workforce readiness should provide adequate labor for the majority partners organizations including PCP's. Resources will be made available of organizations that may need either flex staff up or outside services to provide care. CNYCC will also work to broker services of third party agencies to enable competitive rates across the partnership for locums, travelers, and other support staff. Per Diem hires will be encouraged across the partnership so that the provision of care is appropriate to the level of need.

**Fundamental 5: How does your PPS's funds flow support your Primary Care Strategies?**

CNYCC is supporting primary care practices through various payment structures associated with DSRIP activities within several projects. CNYCC is utilizing a payment structure that incentivizes, supports, and promotes change within the primary care setting. DSRIP project payment policies are designed to support primary care partners with planning, implementation, meeting performance goals and actively engaging patients.

CNYCC's projects that support primary care with active payment mechanisms, include: Integrated Delivery System (2ai), Primary Care/Behavioral Health Integration (3ai), and Cardiovascular Disease Management (3bi). With DSRIP Year one funds, CNYCC has incentivized primary care practices to complete certain activities to begin project implementation. For the Integrated Delivery System project these activities included: executing an agreement with HealtheConnections, the Regional Health Information Organization (RHIO), and establishing workflows for capturing patient consents. The RHIO participation agreement incentivized primary care providers to sign up for the RHIO and begin the process of incorporating the system into their daily functions in order to complete IT tasks and milestones within each project. Another incentive payment was provided to practices that completed an electronic medical record assessment designed to identify the organization's ability to collect, extract, share, and report high quality data. This allowed CNYCC and each PPS partner to identify gaps and develop strategies to meet IT related project goals. The third payment to eligible partners was for the completion of the implementation plan for achieving Patient-Centered Medical Home (PCMH) 2014 Level 3. For the Primary Care/Behavioral Health Integration and Cardiovascular Disease Management projects, participating partners were incentivized to develop an implementation plan for their organization to achieve milestones within each of these projects.

In addition to these items, PPS partners were asked to complete an implementation plan template which detailed required tasks within each project and submit them to CNYCC. The plans gave each partner a roadmap for project implementation success and allowed CNYCC to manage and monitor progress against each plan in comparison to other participating partners. DSRIP funds will then be paid to primary care practices to support the implementation of activities within the submitted plan. Practices can choose to use the implementation funding to support staffing or other resource as needed. Many practices are utilizing these funds for increased staffing and consulting costs incurred to meet project requirements.

In addition to planning payments, CNYCC has a payment mechanism that supports primary care in actively engaging patients. CNYCC has strategically tied payments for Actively Engaged Patients to the interpreted state definitions within each project. In order to receive payment for Actively Engaged Patients, partners are required to complete and report patient engagement activities. These payments are meant to incentivize and motivate practices to support patient care. DSRIP year 2 payment policies are expected to be tied to performance in meeting quality improvement goals. In addition, it is expected that additional funds will flow to primary care for completed activities performed that support other DSRIP projects. Also, as the Population Health Management System in implemented, partners will be incentivized to participate in CNYCC's prescribed data specifications.

Together with direct funds flow, the centralized investments made by CNYCC to ensure that critical functionality is available to primary care partners will offset any operating dollars that would need to be expended to achieve the same results. Included in the centralized investments is the population health management system, employment of a PCMH Certified Content Expert and any future care management/care coordination services CNYCC may procure. CNYCC's funds flow is supporting primary care transformative activities and will continue to do so in future payment years.

**Fundamental 6: How is the PPS progressing toward integrating Primary Care and Behavioral Health?**

CNYCC's partner organizations are progressing toward integration of primary care and behavioral health and improving access to care through multiple DSRIP projects. One goal is to achieve integration through the development of individual relationships between primary care practices and behavioral health providers, as detailed in fundamental 4. In addition, two of our partner organizations participated in the in the Primary Care/Behavioral health MAX Series, Planned Parenthood of Mohawk Hudson (via CNYCC) and Community Memorial Hospital in Hamilton, NY (via their participation in the Leatherstocking Collaborative Health Partners PPS) have received hands on support in building an integrated culture, establishing workflows around new behavioral health staff, and looking at practice data in support of quality care. The MAX Series program has served and will continue to serve as a resource for other partners integrating care, as those partner organizations which participated directly will share their knowledge and best practices with other partners through vehicles such as CNYCC's outpatient-focused learning collaborative.

