Advocate Community PPS Primary Care Plan Narrative

1. **Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs**
   - PPS's over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)
   - How is the PPS working with community-based PCPs, as well as institution-based PCPs?

A. Current Capacity

Advocate Community Providers (ACP) is a network of diverse, community-based, culturally-sensitive physicians. The ACP PPS network consists of ~2,000 physicians, including ~1,200 PCPs and 800 specialists, who care for 637,239 Medicaid beneficiaries residing in the Bronx, Brooklyn, Manhattan and Queens.

As part of the Delivery System Reform Incentive Payment (DSRIP) program, ACP conducted a workforce survey to collect data as of December 2015 from ACP network providers on their current workforce, vacancies, compensation and benefits, current training efforts, future training needs, and staff functions and responsibilities. ACP retained the Albany-based Center for Health Workforce Studies (CHWS) to administer the survey and analyze the data to develop a current workforce state analysis.

ACP's current primary care network consists of 1,046 Primary Care Providers (PCP), including (fig 1): family medicine, general medicine, geriatric medicine, internal medicine, nurse practitioners, pediatrics and physician assistants. In the Bronx, ACP has 171 PCPs (16% of the network); in Brooklyn, there are 149 PCPs (14%); in Manhattan there are 265 PCPs (25%) and in Queens there are 461 PCPs (44% of the network).

The total ACP attributed population is 637,239 Medicaid members (fig 2). In the Bronx, ACP has 85,412 attributed members (13%), Kings has 90,303 attributed lives (14%), Manhattan has 165,243 (26%), and Queens has 296,281 attributed lives (46%). In addition to the attributed population, another 12% of patients are considered low- or non-utilizers. The typical PCP panel ranges from 600-800 Medicaid patients per primary care location (Fig. 3).

Fig. 1 Primary Care Distribution by Type / Borough.

ACP Attributed Lives by Borough				
County	**Total**	**# of PCPs by County**	**Average Panel**	**% Distribution**
Queens	296,281	461	643	46%
Manhattan	165,243	265	624	26%
Brooklyn (Kings)	90,303	149	606	14%
Bronx	85,412	171	499	13%
Total	**637,239**	**1,046**	**609**	**100%**

County	**Bronx**	**Brooklyn**	**Manhattan**	**Queens**	**Total**	**% Distribution**
Family Medicine	25	37	28	73	163	16%
General Medicine	2	0	8	2	12	1%
Geriatric Medicine	2	1	3	7	13	1%
Internal Medicine	72	76	153	187	488	47%
Nurse Practitioner	17	4	8	25	54	5%
Pediatrics	50	29	58	136	273	26%
Physician Assistant	3	2	7	31	43	4%
Total	**171**	**149**	**265**	**461**	**1046**	**100%**

Fig. 2 Attributed Lives by Borough

County	**Lives**	**% Distribution**
Bronx	85,412	13%
Kings	90,303	14%
Manhattan	165,243	26%
Queens	296,281	46%
Total	**637,239**	**100%**

Fig. 3 Average Panel by PCP/Borough

These three data information grids (figs. 1- 3) demonstrate how strategically ACP is entrenched in the boroughs of Bronx, Brooklyn, Manhattan and Queens to effectively address the primary care and culturally-sensitive needs of the communities we serve.

During the DSRIP years, one of the core criteria for a sustainable health care model is the ability of a PPS to implement effectively and efficiently the dynamic shift to embrace a patient-centered, culturally-sensitive and linguistically competent approach to providing appropriate high-quality care.

In an ongoing effort to improve the performance of the primary care practices and facilitate the transformation into an integrated care delivery system, ACP has supported providers with the following:

ACP is assisting primary care practices to achieve Patient Centered Medical Home (PCMH) Level 3 by the end of 2017. ACP currently has 120 PCPs that have achieved PCMH Level 3 and another 217 PCPs are working toward PCMH Level 3 certification. ACP is working with all participating PCPs to address care barriers that patients routinely experience, such as lack of access to care, social and financial support, and transportation, to name a few.

ACP has partnered with diverse health care organizations and innovative information technology (IT) vendors, such as Insight Management, CCACO, Jamaica Hospital Medical Center, HQ Analytics and Precision Quality to strategically assist our practices to achieve PCMH level 3 accreditation by December 2017.

These vendors were chosen due to their expertise to help providers to achieve PCMH Level 3 certification and EHR Meaningful Use standards by the end of Demonstration Year 3. Combined, these vendors have more than 25 years of experience working with practices toward transformation and their staff are recognized as PCMH Certified Content Experts. Over the past year, these vendors have organized more than 150 provider practices for strategic implementation.

Baseline assessment results from the providers surveyed revealed that a high degree of support would be needed by 53% to improve access (PCMH Standard 1); 38% to improve team-based care (PCMH Standard 2); 52% to improve population health management (PCMH Standard 3); 52% to improve care management and support (PCMH Standard 4); 53% to improve care coordination and care transitions (PCMH Standard 5), and 42% to improve performance measurement and QI (PCMH Standard 6). Our vendors work with each practice to define priorities, write protocols, implement standards, and train staff. All protocols developed are focused on PCMH standards that improve and maximize efficiency of existing primary care resources. This focus allows for enhanced access to care through scheduling improvements, integrated care coordination and, most importantly, using IT to allow patients to independently access providers in an appropriate, timely manner.

ACP has worked closely with our partners and community organizations to identity and close specific provider service care gaps. Together with our strong primary care capacity, the community has a wide range of health care resources available to help meet the needs of the uninsured and/or Medicaid population; however, the following shortages exist in the ACP PPS Network:

I. Primary Care Community Network Assessment (CNA) indicates that 24.1% of the network lives in a primary care health professional shortage area (HPSA): Bronx – 35.7%; Brooklyn – 32.4%; Manhattan – 15.4%, Queens – 15.4% The perception of stakeholders is that there is insufficient access to high-quality providers on a timely basis and a lack of culturally and linguistically competent providers. Learning collaboratives

will be a mechanism to share best practices across the network. ACP will also use care coordination models and staff to expand capacity of traditional providers.

