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

Based on the submitted Mount Sinai PPS Community Needs Assessment in 2014, barriers to access exist regardless of provider types. The leading cause behind challenges to accessing care was reported as difficulty navigating the healthcare system and a lack of awareness of available resources for patients within the community. In a specific survey from the PPS, it was noted that approximately one-third of respondents believed that it was difficult for patients to see a primary care provider within seven days of being discharged from the hospital. Only 20% of respondents reported that Medicaid beneficiaries could see a primary care provider within seven days of being discharged from an acute care facility.

The primary care capacity of the PPS currently includes 1,720 primary care practitioners, of which specialty types include internal medicine, family practice and pediatrics. The current total PPS attributed lives population is 394,789 Medicaid members. While the low ratio of primary care practitioner to attributed lives population of the PPS would suggest better clinical outcome per member, the MSPPS Measurement Year 1 results demonstrated the opposite. In fact, key performance measures, such as Children and Adult Preventive or Ambulatory Care Access and Preventive Quality Indicators have not met the performance targets and have further highlighted the need for the PPS to explore other drivers beyond expanding primary care capacity as a barrier to access. While the PPS service areas include Manhattan, where there an abundance of primary care providers and other provider types, the two other service areas, Brooklyn and Queens the largest geographic area of the PPS, are HRSA designated Health Professional Shortage Areas (HPSA) of a less densely populated multiethnic and multicultural medically underserved area with a lower penetration of all provider types including primary care providers.

As a result, the PPS have begun exploring collaboration opportunities with the leadership of larger FQHC by initially assessing their primary care and integrated behavioral health availability, access, and capacity throughout all of the PPS service areas. Specifically, the PPS is attempting to assess if these FQHC's panels are at full capacity, and ensuring attributed patients can then be connected to primary care as needed as the PPS launch the community care Hubs. The PPS is also exploring partnering opportunities with FQHCs that are strategically expanding their primary care footprint to address the health services needs of low primary care penetration and increase emergency services utilization. In addition to addressing the aforementioned issues with FQHC partners, the PPS is monitoring FQHCs and other partners' innovative models that include talent pipeline models to address staffing concerns of primary care physicians, nurse practitioners, and physician assistants. One of the PPS' largest FQHCs is studying

the use of nurse practitioners to increase patients' access to primary care. The PPS will continue assessing and leveraging nurse led and other creative models with its FQHC and other partners.

Other ongoing efforts include discussions with Health Home networks to understand, socialize, and optimize the use of the Health Home structure. Fundamental to the PPSs' care management strategy, optimizing the enrollment of all Health Home eligible patients and connecting them to a care manager as a central member of the care team who will educate, engage, maintain the necessary connections with primary care, specialty, and social service providers to address all of their health, behavioral and social unmet needs is a central component. The initial phase of the PPS' care management strategy includes identifying high risk and high need population, assessing their care management needs and eligibility, enrollment into care management services including Health Home, intensive care management programs, and/or HARP services by targeting four care settings, inpatient hospitals and psychiatric units, emergency departments, outpatient and community based primary care clinics, and specialty care clinics, as well as, periodic monitoring and tracking of metrics related to engagement in care such as PCP, behavioral health and specialty visits. The second phase of the PPS' care management strategy includes identifying the rising risk patients in all setting in need of care coordination services and connection to primary care, by utilizing the PPSs' digitized resource guide to generate referrals, track connection to care and services, and monitor performance measures to identify clinical opportunities.

As the PPS launch its clinical implementation strategy through the community care Hub, a model whereby many different clinical and social provider types in the same or nearby zip codes serving the regional population will work collectively to improve communication and care coordination by positively impacting the patients' clinical outcomes and experience while reducing waste and redundancy at various points in the patients' continuum of care. At the center of the provider network and care hubs are the community primary care practitioner, who typically provides the initial episode of care. The PCP, as the primary coordinator of care in collaboration with behavioral health, specialty, and social service providers including a care manager will transform a care delivery model that addresses some of the health system challenges of providing timely and appropriate access to clinical care, navigating patients to services to address their social determinants of health needs, and providing care transition services with the goal of avoiding preventable emergency room utilization and potentially preventable admissions and readmissions. The PPS is launching the first care hub in the coming months and are targeting access to primary care and specialty services as one of the primary focus of the strategy.

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

The Practice Transformation cross-functional workgroup has been assessing the best strategies and approaches to provide practice sites within the PPS network with the support and assistance needed to transform their practices.

The group has acknowledged that practice sites are at varying levels of maturity with respect to ability, capacity and interest to pursue practice transformation. Additionally, certain practices, specifically those associated with larger institutional support, may wish to pursue alternative models of practice transformation like the Joint Commission Primary Care Medical Home. The PPS will plan to support practices who wish to pursue any practice transformation model (NCQA, APC, Joint Commission, etc.).