CNYCC is also promoting shifts in reimbursement by the Office of Mental Health for "off-site" behavioral health services. The Licensed Behavioral Health Practitioner Benefit, which allows reimbursement for behavioral health services provided outside of the clinic ("off-site") will also support partnerships in integration if primary care practices are concerned about billing feasibility leading up to value-based payment arrangements. CNYCC is promoting this information as a way to build partnerships and accomplish flexible integration at a primary care site.

Beyond what is required for Project 3ai, CNYCC's Clinical Governance Committee-approved Standard of Care includes both a mental screening as well as a substance abuse screening for partner organizations integrating under Model 1. This was the subject of robust discussion within the multi-disciplinary workgroup that developed the Standards of Care as well as within the Clinical Governance Committee. Ultimately, the capacity challenge this presents to primary care practices was reconciled by the universal recognition of the patient benefit of identifying substance abuse disorder through a phased approach to implementation of the mental health and substance abuse screenings. This approach aligns with the PCMH Level (2014) standards' near-term inclusion of depression screening and our PPS's planned, longer term expansion of access to substance abuse provider services that will be necessary to meet the increase in demand that universal screening within the primary care setting will likely create.

CNYCC is also supporting integrating primary care and behavioral health services through project activities related to DSRIP project 3aii, Behavioral Health Crisis Stabilization, and the Mental Health and Substance Use infrastructure project, 4aiii. The Behavioral Health Crisis Stabilization project (3aii) seeks to expand access to community based crisis services to include mobile crisis, respite and other community based options. These services will be important resources for primary care practices when a patient's needs exceed the capacity of behavioral services at an integrated site. In the development of the Clinical Governance Committee Approved Standards of Care, workgroup members representing primary care and behavioral health identified that establishing relationships with these services would create an added layer of service and supports for patients in the practice. In addition to service development, project activities in 3aii seek to address issues of access (waitlist, of behavioral health services). Streamlined and timely access to mental health and substance use services are critical in meeting patient need, leading to quality outcomes.

Project activities in project 4aiii – Mental Health and Substance Use Infrastructure, including the creation of a "Collaborations for Health" RFP that, when awarded, will facilitate collaborations between medical, mental and substance use providers that will identify, plan and implement solutions for improving health outcomes related to community challenges such as rates of opioid addiction, suicide and serious mental illness. These collaborations will increase access to services referred from primary care providers.
Through the completion of these projects, patients will have greater access to services and providers will have additional resources to call upon to meet the needs of their patients.

## Conclusion:

The preceding Primary Care Practice (PCP) Plan provides a detailed outline of CNYCC's approach to building and fostering relationships with PCPs across the region. CNYCC recognizes that the ability to adapt these strategies will play a major role in the success of the PPS. Successful engagement and development of programs and policies that support PCPs will ultimately determine the effective implementation and sustainability of the DSRIP program. Additionally, strengthening PCP capacity, performance, and access provides the best opportunity to improve outcomes and the overall quality of car for our community.

CNYCC will continue to work closely with PCPs to develop a framework that encourages participation and provides resources that will enable partners to be successful as we work together to transform healthcare for the Central New York community.