II. Mental Health CNA indicates that 15.4% of the network lives in a mental health HPSA. In addition, the network has low ancillary providers per 100,000 population.

III. Clinical Psychologists: 45.9% of the network across all four boroughs are in neighborhoods with shortages of mental health providers. For example, in Queens, mental health shortages exist in the North, Northwest and Southeast regions of the borough. To address this shortage, ACP will partner mental health and primary care providers to better meet the needs of patients. ACP will leverage existing registries to identify patients who would benefit from care coordination, especially those who live in an HPSA.

IV. Facility Capacity: There is a facility and bed shortage in all boroughs in the PPS:

Hospital Beds (per 1,000 Population, compared to U.S. Benchmark): Queens (2,250); Brooklyn (1,500);

Nursing Home Facilities (Health and Hospitals Corporation Health Care), Brooklyn (zero), Manhattan (zero).

ACP will enhance current health information technology infrastructure to connect facilities and reduce the burden of bed shortages.

ACP is working to structurally enhance primary care capacity for expanded access. ACP identified a shortage of "after hour" and weekend care centers in neighborhoods with high concentrations of Medicaid members. To address this, ACP will develop strategically located "one-stop" urgent care centers staffed by high-quality, culturally-competent providers, including specialists. Hours of care will be compatible with patients who work long or non-traditional hours.

Furthermore, the data supports the causes for the identified gaps (e.g., availability, accessibility, affordability, acceptability and quality of health services) and issues that may influence utilization of services (e.g., hours of operation and transportation) that are contributing to the identified needs of the community. Based on the primary data collected, causes of gaps are as follows:

Quality of Care

- Potentially Preventable Visit (PPV) rates may be driven by the adequacy and perceived quality of the supply of primary care resources as well as personal choice and knowledge of alternative care (or self-care) options;
- Potentially Preventable Readmission (PPR) rates can be an indicator of quality problems in several parts of the care delivery system, including quality of care inside

the hospital, quality of discharge instructions and follow-up to support self-care and care transitions to rehabilitation, specialists and/or primary care physicians in the community.

Availability

- Healthcare Effectiveness Data and Information Set (HEDIS) data points to limited supply of preventive, ambulatory services;
- Consumer Assessment of Healthcare Providers and System (CAHPS) survey measures identify reasons related to accessibility that limit adequate care Accessibility;
- Poor reimbursements that have the effect of limiting supply for Medicaid members; managed care plan limits on the number of visits per year; and a lack of coverage of some medications;
- Long scheduling wait times for appointments;
- Limited evening and weekend hours;
- Limited awareness of and knowledge about services;
- Limited health literacy;
- Lack of culturally competent and language accessible information;
- Stigma around using community services;

Transportation

- Limited transportation services in some areas for older individuals with general mobility or disability issues;
- Limited access to healthy and affordable food, transportation, employment and family and income support services

Affordability

- There is a direct relationship to high rates of household poverty and high rates of unemployment and the uninsured;
- Low levels of education;
- A variety of barriers to care, including eligibility for insurance, low levels of health literacy, and limited English proficiency.

These demographic indicators demonstrated that gaps are closely linked to socioeconomic issues.

ACP Data Sharing Plan

ACP will facilitate data sharing among our partner organizations by working with our electronic medical records vendors to develop a centralized platform that gives network partners access to a comprehensive view of patient needs, allows for effective care management and assists with navigation of the healthcare system while maintaining regulations as required by the Health Insurance Portability and Accountability Act (HIPAA) to safeguard patient privacy and safety.

eCW is the most prevalent EHR in our provider network. 80% of ACP's PCPs use eCW or MDLand EHRs. Additionally, cloud technology will capture information from a range of different systems (e.g., institutional systems, registries, labs and imaging, other EHRs/HIEs, public health agencies, payers, clearinghouses, and pharmacies) into a data warehouse. Also, processes and workflows are to be established in physician offices that include appropriate retrieval of consent forms.

ACP partners will act in unison to ensure data privacy and security, including upholding all HIPAA privacy provisions. ACP has developed a Health Information Technology (HIT) Committee that focuses on data sharing issues, such as ensuring privacy and security of data. The HIT Committee, which reports to the Board, will act in accordance with evolving views and regulations developed by the State and establish contracts with partners that will include terms and conditions that cover data sharing obligations, data-driven performance, data usage and meet DSRIP requirements such as care management and care coordination. The HIT Committee will be responsible for developing the data-centric protocols that our PPS partners must agree to, including reporting, data access, and data exchange requirements. Appropriate Business Associate agreements will be required by covered entities, as well as annual HIPAA training and attestations for all required entities.

ACP is developing the capability to share relevant patient information in real time so as to ensure that patient needs are met and care is provided efficiently and effectively while maintaining patient privacy. ACP is working with eCW and MDLand, the most prevalent EHRs in use by physicians and community centers in our region, to connect and centralize providers and share data. With these data sharing capabilities, the PPS will have access to centralized data that will provide comprehensive patient information from varying care settings intro actionable information.

This comprehensive data set will allow our PPS to stratify and target high-risk populations that require additional care, and maintain the status of patients who are identified as lower risk by providing preventive care. Real-time data will identify patients potentially accessing care in inappropriate settings and generate alerts to physicians and care managers. Additionally, our PPS will integrate with Healthix, the Regional Health Information Organization (RHIO), in order to exchange data appropriately but compliantly to further provide proper care management. For PPS partners who have limited or no data-sharing capabilities, such as practices with paper medical records or

standalone systems, ACP will provide a variety of solutions that will assist their EHR infrastructure, including EHR build support or workarounds that use portals to capture and structure appropriate data. By offering these solutions, such as an EHR-light or portal, our PPS will encourage partners to connect existing IT capabilities and develop capabilities to promote data exchange.