Practice transformation vendors have been assessed by the PPS for specific services they can provide practice sites. However, the PPS must determine practice sites' current level of maturity and interest in practice transformation. Potential services to be offered range from dedicated and focused technical assistance, to final application submission review, to learning symposium to foster group training and sharing of best practices. The latter service option is considered a suitable option to allowing practice sites to better understand the requirements and efforts of practice transformation with peer practice sites prior to a commitment of resources, time, effort, and funding.

The PPS has reviewed the statewide resources provided; however, much data has been outdated and not of much utility. The PPS has obtained the NCQA database to grasp real-time data for decision making. The Statewide resources are valuable in providing regional analyses for comparison purposes and key takeaways. Current data on the PPS' PCMH maturity indicate that of the PPS' safety net and non-safety net PCP providers, that 39% are either 2011 or 2014 indication, and the remaining 28% are not PCMH-recognized or have any Meaningful Use indication.

As the PPS progresses towards the Hub model, the specific partner site locations in a geographical region will participate in care coordination efforts that emphasize improvement on prioritized performance measures that addresses the underlying clinical and service inefficiencies of that region.

To facilitate practices to participate in an integrated delivery system, the partner connection to the Mt. Sinai HIE and local RHIO, Healthix, will be launched in waves, with larger attribution partners being implemented initially. Primary care practices, FQHCs, as well as clinics, represent six of these larger attribution Partners. One of the many implementation goals of the launch will

support regionally located partners to share patient alerts and care plan data from a comprehensive and unified platform. In addition to HIE connectivity, the PPS is implementing a performance measure tracking solution that allows PPS partners, including PCPs to monitor their performance on key measures at an organizational level view. Tracking progress on measures such as access to preventive and ambulatory care as well as other key performance metrics will be carefully monitored to assess impact of PCP engagement and highlight barriers to access challenges that will be addressed through the Hubs' continuous quality team utilizing rapid cycle improvement strategy.

The PPS is engaging in various activities that provide support for PCPs beyond the PCMH requirements. The PPS is exploring patient facing technological solutions that will empower patients to play a greater role in managing their own health while simultaneously assessing our PCP partners' current use of patient technology, such as patient portals. PCPs have also expressed interest in participating in an innovative, PPS funded community paramedicine program where collaboration between PCPs, ED physicians, and EMS technicians in the patients' home setting can address a patient's deteriorating condition and potentially avoid an ER visit if deemed appropriate. The PPS is spearheading discussions with the most popular EMR vendors in advocating for EMR changes that improve work flows and capture essential DSRIP elements. The PPSs' PCPs and specialists have also engaged and collaborated on educational activities that range from case base training on management of the more complex multiple comorbid chronically ill patients with social determinant of health challenges, as well as, training on appropriate patient referrals to specialists in order to maximize the clinical encounter to a limited pool of available specialist. Furthermore, to address the barriers to access to specialist and mental health services, the PPS is facilitating discussions with PCPs and specialist to identify and implement creative solutions, like telehealth and electronic consults, to improve access, improve real-time communication and care coordination between these providers with the goal of improving clinical outcomes, patient experience, and reducing avoidable preventable emergency utilization and admissions.

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

The PPS vision, or community care Hub model, places the PCP as a focal point of the care team collaborating and coordinating the care of patients with the multiple provider types and community based service providers that interact with patients. This vision has been vetted through many stakeholder committees as well as Town Hall to partners and the community.

Although patients may enter the care system through other provider types, such as behavioral health and/or substance abuse or health home care manager, the PCP typically serves as the primary point of care entry into the PPSs' integrated delivery system. A care management and IT/Data infrastructure is in development to support and facilitate care coordination and partner communication to be piloted in the first hub and later disseminated to other hubs.

The PPS is developing systems that will facilitate and support the PCP in eliminating the fragmentation of care in our current delivery model. The silo approach to care whereby patient utilize emergency room as usual source of care or are admitted and readmitted in acute care settings for ambulatory sensitive conditions that are potentially preventable by an engaged PCP and care team including care management is a focus of the PPSs community care Hub model. In fact, one of the key metrics for care coordination in the hub model is to identify and engage the PCP and connect all other members of the care team during an episode of illness. To transition the PPSs' care delivery model from a silo approach of care to a more synchronized care delivery, the PPS will collaborate with all the partners to facilitate the development of clear and real-time communication, care coordination, and integration of medical and non-medical services across PCPs, acute care settings, and community based services.

The PPS has recognized the tremendous value and contribution of primary care practitioners in helping to design a more synchronized delivery system. Approximately twenty-five percent of the PPS governance structure, including Clinical committees and Board of Managers is comprised of PCPs. Primary care practitioners are well-represented in the PPS governance structure including at the board, committee and project workgroup leadership level. President/CEO and other senior leadership of FQHCs, clinics, as well as other provider types are members of the PPS Board of Managers. Additionally, several chief medical officers of federally qualified health centers FQHCs have a leadership role on the PPSs' clinical committee, care transition workgroup, and practice transformation workgroup. The PPS aims to leverage the years of experience and expertise of the FQHC partners in building a sustainable care delivery

system that will transition and prepare the PPS partners to a care delivery that focuses on value, not volume of care.

