Forward Leading IPA
FLIPA
Common Purpose. Innovative Solutions.

Navigating Value Based Care in Rural Primary Care
January 10, 2025

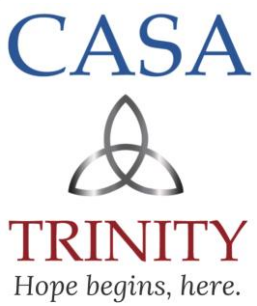
Dr. Briannon O'Connor
Chief Clinical Officer
Forward Leading IPA

About FLIPA

Mission and Vision

The mission of Forward Leading IPA (FLIPA; formerly Finger Lakes IPA) is to be an **organized, highly effective integrated delivery network** of community health centers, behavioral health and social care partners that promotes an **equitable, accessible, and integrated healthcare system** that leads to improved overall health and well-being for all.

As an integrated delivery network, FLIPA has and will continue to enter agreements with health plans offering financial incentives to improve patient outcomes. **FLIPA's mission is built on the vision that the integration of behavioral health, social care needs and primary care is essential to improve the health and wellness of patients, and that failing to meet the needs in any one of these areas leads to greater challenges in the other two.**



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FLIPA History

Friday Morning Meetings for more than a decade that included BH partners

2017
Incorporated as an IPA

2019
First VBP contract
- Fidelis Medicaid VBP Level I

2020
Moved to VBP Level II
- Moved to Fidelis Medicaid VBP Level II

2021
Added two more VBP contracts
- Added Fidelis HARP VBP Level I
- Added United Healthcare Medicaid VBP I

2022
Expanded unique members in all contracts
- Moved to Fidelis HARP Level II
- FLIPA & UCHC joined

2023 and 2024
Continue to expand attribution and add contracts
- Moved United Healthcare to Level II (2024)
- Added Medicare MSSP contract with Signify/CVS

2025
Continue to expand attribution and add changed Medicare arrangement
- Moved to ACO REACH with CVS

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- Initial STACI investment

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- Moved United Healthcare to Level II (2024)
- Added Medicare MSSP contract with Signify/CVS
- HRSA Neonatal Abstinence Syndrome
- SAMHSA Project LAUNCH

2024
Continue to expand attribution and add changed Medicare arrangement
- Moved to ACO REACH with CVS
- HRSA Building Bridges
- Social Care Network Lead Entity
- SAMHSA Community Maternal BH

2025
Continue to expand attribution and add changed Medicare arrangement
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Forward Leading IPA, formerly Finger Lakes IPA