B. Performance

ACP has selected 10 projects to achieve the goals of DSRIP. ACP's goal is to achieve positive outcomes in all of these projects and additionally show a decrease in hospital utilization, greater value of care and create health reform through a robust clinically integrated system that is based on value and not quantity of services, thereby increasing the health of the population while reducing cost. ACP has aligned all of these efforts in a measurable structure that includes qualitative and quantitative results, including initiatives such as:

- Hypertension, cardiovascular disease, diabetes, asthma, blood pressure screening;
- Population health education and training;
- Promoting healthy lifestyle;
- Addressing Behavioral Health and substance use disorders;
- PCMH 2014: Transforming primary care;
- Training ACP project managers on the workforce implications (i.e., training and hiring) of each of the 10 DSRIP projects for neighborhood medical practices;
- Symposium on "The Workforce: Challenges and Opportunities for Neighborhood Medical Practices and Providers" to gain a better understanding of the impact of DSRIP within the Primary Care setting;
- ACP and Community Health Workers (CHWs), in collaboration with IHS, Inc., worked to define the future target workforce state through the analysis of workforce impacts as a result of system transformation and implementation of clinically integrated programs;
- Contracted with Healthicity, a compliance consultant, to develop internal compliance and quality auditing tools.

The above efforts should lead ACP to continuously improve its performance, once we begin to analyze our claims and demographic data to produce performance reports. We continue to review performance data from the state, evaluating the discrepancy in higher average utilization despite lower average costs.

C. Ongoing Efforts to Better Implementation and Outcomes Include:

- ACP is partnering with Managed Care Organizations to obtain reports to identify areas of improvement; these reports include:

    - Claims;
    - Non-users of services (not seen by the PCP);
    - Over-utilizers (readmission, avoidable ER visits, etc.);
    - Under-utilizers (without annual screening or preventive care);
    - Medication adherence levels;
    - Medication reconciliation completion.

- ACP is working to develop strong relationships with community pharmacies to improve refill adherence, reinforce medication adherence, and encourage free blood pressure monitoring in the pharmacy.

ACP also is working to:

- Refine and finalize its master provider directory electronically to easily identify all providers in the ACP network, changes in demographics, the insurances that they participate in, their performance metrics, etc.;

- Identify patients by residency and identify gaps in access to providers;

- Provide resources to 70 offices that need to convert from paper to electronic health records.

D. Action Plan

Provide PCMH incentives and on-going support to:

- Improve HEDIS measures and better outcomes for our populations;
- Use workflows to proactively contact patients for appointments, pre-screen for care gaps, effective follow-up with specialists and other providers;
- Improve patient care access;
- Assist with transitional care through internal care management and care coordination within the ACP network;
- Restructure the IT department to capture, analyze, model and track “big data” to monitor quality improvement metrics;
- Restructure the Community Provider Network department;
- Create protocols for monthly calendar visit to providers;

- Create a strategic plan to support practices/providers for PCMH 2014 Level 3 certification. ACP will also leverage relationships between our PCMH vendors and the community providers they work with;
- Use tools provided by NCQA and our EHR vendors;
- Contract with EMR vendors, such as eCW and MDland, to provide cost-effective agreements for practices without EMRs;
- Develop a Quality Improvement strategic plan to support primary care performance;
- Complete evidence-based protocols for all chronic disease programs (e.g., cardiovascular disease, diabetes, asthma) across all practices;
- Assist with the transitional care process using internal care management and care coordination services within the ACP network;
- Use ACP CHWs as subject matter experts to perform a detailed gap analysis between current workforce and future needs;
- Develop a comprehensive training strategy with 1199SEIU to mitigate workforce training gaps, create an online portal to facilitate and promote training opportunities and resources, and serve as a recruitment center;
- Create a workforce portal to help provider offices access information about DSRIP, ACP and other healthcare updates;
- Make available data analysis on a patient basis;
- Develop the Provider Performance Scorecard tool.

In terms of working with community-based PCPs, as well as institution-based PCPs, ACP is:

- Working to expand our relationships with partner hospitals engaged in Projects 2.b.iii and 2.b.iv to ensure seamless communication between community providers and institution-based providers.
- Working with our hospitals and CBOs to create mutual agreements.
- Hiring two designated project managers for 2.b.iii and 2.b.iv.
- Participating with GNYHA in the clinical leader forums.
- Developing cultural competency and health literacy (CCHL) education materials for provider offices and patients.
- Expanding and growing the internal case management and care coordination staff.
- Expanding our efforts to recruit PCPs
- and specialists in the community.
- Providing compliance and quality improvement technical support.

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

   - 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?
   - Resources could include collaboration, accreditation, incentives, training/staffing support, practice transformation support, etcetera.
   - l resources, vendors to support key activities, additional staffing resources, etc.
   - How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

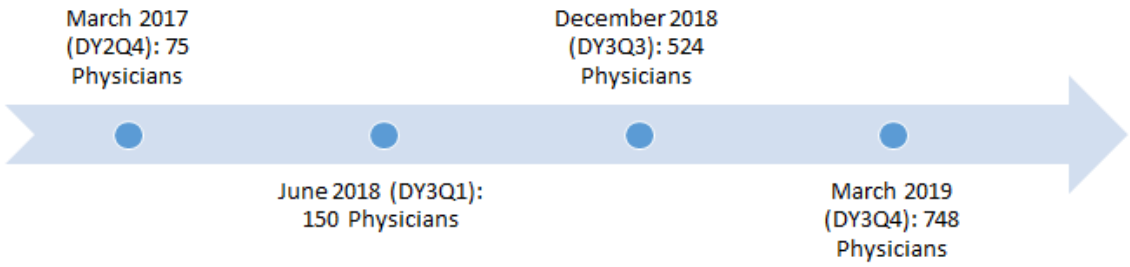
ACP is helping its network of PCPs achieve PCMH certification to improve and transform their practices. While many of ACP's PCPs provide high-quality, patient-centered care, formalizing processes in the office has shown to improve accessibility, performance and quality. Appointment availability and wait times have been reduced, preventive care has increased and quality care gap close rates are much higher. Some of these metrics are evident in the feedback from Managed Care Organizations (MCOs) provided to the IPAs within ACP – preventive care and quality scores have improved for PCMH Level 3 practices.

