



The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program is to restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. In partnership with hospitals, public health agencies, physicians and community-based organizations, the North Country Initiative is advancing state-wide projects to transform the healthcare system, coordinate care, and improve the health and wellness for our population.

2.a.ii

Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))

Project Objective:

This project will transform all participating safety net providers in primary care practices into NCQA 2014 Level 3 Patient Centered Medical Homes (PCMHs) or Advanced Primary Care Models by the end of Demonstration Year (DY) 3.

Project Description:

A key requirement of the healthcare transformation is the availability of high quality primary care for all Medicaid recipients and uninsured, including children and patients with higher risks. This project will address those providers who are not otherwise eligible for the necessary support or resources for practice advancement as well as those providers with multiple sites that wish to undergo a rapid transformation by achieving NCQA 2014 Level 3 Patient Centered Medical Homes (PCMHs) or Advanced Primary Care Models by the end of Demonstration Year (DY) 3. Performing Provider Systems undertaking this project, while focused on the full range of attributed Medicaid recipients and uninsured, should place special focus on ensuring children and parenting adults, and other high needs populations, to have access to high quality of care, including integration of primary, specialty, behavioral and social care services.

Patient Population:

Medicaid recipients, uninsured with a special focus on children and parenting adults.

Identified Community Need:

Availability and accessibility. Our Tug Hill Seaway Region has been federally designated as a low income Medicaid Health Professional Shortage Area (HPSA) Therefore, it is critical that we develop a more effective and efficient means for patients to receive care from our limited resources. This project will incorporate medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system from one that is institutional-based to one that is community-based. This project will create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of services.



2.a.ii

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Project Milestones	
1	Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of Demonstration Year (DY) 3.
2	Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.
3	Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.
4	Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.
5	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of DY 3.
6	Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.
7	Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.
8	Implement preventive care screening protocols including behavioral health screenings (PHQ-2 9, or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.
9	Implement open access scheduling in all participating primary care practices.