23 member organizations

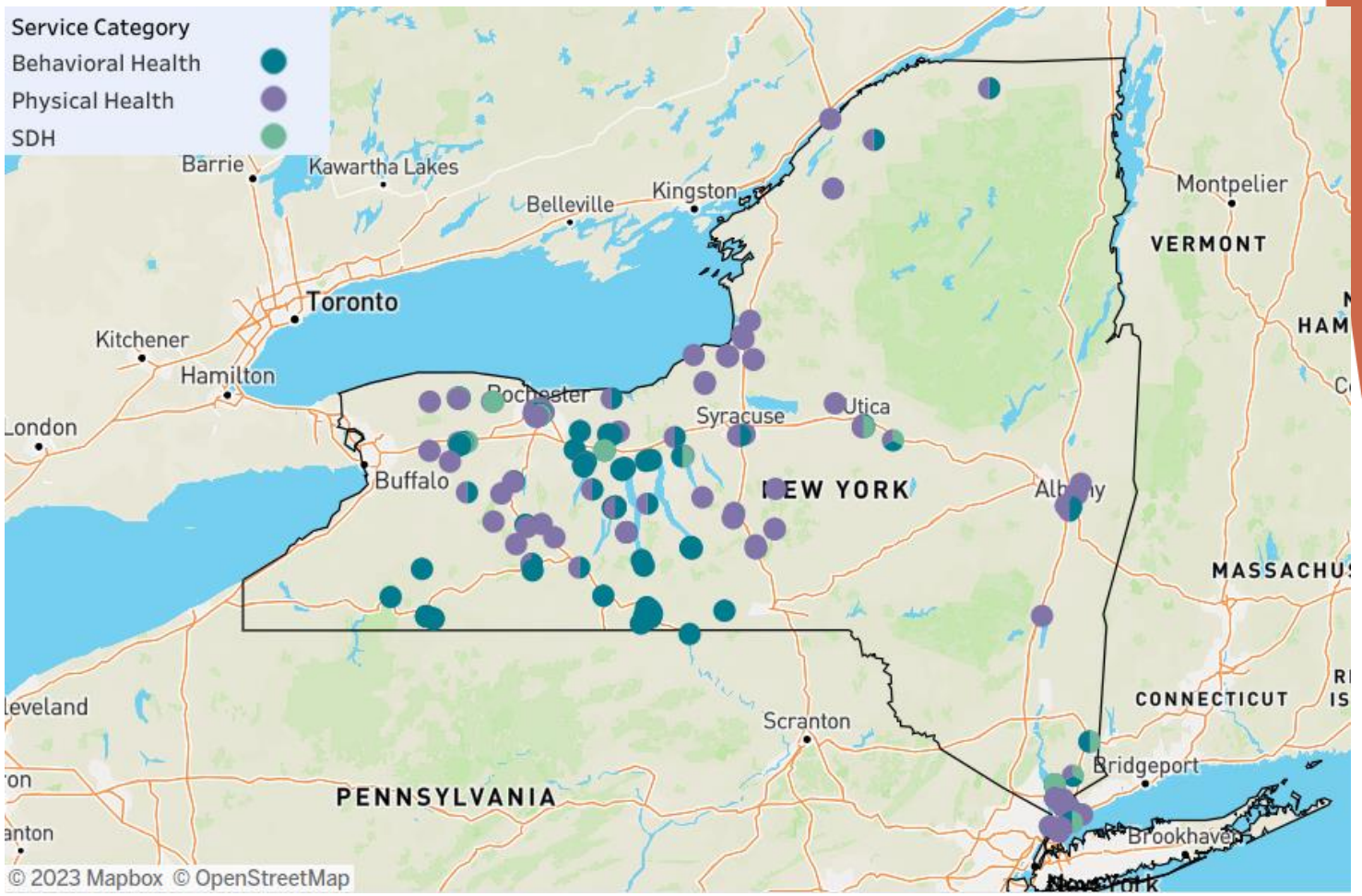
330,000+ lives served annually across Upstate New York

14+ million dollars worth of external funding in past few years

6+ years with Value Based Payment contracting experience with multiple MCOs

National recognition for innovative integration solutions

Social Care Network lead entity in the Finger Lakes Region



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Our Member Services

Physical Health

- Primary care
- Vision
- Dental
- Pediatrics
- OB-GYN/Women's Health
- Community preventative services
- Podiatry
- Endocrinology
- Psychiatry

Behavioral Health

- Mental Health & Substance Use
  - Inpatient
  - Outpatient
  - Residential
  - School-based
  - Prevention
  - Crisis
  - Harm Reduction
  - Recovery
- Care Coordination
- Health Home Care Management

Social Care

Including but not limited to:

- Housing
- Food support
- Employment services
- Education services
- Transportation
- Childcare
- Benefits navigation
- Care Coordination

VBP Success

FLIPA

Value Based Payment models and strategies for success

Population health management

Strategy

Clinical standards of care

Support for providers

Convene integrated member network

Provide higher quality care

Preventive, integrated, coordinated care reduces costs

Projects and areas of focus

Others
- Special populations
- Outreach to unengaged and high ER users
- Reducing potentially preventable visits
- High-cost protocol

Integration
- i-ACT integrated care coordination
- Social Care screening
- Expanding social care needs connections
- HIE alerts
- Screening and transition of care protocols