ACP has carefully selected vendors based on their track records and the ability to form relationships with our community-based PCP network. Often, these vendors previously helped these PCPs attain 2008 and 2011 Level 3 certification. This granular level of familiarity is helpful as each vendor carefully understands practice capabilities, workflows, established processes and office culture. The vendors understand strengths and weaknesses and can provide the practice with tailored guidance in order to meet PCMH criteria. Some of our vendors employ certified content experts who have worked with NCQA and fully understand requirements. ACP is leveraging this additional level of expertise to assist physicians with improvement of their practice.

The cost of acquiring PCMH certification is being covered by ACP as a network benefit. These costs are fully covered if the practice selects a preferred ACP vendor (where costs have been contractually agreed) and are subsidized if a practice elects to use a non-ACP preferred vendor. ACP believes that providing financial assistance to these practices is appropriate to satisfy DSRIP requirements. Many of the projects selected by ACP are primary care-centric and ACP has to ensure that best practices are adopted within these community-based practices so that patient engagement and quality performance impact the overall DSRIP goal of reducing avoidable hospitalizations and ED use.

- Insight Management – 350 practices
- CCACO – 100 practices
- HQ Analytics – 25
- Precision Quality – 10
- Physicians achieving certification independently – ~25
- Partner Hospital-affiliated practices – 10

These 560 practices represent 748 physicians, which is the number of physicians ACP has committed to achieve PCMH Level 3 certification.



Communication efforts to offer expertise and financial assistance to ACP's network of primary care practices are well underway. Because of ACP's approach as well as the long-term relationships of the IPAs with their physicians, many physicians are eager to improve their practices by working toward PCMH Level 3 certification. The insular nature of the IPAs and the relationship with its physicians makes it simpler to identify physician champions who have influence. ACP leverages these relationships to help with its recruitment efforts. Lastly, the State Medicaid incentive of up to $8 PMPM for a practice with Level 3 certification translates into significant sums for practices, some of which have thousands of Medicaid patients. This incentive is heavily promoted in an effort to recruit physicians to become certified. All of these approaches are welcomed by PCPs and make the transition to PCMH widely accepted.

Overall, ACP's PCMH strategy has been widely accepted and many physicians are taking advantage of the subsidies. The benefits will be evident to ACP as well. Improved quality ratings, appropriate coding and documentation, and diligent patient engagement will lead to outcomes that the DSRIP program expects.

Strategy to convert practices from paper medical records to EMRs.

ACP has had numerous discussions with physicians still utilizing paper medical records. Some physicians are open to covert to an EHR, but there are others who may not agree to conversion (some physicians are nearing retirement age). The timeline for conversion aligns with the overall timeline for PCMH. ACP is encouraging each of the 70 physician practices that are currently on manual documentation systems to convert to electronic systems through a variety of mechanisms.

- First and foremost, ACP will not permit a physician using a paper EMR to participate in a VBP arrangement. As a condition of participation in any risk arrangement, at any level, ACP providers will be required to have an EMR that establishes connectivity with ACP systems.
- Further, ACP is offering substantial consulting support to its providers who wish to convert to an EMR, inclusive of coordination with the NYC PCIP office for receipt of incentive payments. ACP's physician engagement team will provide information and encouragement to physicians to convert to an EMR. When a physician expresses a wiliness to convert to an EMR, then the provider engagement representative will coordinate consultative services for those physicians and broker an introduction to the PCIP program.
- ACP has also contracted with its EMR vendors (MD Land and eCW) to provide additional support to providers in installing an EMR and connecting their practices with ACP systems to advance data collection efforts for QARR, Engagement and other Project initiatives. The ACP physician engagement representative will activate the services of the EMR vendor when a physician communicates readiness to convert to an EMR.
- ACP has also contracted with Optimus to provide physician-to-physician (peer support) in addressing appropriate documentation within EMR systems and assist the provider to transition from documenting in manual systems to documenting in electronic systems. This specifically includes gaps in care and accurate and complete coding. For those who are converting, ACP has negotiated special pricing and added features for its two key EHR partners, MDLand and eCW, when providers are ready to convert. For MDLand, this includes a pre-defined process that works with the physician workflow that was created specifically for DSRIP reporting and performance goals. Additionally, there are back-end processes that can easily adopt to RHIO connectivity (such as various consent tracking mechanisms), a centralized reporting data repository that can analyze across-the-board performance, PCMH pre-validation points and future-state processes such as easier tracking of screenings such as the PHQ2/9. For eCW, the processes are similar including RHIO connectivity, population health dashboards and PCMH pre-validation points and dashboards. These options are also open to providers who are using an EHR platform other than MDLand or eCW.
- ACP is combining the efforts of transitioning paper-based medical records providers with PCMH. This allows for an extra incentive for physicians to transition into an EHR.

Innovative Technology implementation

ACP is partnering with its network providers to explore innovative technology to achieve population health goals and outcomes of care. Specifically, as a mechanism to improve the rate of screening through dilated retinal examinations for its patients with Diabetes Mellitus, ACP is planning to introduce the use of retinal cameras to screen eye grounds. The digital camera will be placed in select PCP offices and take a high resolution photo of the patient's retina. The digital image will be transmitted to either an Ophthalmologist or Optometrist who will read the image and provide a report of findings to the PCP. ACP's care partners at the SUNY College of Optometry, the Ophthalmology program at Medisys Hospitals and the Montefiore Medical Center Ophthalmology program are planning for this new service.