Appendix A – PCMH Training Schedule

| Date | Focus/Topic | Trainer/Sponsor | Training Format | Training Topic Category |
|---|---|---|---|---|
| Free to download | PCMH Transformation Toolkit | NCQA | Web on Demand for practices to access | Practice Transformation Process |
| 2/26/2016 | Getting Started with Practice Transformation | CNYCC PCMH CCE | Live Webinar | Practice Transformation Process |
| 2/26/2016 | Introduction to PCMH 2017 Redesign | CNYCC PCMH CCE | Live Webinar | Practice Transformation Process |
| 6/24/2016 | Update on PCMH 2017 Redesign- Standard Recommendations open for comment | CNYCC PCMH CCE | Live Webinar | Practice Transformation Process |
| 3/1/2016 | Documentation Miscues- Preparing a Strategy to Master the PCMH Must Pass Standards | NCQA | Live Webinar | Practice Transformation Process |
| 4/8/2016 | Overview of NCQA PCMH 2014 Standards, Must Pass Elements, Scoring and Documentation Requirements | CNYCC PCMH CCE | Live Webinar | Practice Transformation Process |
| 5/13/2016 | Overview of Transformation Process, Roadmap and Project Team | CNYCC PCMH CCE | Live Webinar | Practice Transformation Process |
| 6/24/2016 | Health Homes in Primary Care Setting | CNY Lead Health Homes | Live Webinar | Care Coordination |
| 5/13/2016 | Overview of Policy/Documented Process/Procedure | CNYCC PCMH CCE | Live Webinar | Practice Transformation Process |
| 6/24/2016 | Care Transitions/ DSRIP and PCMH Alignment | CNYCC PCMH CCE | Live Webinar | Care Coordination/Care Transitions |
| 6/30/16 | Team-based Care-It Takes a Village to Transform a Medical Home | NCQA | Live Webinar/ offered in person only | Team Based Care |
| 7/20-21/16 | Practice Transformation 1 1/2 days topics Include: | HANYS Solutions-PCMH Advisory Services | In-person | Multiple topics |
| 7/20-21/17 | Why Transform | HANYS Solutions-PCMH Advisory Services | In-person | Care Coordination |
| 7/20-21/18 | Transformation (Change) Approaches | HANYS Solutions-PCMH Advisory Services | In-person | Change Management |

| | | | | |
|---|---|---|---|---|
| 7/20-21/19 | Policy and Procedure Development | HANYS Solutions-PCMH Advisory Services | In-person | Practice Transformation Process |
| 7/20-21/20 | Access and Continuity | HANYS Solutions-PCMH Advisory Services | In-person | Patient Access |
| 7/20-21/21 | Understanding and Communicating with patients | HANYS Solutions-PCMH Advisory Services | In-person | Patient Engagement |
| 7/20-21/22 | Team-based Care | HANYS Solutions-PCMH Advisory Services | In-person | Team Based Care |
| 7/20-21/23 | Population Health Management | HANYS Solutions-PCMH Advisory Services | In-person | Population Health Management |
| 7/20-21/24 | Care Coordination | HANYS Solutions-PCMH Advisory Services | In-person | Care Coordination |
| 7/20-21/25 | Care Management | HANYS Solutions-PCMH Advisory Services | In-person | Care Management |
| 7/20-21/26 | Performance Quality Improvement | HANYS Solutions-PCMH Advisory Services | In-person | Quality Improvement |
| 7/29/16 | PCMH Alignment with the Chronic Care Model and DSRIP Cardiovascular Disease Management Project | CNYCC PCMH CCE | Live Webinar | Population Health Management |
| 10/19/16 | Denominators Demystified- | NCQA | Live Webinar/ offered in person only | Quality Improvement |
| 8/30-11/9/2016 | Lean Six Sigma - Series of Six trainings | NCQA | Live Webinar/ offered in person only | Change Management |
| TBD | Chronic Care Management: Why it Pays to Invest in Transformation | NCQA | Web on Demand/ offered in person only | Population Health Management |
| TBD | Practice Transformation and Quality Improvement-Why Include Patients? | NCQA | Web on Demand/ offered in person only | Quality Improvement |
| TBD | The Building Blocks of an Individual Care Plan Registration | NCQA | Web on Demand/ offered in person only | Care Management |
| TBD | Patient Navigation is Not a “One Size Fits All” in the Patient Centered Medical Home | NCQA | Web on Demand/ offered in person only | Care Coordination |
| TBD | Rapid Cycle Improvement | TBD | TBD | Change Management |
| TBD | Population Health Management Trainings | CNYCC PHM trainers | TBD | Population Health Management |
| TBD | Motivational Interviewing | TBD | TBD | Patient Engagement |
| TBD | Cultural Competency and Health Literacy | TBD | TBD | Patient Engagement |
| Available free on website with log-in | Team Based Care | IHI | Web on Demand | Team Based Care |
| Available free on website with log-in | Strategies for Success | NCQA | Web on Demand | Clinical Quality/Patient Engagement |
| TBD | Submission Process | Live Webinar | TBD | Practice Transformation Process |