Maternal Child Health
- Project Launch
- 0–30-month workflow
- Doula connections
- Specialized care coordination for prenatal SUD patients
- Birth-related inpatient census

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Role of an IPA in Navigating VBP in Rural Health Care

Role of an IPA in Navigating VBP in Rural Health Care

- Louder voice for negotiation and advocacy
- Shared learning
- Sharing resources
- Leveraging regional resources
- Centralizing functions to reduce barriers

Louder voice for negotiation and advocacy

- Dedicated staff time for contract negotiation, contract performance reviews, data analyses, MCO communication
  - Deeper understanding of levers of change to use limited resources to impact VBP success
- Support for roster management and supplemental data submission
- Role on numerous state committees and ad hoc meetings to voice needs for true integration to better meet patient needs
- Visibility at state and national level for the good work of FLIPA member organizations, the needs of FQHCs, and the mission of FLIPA

Shared learning

Training

- CME-Certified Children's Mental Health Treatment (Project Teach)
- Cost deferment for grant-related trainings
- Basics of Excel for data organization for all member staff
- VBP fundamentals for all levels of staff

Input

- Learning community that shares workflows, patient guides, EHR tricks and templates
- Affinity groups for Human Resources staff, Analytics teams
- FLIPA Standards of Care
- Best practice research and sharing
- Medicaid-member focus groups

Sharing resources

- Subject matter experts more accessible with pooled resources
  - Coding, data/IT subject matter experts

- Grants are stronger with larger impacts and more partners and leaner with centralized project support team
  - HRSA Building Bridges to Primary Care Competition
  - SAMHSA Project LAUNCH
  - HRSA Healthy Moms, Healthy Babies
  - SAMHSA Community-Based Maternal Behavioral Health

- Screening tools for infants and young children

Leveraging regional resources

- DSRIP extension dollars turned to community investments
  - Infrastructure, analytics, expertise, innovative projects, Social Care Network
  - Seed funding for integrated care coordination model
- Social Care Network
  - Early and ongoing advocacy with the state to consider impacts for and critical role of FQHCs
  - Up to date on current requirements, progress, and potential paths to engage for FQHCs

Centralizing functions to reduce barriers for patients and staff

- Telehealth consultations with specialists
- Barrier removal funds for nonreimbursable patient needs
- Centralized feeds for data and reporting for multiple contracts
- Grant writing support
- Project management
- Research and evaluation support

Navigating Value Based Care in Rural Health Centers
January 10, 2025

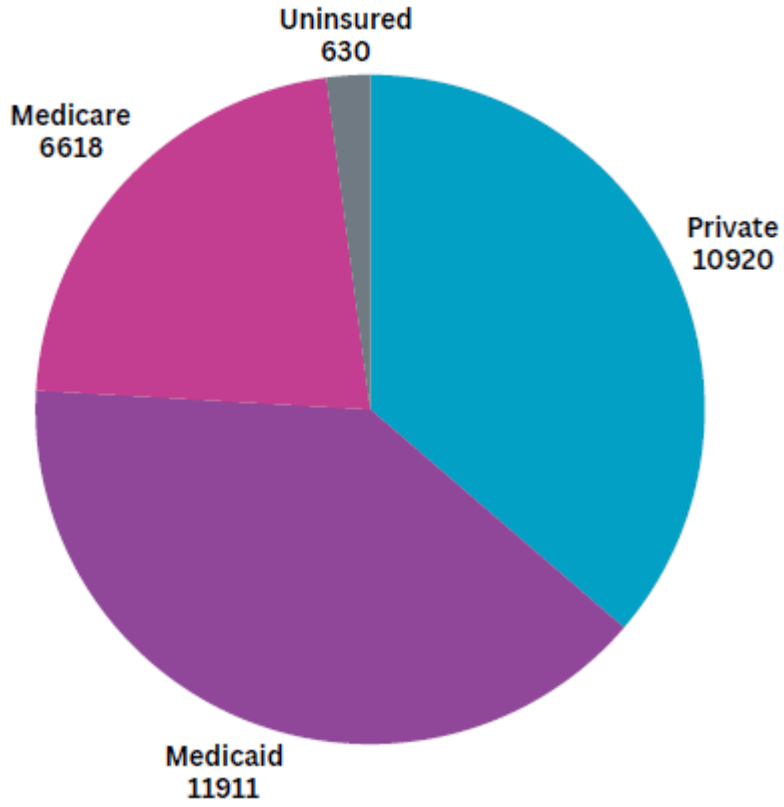
Nancy Deavers, RN, MSN
Sr. Vice President/ Chief Nursing and Quality Officer