It is anticipated, that in the future, ACP will explore other types of Tele-Medicine upon successful waiver application. Such applications may include tele-psychiatry as is currently offered by Northwell health system.

Workforce Training and Support:

Training, supporting, and monitoring the labor force transformation required for proper implementation of DSRIP is a core priority of ACP PPS. ACP directly undertakes the task of training its membership, largely small and independent neighborhood-based medical practices, to:

- Implement the 10 DSRIP projects;
- Reinforce the cultural competency of its providers and the health literacy of its patients;
- Assist its network PCPs in obtaining NCQA 2014 PCMH Level 3 Certification, and
- Support readiness for VBP.

ACP has developed a comprehensive workforce training strategy that includes information on the approach, methodology, timeline, evaluation, reporting, and communications.

ACP has secured 1199 SEIU Training and Employment Fund to develop its workforce portal through the HWapps learning management system to:

- Provide access to online trainings, lessons, and a document library;
- Promote in-person trainings and learning opportunities at ACP headquarters or off-site;
- Provide access to a recruitment center where ACP network providers can post vacancies and interested candidates can submit their resumes and applications;
- Provide a platform for two-way communication with the workforce through the use of groups, forums and blogs for practice transformation support.

Through a collaboration with Columbia University Health Informatics for Innovation, Value and Enrichment (HI-FIVE), ACP will carry out an online training program for clinical, administrative, and social/peer group staff across the network in new health information technologies in team-based environments. The initiative, funded by the Office of the National Coordinator for Health Information Technology (ONC), seeks to train the workforce to improve health care delivery by focusing on the areas of health data analytics, population health management, care coordination and interoperability, value-based care and patient-centered care. Trainings and supporting materials will be available on HWApps.

ACP has contracted with Healthy People and Quality and Technical Assistance Center (QTAC) to train selected staff and attributed patients in the Stanford Model. Trainees will carry out workshops in the community to increase chronic disease knowledge and awareness and promote self-management.

ACP has deployed a team of Physician Engagement specialists to carry out in-person train-the-trainer sessions on DSRIP transformation and ACP project metrics. In addition, ACP will make available Care Managers, Care Coordinators and Community Health Workers (CHWs) to enhance practices' team-based care, care management and support, care coordination, and clinical quality performance.

ACP has developed and implemented a CHW training and deployment program to support the network through effective patient engagement, tracking, navigation and retention, and community outreach and education, informed counseling, social support, and advocacy. As front-line workers, ACP CHWs will serve as liaisons between health/social services and the community to facilitate access to service.

ACP will develop a Resource Guide to centralize social service information at the city and community levels to assist staff and network providers in addressing social determinants of health and patient advocacy efforts. For this purpose, ACP is establishing partnerships with public agencies and community-based organizations.

ACP will provide additional staffing resources through New York City Workforce1 Healthcare Center, and training resources through 1199SEIU Training and Employment Fund and the New York Alliance for Careers in Healthcare.

ACP will organize community events to improve health literacy and reinforce the work of its network providers through the promotion of culturally competent informational materials.

This plan addresses the training needs of ACP network providers for proper implementation of its DSRIP projects and PCMH transformation while fully integrating ACP's cultural competency and health literacy implementation strategy.

ACP's Cultural Competency and Health Literacy team provides support to PCPs in the following ways: assessment of practices for improvement on CCHL issues raised below; two-way communications are encouraged with patients using Teach Back and Ask Me 3 methods; and community connections are created to address social impacts on health

outcomes (commonly referred to as social determinants of health) through community mapping activities.

1) Cultural Competence: Ensure that Physicians understand the importance of addressing and understanding their patients and their customs, culture, religious beliefs, rituals and practices.

2) Health Disparities: Ensure that Physicians are informed on prevalent health disparities and how to counteract them within their practices.

3) Social Determinants of Health: The impact that health disparities and social determinants of health have on patient health outcomes and the need to be mindful and aware of these challenges to reduce emergency room visits.

4) Health Literacy: Fostering health literacy in patients by creating supportive health education materials to facilitate patient-physician discussions around lifestyle modification, medication adherence, and encourage positive habits and behaviors.

    a. Stanford Model implementation: Support physicians with high numbers of patients with chronic illnesses like Asthma, Diabetes, and Cardiovascular and Pulmonary illnesses.
    b. Promoting awareness that low levels of health literacy affect patients of all education levels and are an invisible issue they must be aware of when addressing patients.

5) Plain Language, Teach Back, and Ask Me 3: Tools that physicians are trained on, either in person or via online portals by the CCHL team, to facilitate patient understanding.

Care Management

ACP's Care Management program employs a telephonic disease care management model to strategically work alongside the PCP practice as an integrated support team to meet the needs of our culturally diverse population. The goal of ACP's Care Management program is to expand access to community primary care services and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers from Health Homes) to meet the individual needs of our most at-risk patients. ACP's Care Management program is designed to provide proactive management of higher-risk patients who are not currently eligible for Health Home services through access to high-quality primary care and support services and by implementing a comprehensive care management model to increase quality, adequacy and frequency of care that they receive to improve their health, thus avoiding disease progression and poor health outcomes.

ACP's Care Managers are available Monday through Friday, during normal business hours. ACP patients reach ACP Care Managers directly through telephonic services. Additionally, patients may be referred to ACP Care Managers through their physician's office. ACP care managers may also receive referrals from Community Health Workers.