Department of Health

Appendix B – Excerpt from CNYCC Workforce Transition Roadmap

| Recruitment/Retention | | |
|---|---|---|
| **Proposed Strategy** | **Targeted Positions** | **Projected Timeline** |
| **Partner with local universities and community colleges to develop or expand training programs for gap positions**<br><br>Recommended Steps:<br>1. Inventory currently available programs offered by local universities and community colleges and compare to gap positions<br>2. For programs aligned with gap positions, gather historical enrollment, tuition, and other program details<br>3. For programs aligned with gap positions with limited capacity for additional enrollment, engage with leadership to identify opportunities for & barriers to program expansion<br>4. For gap positions without existing programs, gauge local universities/community college interest in developing new programs<br>5. Provide both expanding and new program with PPS vacancy and compensation data & facilitate access to preceptor/mentorship programs to enhance job readiness of program graduates | Primary Care Physicians (PCPs), Psychiatrists, Nurses (BSN, RN, LPN), Mid-levels (PA, NP), Social Workers, Psychologists, other behavioral health (BH) counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | January 2017, ongoing |
| **Establish a central job posting resource**<br><br>Recommended Steps:<br>1. Identify and engage with vendor<br>2. Engage with partner organizations to create linkages to their existing, organization-specific postings<br>3. Share layout and demo capability of central job posting resource with Workforce Committee before publication | PCPs, Psychiatrists,<br>Nurses (BSN, RN, LPN), Mid-levels (PA, NP), Social Workers, Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | April 2017 |
| **Execute recruitment marketing campaigns for gap positions outside the Central New York region**<br><br>Recommended Steps:<br>1. Develop prototype ads for gap positions<br>2. Work with firm to identify national and/or international target markets outside of range of partners' current ad reach<br>3. Vet and refine prototype ads and target markets with input from workforce committee before deployment | PCPs, Psychiatrists,<br>Nurses (BSN, RN, LPN), Mid-levels (PA, NP),<br>Social Workers,<br>Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | July 2017 |
| **Publicize and share best practices supporting job shadowing, preceptor/mentorship, and volunteer programs**<br><br>Recommended Steps:<br>1. Inventory available preceptors/mentors/shadow leader programs<br>2. Convene identified programs to discuss best practices<br>3. Communicate best practices to broader partner network | PCPs, Psychiatrists, Nurses (BSN, RN, LPN), Mid-levels (PA, NP), Social Workers, Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | October 2017 |