ConnextCare by the Numbers Fiscal year 2023

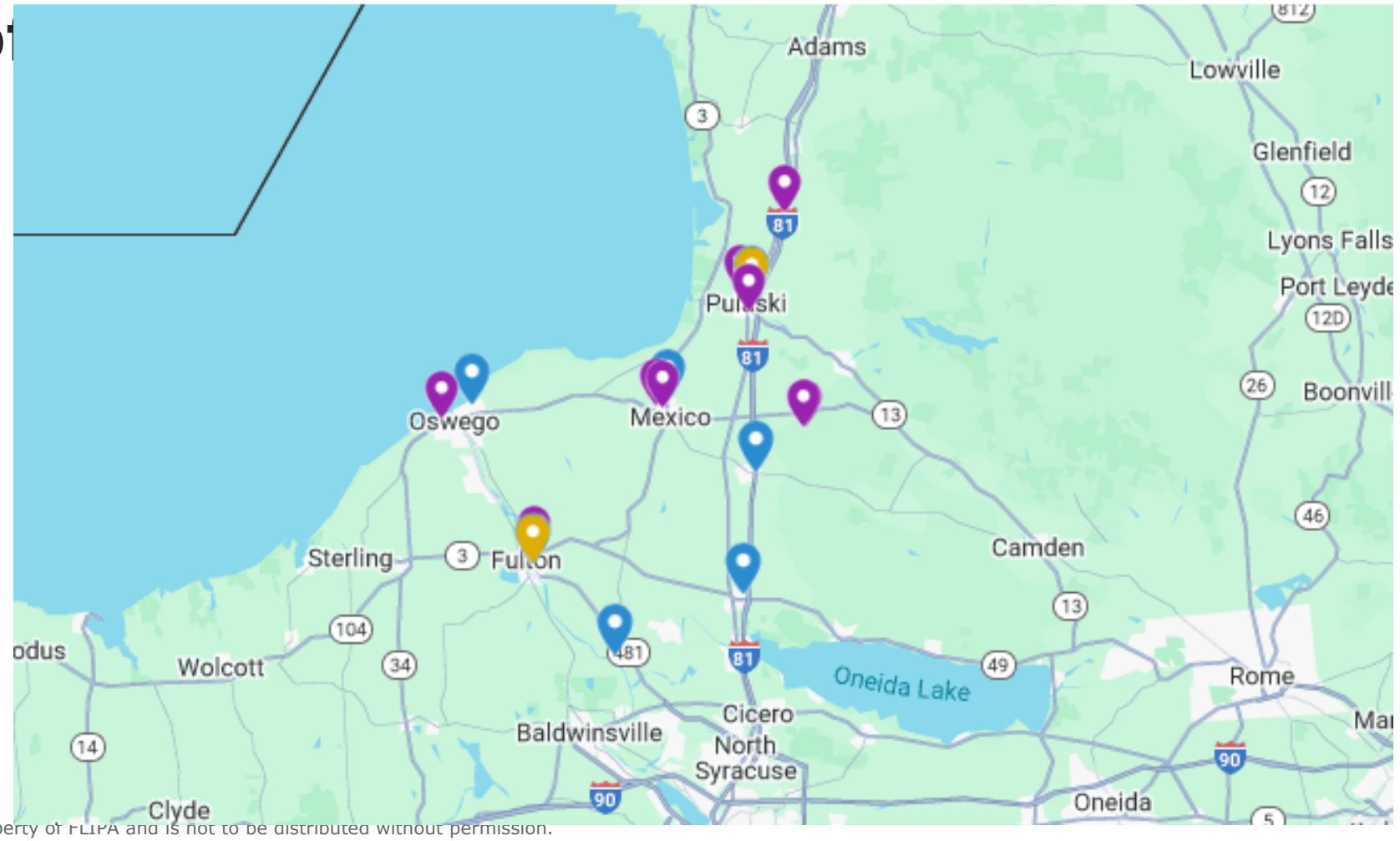
Employee Count ~ 276
Provider Count ~ 51 Medical Providers, 11 Dental Providers, 17 Mental Health Providers