ACP's Care Managers coordinate with their counterpart care managers at the Medicaid Managed Care Organizations so as not to duplicate care management services but the complement and extend the reach of care management into the community. By way of example, while a patient may receive formal care management services through the health plan, in collaboration with the health plan care manager, the ACP care manager may activate the community health worker to find the patient in the community and schedule the patient for an appointment; address outstanding social and financial referrals through referral to CBO's; and lastly identify and refer patients as appropriate to Health Homes.

ACP's Care Management Program, in compliance with DSRIP, will ensure the following services to its care managed patients, with a focus on its Health Home At-Risk eligible patients:

- Integrated Care Management Services
- Care Coordination Services
- Health Promotion
- Comprehensive Transitional Care/Follow-up
- Patient, Family/Care Giver Integrated Support and Participation
- Referral to Community and Social Services
- Use of HIT to Link Services, as feasible and appropriate
- Care Efforts Address and Support Patient well-being and safety

The care manager will lead the patient care management process by working closely with the practice providers, care coordination team, and CHWs team to ensure all patient care service activities and referrals are addressed appropriately, timely and in a culturally sensitive manner to the patient and family needs. The care manager will be the point person of the integrated care team with responsibility for ensuring a seamless flow of communication across and between the patient's care team (medical, behavioral health and social services) so that needs are addressed in a comprehensive manner. The overall goal of the care management team is to support the primary care practice to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalization and emergency room visits, promote use of Health Information Technology (HIT), and avoid unnecessary care.

ACP recognizes the importance of a robust care management team to support our patients in becoming active participants in their care decisions and self-managing their health. ACP has partnered with Healthly People to provide comprehensive Stanford Model training to our care management and CHW teams. This training program will provide the essential tools and skill sets to effectively provide evidence-based chronic

disease patient self-management skills in an integrated and culturally-sensitive community setting. Furthermore, ACP care managers have participated in comprehensive HEDIS training offered by NCQA.

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

   - How will the PPS strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services?
   - How is Primary Care represented in your PPS's governance committees and structure and clinical quality committees?

ACP's backbone, from its inception, is community-based PCPs and the IPAs that provide the leadership and administrative support to manage these relationships. The ACP model places the PCP in a central role for meeting quality metrics, appropriate utilization, and the cost-efficient use of expensive health resources.

The overall program's success will largely be based on the outcomes of care, such as a reduction in potentially preventable hospital admissions and readmissions as well as preventable emergency department visits.

Through DSRIP, ACP is providing its physicians with tools and support to be successful. ACP is in the process of centralizing EHR systems (primarily MDLand and eCW, the two most widely used EHRs within its PCP network). This consolidation will allow for consistent clinical data streams, funding PCMH designation, and subsidizing RHIO connectivity fees. Additionally, ACP is developing a Care Management/Care Coordination department with call center functionality to provide administrative support to PCPs, such as outreach calls to patients with care gaps. These are tools that are currently lacking in most practices but will provide the support that PCPs require. ACP's PCPs are also culturally and linguistically competent to best serve their patients' needs. The physicians and staff often come from the same cultural backgrounds as their patients. This is a valuable characteristic that fosters patient adherence to therapy and promotes an effective medical home environment.

ACP also has a data strategy to consistently monitor patient data and resource utilization. EHR clinical data, clinical event notifications, and historical plan and state utilization data are sources that ACP will use to empower its PCPs to play an active and more effective role in the care of their patients. This information will allow our PCPs to develop care plans that strengthen their role in the continuum of care for patients. PCPs are central to providing this care and are key to an integrated delivery system. Comprehensive care planning by ACP along with the appropriate coordination and follow-up care provided by PCPs will help patients receive care in appropriate delivery settings and reduce avoidable admissions and ED visits. All of these efforts by ACP support providers as they develop effective individual care plans, which often involve specialty and ancillary care as well as social support, including housing and health system navigation.

How ACP is strengthening the continuum of primary care and ensuring meaningful linkages to necessary secondary and tertiary services:

By providing resources to strengthen practices' infrastructure and providing practice-wide demographic and utilization data on their patients, ACP will enable practices to identify patients requiring more intensive follow-up and care management. ACP will assign CHWs, care managers, and care coordinators to help better manage the most difficult members and help overcome the limited staffing and expertise found in most practices.

By addressing care transitions from facility care, providing electronic record linkages to facilitate communication among specialists and PCPs, and by linking secondary and tertiary facilities to practices through a PPS-wide network, PCPs will be empowered to be more fully informed about all the care that all of their patients are receiving and in a timely manner. This enhanced information infrastructure will also PCPs to formulate more effective care plans that leverage the spectrum of providers their patients have had contact with.

How primary care is represented in ACP's governance committees and structure and clinical quality committees:

ACP is fortunate in being a primary care physician IPA-led PPS. PCPs are on all governance committees and in leadership roles. They are also well represented on clinical quality committees.

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

    - How will key issues for shifting to VBP be managed? (e.g., technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals/emergency departments (EDs), creating transition plans, addressing workforce needs and behavioral health integration)?

ACP fervently believes that Value-Based Payments (VBP) are the future, desired state for transforming healthcare in New York. ACP understands that resources provided through DSRIP funding are the catalyst to transform community-based provider practices so they may participate in a payment structure that recognizes the contribution of PCPs to influencing cost-effective quality care. These new payment structures promote higher quality of care versus the traditional quantity-based reimbursement system. VBP offers a sustainable mechanism for sufficient funding to support the expanded role of community-based PCPs that includes activities such as care management, meaningful use, PCMH Level 3, integration of behavioral health in the primary care setting, and more.

VBP is not merely a roadmap task; it also is a driving imperative for ACP. Our PPS acknowledges that ACP's practices are hard pressed to continue providing services under current payment arrangements. VBP is essential for our primary care practices to not only survive, but to flourish and continue to render essential services to vulnerable populations in a culturally competent and health literate approach.