| | | |
|---|---|---|
| **Incentivize recruitment of targeted gap positions for partner organizations with compensations rates in the lower 50 percentile**<br><br>Recommended Steps:<br>1. Identify eligible partner organizations<br>2. Establish incentive program details with input from workforce & finance committee<br>3. Publicize funding opportunity to eligible partner organizations<br>4. Measure results of the program to determine effectiveness, make adjustments to the program design as needed | PCPs, Psychiatrists,<br>Nurses (BSN, RN, LPN), Mid-levels (PA, NP),<br>Social Workers,<br>Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | October 2017 |
| **Develop career ladders to advance workers into gap positions**<br><br>Recommended Steps:<br>1. Partner with academia, organized labor, and existing regional workforce development entities to identify and define career ladders for gap positions<br>2. Identify partner organizations with employees at lower rungs of identified career ladders<br>3. Engage with the leadership of identified organization to develop plans for advancing employees to higher rungs of the career ladders | PCPs, Psychiatrists,<br>Nurses (BSN, RN, LPN), Mid-levels (PA, NP),<br>Social Workers,<br>Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | June 2018 |
| **Develop PPS-wide professional development resource service**<br><br>Recommended Steps:<br>1. Identify existing career counseling/coaching programs<br>2. Contract with program(s) to offer discounted access to employees of partner organizations<br>3. Publicize the service to the HR departments of partner organizations with promotional materials for employees | PCPs, Psychiatrists,<br>Nurses (BSN, RN, LPN), Mid-levels (PA, NP),<br>Social Workers,<br>Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | June 2018 |
| **Support succession planning for partners with physicians approaching retirement**<br><br>Recommended Steps:<br>1. Identify physicians in gap positions nearing retirement age or planning to vacate their positions for other reasons<br>2. Approach practices to determine if a succession is in place or if assistance is desired<br>3. Approach residency programs to identify residents interested in local placements after graduation<br>4. Develop pairings of residents and retirement age physicians for mentorship and to increase familiarity with practice | PCPs, Psychiatrists, Nurses (BSN, RN, LPN), Mid-levels (PA, NP), Social Workers, Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | January 2017 |

| Training | | |
|---|---|---|
| Strategy | Targeted Positions | Projected Timeline |
| Please refer to CNYCC Training Strategy | | |

| Deployment |
|---|

| Strategy | Targeted Positions | Projected Timeline |
|---|---|---|
| **Contract with staffing vendor(s) to offer discounted placement services to PPS network**<br><br>Recommended Steps:<br>1. Identify local firms with demonstrated success in recruiting gap positions<br>2. Contract with identified firm(s) to offer discounted services to partner organizations<br>3. Measure results of recruitment efforts to evaluate effectiveness | PCPs, Psychiatrists,<br>Nurses (BSN, RN, LPN), Mid-levels (PA, NP),<br>Social Workers,<br>Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | April 2017 |
| **Identify and facilitate opportunities for staff sharing by partner organizations**<br><br>Recommended Steps:<br>1. Scan centralize job postings for complimentary part-time openings and identify partner organizations with unmet need for part-time coverage for gap positions<br>2. Broker relationships between partner organizations with complimentary needs and support recruitment of shared employee | PCPs, Psychiatrists,<br>Nurses (BSN, RN, LPN), Mid-levels (PA, NP),<br>Social Workers,<br>Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | April 2017 |
| **Contract with local firm to establish a float pool for gap positions**<br><br>Recommended Steps:<br>1. Identify local firms with capability to establish float pools for gap positions<br>2. Contract with identified firm(s) to offer discounted access to partner organizations<br>3. Measure results of program to evaluate effectiveness | Nurses (LPN, RN), Social Workers,<br>Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | October 2017 |
| **Identify and facilitate placement for displaced PPS partner employees into gap positions**<br><br>Recommended Steps:<br>1. Establish infrastructure & process for partner reporting of displaced workers<br>2. Identify displaced workers from positions at lower rungs of identified career ladders and target for training<br>3. Support displaced workers in accessing appropriate training resources | LPNs, Social Workers, Psychologists, other BH counselors, peer specialists, Care Coordinators/Navigators, Medical Assistants and Patient Care Techs | October 2017 |
| **Develop program to ensure delivery of care coordination services across the PPS network**<br><br>Recommended Steps:<br>1. As part of development of PPS-wide care coordination strategy, identify unmet need for care coordination across the PPS<br>2. Evaluate options to deploy care coordinators to fill identified unmet need<br>3. Support the ongoing training of care coordinators | Care Coordinators/ Navigators | June 2017 |