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

The PPS has discussed the role of each provider type with respect to value based payment arrangements. Each provider type, from PCP to non-provider community based organizations to acute care facilities, will play a unique role in managing and improving population health.

The PPS has socialized and introduced the key principles and concepts of value based payment arrangements with a host of PPS partners and provider types. Key topics included overview of the VBP roadmap and funds flow scenarios. Such discussions have occurred with FQHCs, clinics, and other primary care-centric partners to ensure key considerations are taken into account.

The PPS' Workforce Committee's training strategy includes training and technical assistance resources to help PPS partners understand value-based payment arrangements. To assist with ensuring PCPs and other provider receive the necessary data from all PPS partners, including acute care facilities and emergency departments, technological platforms that will display the longitudinal view of an attributed patient's care is under development. As a result, transmission of data between Partners and the Mt. Sinai HIE and local RHIO, Healthix, are crucial.

There are unique challenges that certain PCP-centric partners currently face that will impact contracting arrangements. There are also unique benefits and strengths that these partners offer that allow a value-based payment arrangement appear beneficial. Through DSRIP Project 2ai workgroup, the PPS have begun to message VBP arrangement concepts and provide a high-level understanding of the Mt. Sinai Health System's Medicaid IPA strategy. This forum of discussions will allow for clear and direct input into the strategy across all provider types, including PCPs.

The PPS partner participation agreements are currently based on a model that delivers incentive payments to partners for meeting performance metrics. The partner contract deliverables are increasingly requesting PCPs to make changes in practice workflows, as an example, develop better communication strategies with other providers to facilitate transition plans. These are the early stages in distributing payments for value based activities.

5. **How does your PPS's funds flow support your Primary Care strategies?**

The current PPS funds flow will take into consideration the strategies previously discussed to support primary care.

The PPS is considering supporting partners with funding who wish to pursue practice transformation. Since many partners vary in maturity and interest levels to pursue practice transformation, and the results and maintenance of such practice transformation reside with those practices, the PPS may provide contract metrics to support, facilitate, and incentivize partners to pursue practice transformation. Preliminary suggestions center around providing clear contract metrics for partners to reach specific milestones or requirements until a complete and successful practice transformation has been achieved.

The PPS has recently undertaken a new initiative to assess the impact of provider types to the PPS prioritized performance measures. This is crucial as the DSRIP program award payment distribution begins to transition towards pay for performance. With input from clinical project and PPS clinical leadership, it was determined that a significant number of performance measures appear to be positively and highly impacted by primary care practitioners, primary care clinics, and FQHCs. As a result, the PPS funds flow methodology will model incentive payment distributions to reflect the significant impact of primary care practitioners, clinics and FQHCs.

To date, the PPS has distributed significant contractual incentive payments to larger primary care practices and FQHCs. The sum of current payments to the PPS' partners classified as clinics and PCPs total approximately $1.9MM. The current contract metrics for distributed dollars include reporting, engagement, and performance. Examples of engagement metrics include participation in educational webinars, Town Halls, and attendance of key events, such as the Cultural Competency kick-off event and reporting by providing baseline data on some key diagnosis.

### 6. How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?

Project 3ai has maintained progress and accomplished key steps in its effort to integrate primary care and behavioral health services.

The project has implemented a 5-prong strategic approach to implement key requirements and ensure project success:

- Connectivity and Alignment with overall MSPPS structure, content, and process
- Building a Team at All Levels - Inclusivity and Building Consensus with partner
- Standardization (but build in flexibility)
- Problem Solving Mode throughout provides *Momentum*
- Beyond Project Management - Clinical and Business Operations provides S*ustainability*

Also, models 1 and 3 of the project have actively been developing an evidence based protocols manual for use by partners across the PPS to provide guidance with implementing the projects. Key components of the manual include information on care team members, screening protocols, warm handoffs, medication management, case review, and screening tools.

The manual provides more information on who are key integrated care team members, which may include Psychiatrics Social Work Care Manager, PCP, peers, and Psychiatrist. The use of screening tools, such as PHQ2 and PHQ9, differ for adults and adolescents/pediatrics, other screening tools are also outlined. The inclusion of screening tools for alcohol and substance use by utilizing SBIRT has also been integral in the primary care and behavioral health co-location efforts. Additionally, general principles and components around warm handoffs in integrated care have been identified, as well as clarification on the difference between a warm handoff and traditional referral. Additionally, workflows have been developed to identify how a behavioral health provider communicates with the PCP and collaborative care team, and data sharing concerns are also addressed.

Upcoming activities of the Project include piloting protocols, creating an implementation tool kit, identify and conduct trainings, focusing on DSRIP performance measures, and engaging partners.

The PPS has been made aware that the PCMH/APC requirement for Model 2 of Project 3ai no longer is applicable. The PPS continues to further understand the regulations that can be waived for allowing sites to integrate the two services.