ACP has developed a comprehensive approach preparing for VBP. The various initiatives are enumerated below.

1. Core Team for VBP

ACP has established a core working group to address preparedness for VPB. The team includes representatives from Executive Administration, Finance, Technology, the PMO and Operations. ACP has hired a number of individuals and retained a few select consultants with backgrounds in the managed care industry to work with the team.

One of the hallmarks of ACP are the Independent Physician Associations (IPAs). It was through the coming together of these IPAs that ACP was able to become a vibrant organization of 2,000 physicians (PCPs and specialists) and 950 partners. These providers were identified, contacted and united through the IPAs with whom they have longstanding relationships. ACP will continue to leverage the great organizations through which it was founded and partner with them to implement the Value-Based Payment models throughout its vast network.

2. Technical Assistance on contracting and data analysis

ACP is securing technical assistance for contracting and data analysis. Specifically, ACP has contracted with Milliman Actuarial Service to assist in modeling VBP arrangements. Milliman is an actuarial firm with expertise in modeling the Medicaid population within the ACP service area and providing insight on expected utilization patterns and cost. ACP has newly created an in-house actuarial position and will begin recruitment shortly. ACP will use actuarial information to inform its financial and utilization models. ACP is also negotiating a contract with Treo Solutions and 3-M for technical support in evaluating CRG categories and predicting changes in the financial and utilization models based upon identifying members for outreach and case management. An additional company, Optimus, a medical data and quality company with expertise in quality metrics and performance, is on board to enhance our data analytic capability.

The founding IPAs that comprise ACP have vast experience in evaluating contracts and monitoring expenses. These IPAs have years of experience in contract evaluation and execution. It is through these IPAs that the majority of our PCPs currently have executed contracts with all of the major MCOs in the New York area. The contracting expertise of these IPAs will serve as the basis for the future evaluation and execution of value-based contracts. Additionally, the IPAs already hold some level of value-based contracts in their current shared savings contracts and through these are accustomed to handling large sets of data and monitoring performance and quality metrics.

In summary, ACP will utilize actuarial models (Milliman), historical claims data (3M-CRG), and northeast data sets for Medicaid medical and administrative spend to project models of risk for Pilot (Level 2) and Innovator (Level 3) programs. ACP will utilize the expertise of its staff with managed care experience and consultants such as Dr. Aran Ron and Dr. Richard Bernstein to interpret trends and adjust models as appropriate to the ACP population. ACP is negotiating a contract for analyzing quality data and data visualization services with Arcadia to track quality metrics and the medical spend. ACP is collaborating with health plans to secure reports and data on the 3-M CRG risk adjustment software to analyze, identify and manage patients across the spectrum from healthy to catastrophically ill

3. Ensuring PCPs receive necessary data from hospitals/emergency departments

ACP understands that community-based physicians are often unaware when their patients are brought to hospitals through the EMS system and subsequently admitted as inpatients. Hospitalists often manage the hospital stay. It is possible that PCPs will not know that their patients are admitted and require follow-up care.

As a result, ACP has contracted with Healthix RHIO and is integrating with the RHIO to transmit information from NYC EDs and provide real-time clinical event notifications (CENs) to alert ACP and, through ACP, its physicians when patients are admitted to the hospital or ED.

In addition, ACP has met with partner hospitals to explore ways in which ACP CHWs can interact with hospital navigators to ensure that follow-up appointments provided at the ED occur.

ACP is also working with several of its partner Health Plans to share data and analytics (e.g. CRG scores, PPV's, PPAs and PPRs) that ACP can use to guide VBP modeling and gain insight in managing the population to better outcomes.

In summary, ACP is working closely with its partner hospitals, Healthix and health plans to flow data into ACP that is actionable (improve care) and informative (model care.)

4. Creating transition plans

ACP anticipates that the transition to value-based payments will not overwhelm its physicians because the IPAs will be the primary source for VBP implementation. The majority of ACP's physicians are affiliated with and have joined ACP through a trusted IPA that they allow to negotiate contracts on their behalf. The IPAs currently hold risk/cost savings contracts with which over 600 physicians are participating and achieving success. This is a huge benefit of ACP.

The transition plan is tiered into three sections and has already been set in motion. There are three levels to Value-Based Payments, hence the three tiers.

- Level 1: Physicians have a base capitated agreement paying them a set fee per patient per month and receive cost savings based on meeting higher quality metrics and achieving good care at lower costs. Currently this model is in place for over 600 network PCPs through the IPA negotiated contracts.

- Level 2: Similar to level 1, but there is an added risk of losing pooled monies if the cost of care is higher and if the quality of the care provided is lower. Currently, NYS is running a "PILOT" program on this model. The IPAs have formed a consortium through which they have applied to the NYS Department of Health Pilot program and have received acceptance to move forward with this model. This transition consists of starting with a smaller group of PCPs who have been successful at implementing Level 1 and are now moving through this pilot to Level 2. Lessons learned through the implementation of this model will drive the addition of more PCPs into the model until all network PCPs are at least at a level 2 model of VBP.

- Level 3: In this model, the entity/providers assume full risk. They participate in the gains through higher quality and lower costs of care and participate in the losses due to lower quality and higher costs of care. NYS is currently receiving applications for participation in this type of VBP model through an “Innovator” program. The consortium of IPAs is putting together the modeling and preparing to put forth an application to participate in this model. For participation in this model, the IPAs have selected a small number of physicians who are well versed and successful in implementation of Value-Based Payments. Lessons learned through implementation of this model will be implemented at a larger scale and more PCPs will be added to this Level 3 model over the next three years.

It is our expectation that, as has been the case so far, we will have great success in the implementation of VBP due to the experience of the IPAs in bringing together physicians and implementing value-based care. Leveraging IPA monthly meetings, conferences and other gatherings is a significant advantage to providing feedback both from and to the physicians and applying lessons learned.