Unique patient growth over the past three years:

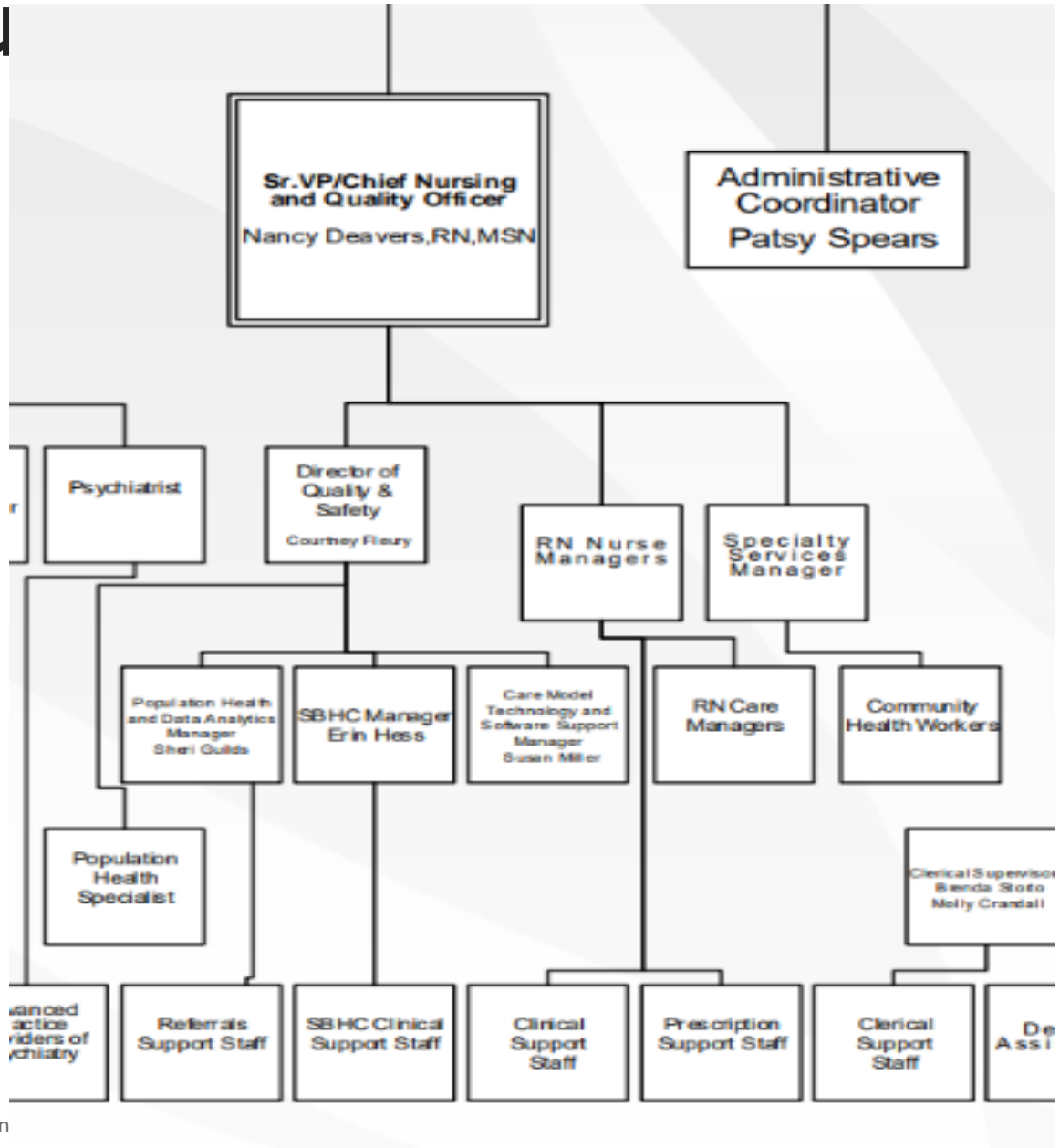
	2021	2022	2023
Uninsured	620	405	647
Medicaid	11,351	11,728	11,283
Medicare	5,754	6,348	6,618
Private Insurance	9,483	10,568	11,531
Total Number of Unique Patients	27,208	29,049	30,079



7 Main Health Centers, 9 School-Based Health Centers across Oswego County: 62% of the county resides in a rural area- the county covers *951 square miles* on the southeastern shore of



Org chart adjusted to assist with Quality Su



Challenges in Oswego County

Ranked 49th out of 62 counties in NYS based on RWJF 2023 County health rankings

Poverty- 34.6% of population reported income below 200% of the Federal Poverty level (29.7% statewide)

Unemployment level 8th highest in the state at 5.1%

Limited Education- 89.8% high school grads, 21.4% Bachelors or higher

2nd highest rate of Neonatal Abstinence Syndrome in NY state

County lacks access to major health care with significant transportation concerns- Provider ratios to population

- Primary Care 2,420:1 (NY avg 1,170:1)
- Dental care 2,170:1 (NY avg 1,220:1)
- Mental Health 600:1 (NY avg 300:1)

ConnextCare's VBP Journey

- Approximately 8 years ago formed the Upstate (Upstate Community Health Collaborative) IPA, with 3 other FQHC's in Central New York and worked collaboratively under two VBP contracts. A joint Clinical Committee focused on clinical metrics, preventable visits and high-cost patients.
- 6 years ago Oswego County developed a local IPA to look at care coordination with community partners- Oswego County Integrated Delivery Network (OCIDN)- includes FQHC, hospital, CBO, SUD provider, Long term care and health home partner

VBP Journey Continued

- 4 years ago UCHC members joined FLIPA- (Forward Leading IPA) and expanded its partnerships to include other statewide FQ's, CBO's and Behavioral Health providers. FLIPA has a Performance Management Committee, who oversees the clinical outcomes of three VBP contracts and focuses on engaging patients, addressing high costs, preventable visits and all other standard quality metrics

Addressing County health rankings

- Joined CHCANYS impact project to work on Hypertension Management about 9 years ago
  - Became Home BP loaner program and developed Care Management Model for increased support
- OCIDN IPA focused on DSRIP initiatives to support Cardiovascular Disease Management, which were some of the lowest scores for Oswego County.
  - Clinical focus expanded to address CHF
  - Used HRSA funding to support BP and weight management purchasing Home BP cuffs and digital scales to provide for patients
  - Standardized education for both programs with OCIDN partners to support patient education showing a decrease in ED and readmissions for these populations
  - Expanded this to Diabetes management in 2024
  - Held case conferences with all members of OCIDN to coordinate/expedite referrals for patients with the greatest needs