The IPAs share cost data, utilization data, and quality metrics with the physicians on a regular basis and deliver incentive payments and initiatives on better outcomes. Physicians in our communities believe in and trust the work that the IPAs do for them every day, from contracting with insurances to EMR support, to PCMH.

5. Addressing workforce needs

ACP believes that an engaged workforce may be the surprise weapon in the arsenal for influencing member behavior in the population we serve. Language, cultural and literacy barriers exist to accessing care and the availability of a culturally competent peer-to-peer support mechanism may increase the likelihood of having members present for physician appointments and comply with their plan of care.

ACP is currently recruiting additional workforce staff and will equip them with tablets to manage their caseload. It is ACP’s intent to develop this workforce and find innovative ways for ACP to document referrals and the effectiveness of the CHW team. Currently, ACP is deploying its workforce to find patients who are CRG Level 1 (Non-Users) and connect them with a PCP for an appointment. In the past 2 months, ACP’s Community Health Worker team has secured a list of 9000 CRG non-users from Affinity Health plan and created a plan to outreach to each of them. Outreach attempts were largely successful, lessons learning and nearly 600 PCP appointments were made. The level of cooperation and collaboration with the health plan was significant.

6. **Behavioral health integration**.

ACP understands that underlying many chronic conditions are issues of anxiety and depression or even substance abuse. Coping with chronic illness is a life-changing situation. ACP further understands that unrecognized or untreated instances of depression, anxiety or substance abuse may manifest in patients' non-compliance with the plan of care and result in complications leading to hospitalization or even death. Therefore, ACP anticipates that the integration of BH in the primary care setting will reduce instances of patient non-compliance, fewer preventable admissions, readmissions, and emergency department visits. This will result in greater success of the VBP incentive arrangement. The VBP Team will integrate the findings of the BH/PC team into strategies for VBP.

ACP has engaged Dr. Les Halpert, a well-respected behavioral health professional to lead the BH/PC Integration project. It is anticipated that care management will coordinate with ACP's BH/PC team to identify underlying BH or SA issues for patients with chronic conditions; and refer these individuals for appropriate treatment with network providers.

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

- What resources are being expended by your PPS to support PCPs in DSRIP?

ACP funds flow is an incentive payment for physicians to join and remain in our network to achieve DSRIP goals. Throughout DY1, ACP successfully established funds flow distribution models to distribute incentive and project implementation funds. As of DY2 Q1, $8.1M was distributed to network providers and hospital partners. Approximately 300 practices and specialists and 5 hospitals have benefited to date. For those providers not yet paid, the funds flow model has been established, calculations completed and ACP is prepared to distribute incentive payments in DY2 Q1 to the Clinic, Case Management, Mental Health, Pharmacy, Hospice, CBO and all Other providers.

In DY2, Physicians, Hospitals and Other partners will continue to be able to earn incentive payments if performance on metrics is achieved. All providers in ACP will be trained to succeed in a managed Medicaid environment where appropriate utilization is encouraged, and performance, quality and outcomes are tracked and rewarded.

ACP is working diligently to ensure the funds flow is distributed fairly and promptly to the network physicians. We have hired outside consultants to help ACP look at funds flow model from a different perspective. We also assigned a financial analyst to be solely responsible for the complete funds flow process, including calculating and monitoring all funds flow payments. A tracking and controlling spreadsheet has been established for any future disputes. In this way, the funds flow process will be monitored and supervised so physicians in our network will be awarded accordingly to ensure provider sustainability.

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

    - This would include both collaborative care and the development of needed community-based providers.

ACP's Integration of Primary Care and Behavioral Health Services project is designed to transform a fragmented system that is primarily focused on traditional medical care without a systematic evaluation of underlying behavioral issues or coordinating care with behavioral health providers. Through implementation of this DSRIP project, collaborative team-based care is provided in an environment in which the patient is comfortable and receives complete comprehensive care. The goal is to create a patient-centered model with primary care providers and behavioral health providers working together to provide quality holistic healthcare.

Improved Primary Care and Behavioral Health infrastructure and sustainability include implementation of three models of collaborative care: Integrating behavioral health services into the primary care settings; Integrating primary care services into the behavioral health sites, and Implementing IMPACT into independent primary care offices.

ACP's implementation of this project and outreach to primary care providers includes:

- Creating standardized protocols to be implemented across our provider network through EHRs that include screening and treatment for depression, substance use, as well as referral for other serious psychiatric conditions, e.g., schizophrenia.
- Employing trained Physician Engagement teams for deployment to PCP practices to distribute protocols and easy-to-follow training materials on performing evidence-based assessments such as PHQ2/9, DAST, and AUDIT C by integrating these into the EHRs and incorporating these into the everyday workflow.
- Contracting with consulting psychiatrists for implementation of the IMPACT model's collaborative care process.
- Ongoing Collaborative Care training provided to physician practice staff by ACP's Behavioral Health team.
- Teaming up with OMH and the University of Washington's AIMS Center to participate in a pilot for the IMPACT Model implementation to carefully review, deliberate, and receive guidance, coaching, and training on the IMPACT Model and the use of behavioral health care managers.
- Collaborating with the New York City OMH and Regional Planning Consortium to share lessons learned amongst the statewide PPSs to incorporate best practices and achieve desired outcomes.

- Collaborating with the state and city OMH in developing a comprehensive evidenced-based SBIRT training for our primary care physicians and team.
- Assisting behavioral health partners in attaining and implementing primary care services.
- Creating tight bonds between our behavioral health partners and our primary care physicians and in-network hospitals to allow for warm handoffs to effectively and efficiently coordinate care.
- Developing contracts with community-based organizations to address social determinants of health, including housing and financial insecurity.
- Developing relationships with alcohol and substance use support groups to provide community-based resources to help patients with ongoing needs.