Addressing concerns with poverty, lack of employment and literacy

- Received financial support from FLIPA to provide gift cards to patients to address barriers to care (food, travel, sneakers, etc)
- Used HRSA funding to purchase Home BP cuffs and Digital scales
- Obtained Early Childhood Development Grant to support parent education and literacy concerns, while coordinating early intervention care when clinically indicated
  - Began reach out and read with training support from FLIPA. HRSA supplied the books free of charge for kids 0-5
  - Worked with county childhood alliance to begin ASQ training and Diaper Bank support for patients
  - Grant support received to onboard Community Health Workers to support increased care coordination for children and caregivers
- Grew Care management support to reach more patients- 1 RN to every 3-4 providers
- Worked with county to support transportation concerns
- Worked with Local Food bank to setup food pantries at each primary health center

Neonatal Abstinence Syndrome

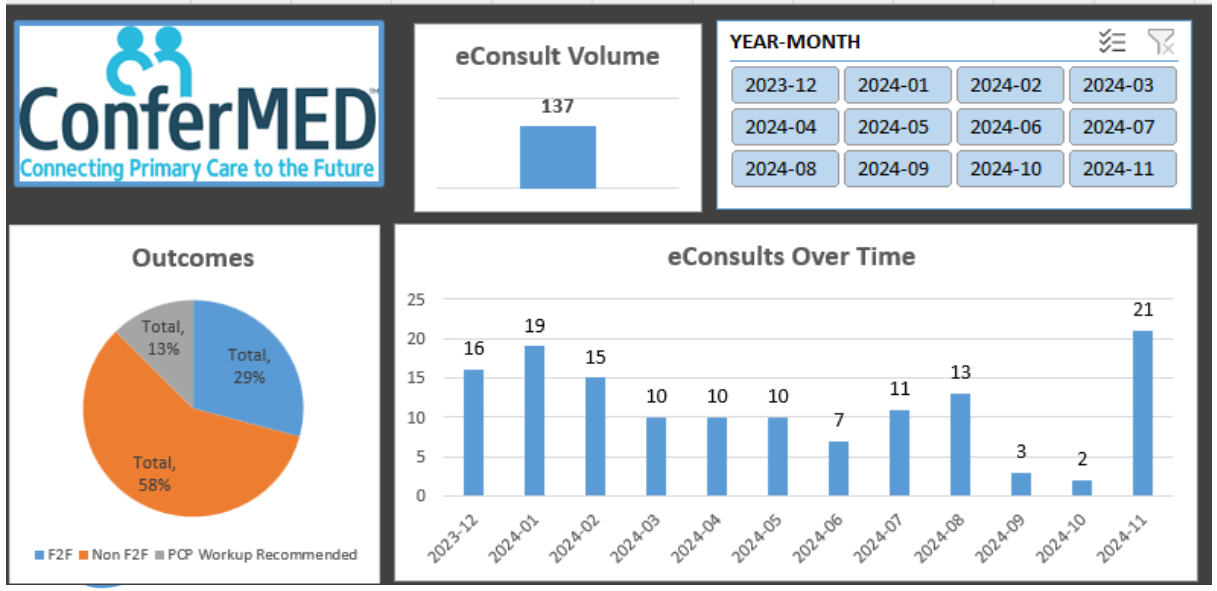
- Received a grant from the County to support this project, including funding for RN Manager and Community Health Worker
- Grant funding also supported training on Dr. Davina Moss's Positive Direction model for the 9 providers supporting Medication Assisted Treatment for SUD patients
- Received training support from FLIPA for clinical staff through Healthy Moms Healthy babies for Positive Dimension Model, supporting the development of a safe plan of care for moms and babies
- Began quarterly pregnancy testing for all women of childbearing age within the program
- Continued use of SBIRT through out our system to identify those in need
- Began review of patients with intent to become pregnant to ensure resources are provided early

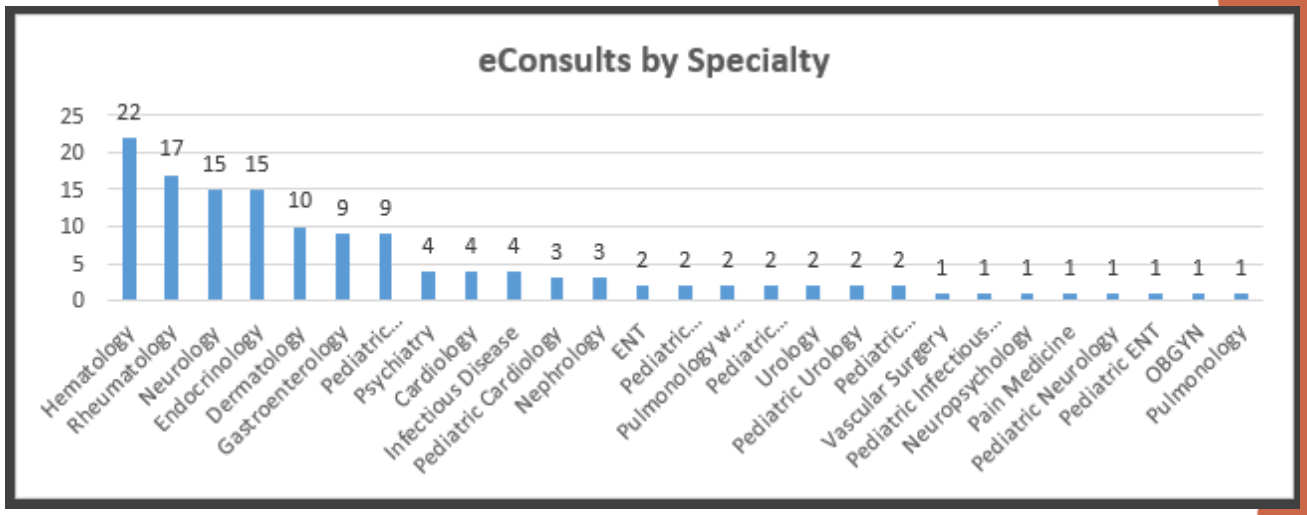
Lack of needed providers and transportation

- RN Care Management staff followed up on patients seen in the ED, urgent care or hospital ensuring contact within 24-48 hours in an effort to improve continuity of care and patient education
- Opened up our 7th health Center in 2020, supplying support to a section of the county that had minimal primary care access
- Developed Psychiatry support as well as mental health counseling for all health centers with integrated care plans and warm hand offs
- Continued to recruit providers and staff to support increased patients
- Implemented the Coleman Model of care to support improved throughput, consistent scheduling and improved staff and patient satisfaction
- With support from FLIPA began E-consults, allowing our patients to get specialty support without travel and decreasing delays in care

Outcomes Achieved:

- Gold certification from AHA for hypertension management, cholesterol control and DM-three years in a row!
- Achieved recognition as a champion for Million Hearts Hypertension Control in 2024
- PCMH certification with Distinction in Behavioral health integration
- Completed 137 E consults





Outcomes continued…

- Achieved low PPR, PPA and PPV rates in our VBP contract

	ConnextCare Rate 2023 Medicaid contract, Paid Thru Jan 24	FLIPA Target Rate 2023 Medicaid contract, Paid Thru Jan 24
PPA	-13.97%	-18.7%
PPR	-8.71%	-26.7%
PPV	3.38	-32.0%

- High rate of Annual Wellness visits

Lessons learned

- Collaborating with community partners is essential to obtaining resources timely for patients
- Integrated care delivery between primary and mental health is essential to improving patient outcomes
- VBP efforts helped obtain resources needed and identify best practices, for the management of complex patient populations
- Change takes time and persistence!

Next Steps for ConnextCare

- Continuing Grant support for NAS and ECD projects
- Continuing VBP efforts to streamline costs, improve clinical outcomes and address patients without connectivity to care
- Began use of AHC tool for SDOH identification in 4th quarter of 2024- will begin identification of patients in need
- Joining the Social Care network for our area to support connectivity to CBOs as well as patient support for SDOH needs

CHCANYS Disclaimer

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