Primary Care Plan Update 2017

Bronx Health Access

September 29, 2017

Introduction

The New York State (NYS) Delivery System Reform Incentive Payment (DSRIP) Program´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent by 2020. To transform the system, the DSRIP Program focuses on the provision of high quality, integrated primary, specialty, and behavioral health care in the community setting, with hospitals used primarily for emergent and tertiary levels of service. The integration of services and the path to value-based care puts primary care at the center of the health care delivery system. Primary care is the cornerstone of the DSRIP Program and is critical to NY State's success in the overall improvement and coordination of health care.

Instructions

The DSRIP Primary Care Plan Update is an opportunity for each PPS to highlight, and inform the New York State Department of Health (the Department) and the DSRIP Project Approval and Oversight Panel (PAOP) of, progress towards and challenges to the improvement of Primary Care under the DSRIP program.

For each fundamental, the PPS is asked to provide a series of brief updates in the space provided (approximately 250 words) to questions under each fundamental in its final Primary Care Plan submitted in 2016. The PPS should reference its previously submitted Primary Care Plan when completing this Update. Completion of the Primary Care Plan Update includes the progress the PPS has made within a fundamental, an outline of any challenges related to implementing the Primary Care Plan strategies, an explanation of any changes that need to be made to the Primary Care Plan, and other related questions where applicable. The Department requests that the PPS be as concise as possible in its responses; where elements are not relevant to their Primary Care Plan, 'N/A' should be written. Under fundamentals where no strategic changes have been made, please describe how the PPS' initial strategies continue to support that fundamental. Throughout the Update, some fields have been auto-populated for the PPS' convenience based on figures available to the DSRIP team. The Department requests that the PPS review these fields for accuracy and make revisions where necessary. The completed template is **due September 29, 2017** to the DSRIP Team at dsrip@health.ny.gov with subject line: 'Primary Care Plan Update'.

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Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

a. From April 1, 2016 to March 31, 2017, describe any overall strategic changes the PPS has made and the impact of these changes on the PPS' final Primary Care Plan submitted in 2016.

In Fall 2016, discussions in the BHA Clinical and Quality Committee began to shift from project milestones to the achievement of the P4P metrics. A result of these discussions was the realization that focusing solely of project performance and monitoring would not impact our all key performance measures. It was proposed and agreed with the Finance and Steering Committee leadership that the PPS would allocate additional funds to creating and implementing specific initiatives targeted towards meeting Pay-for-Performance (P4P) metrics in DY3 and beyond. Initiatives that are being funded as a result include Care Transitions for BH patients, Access Improvement, Integrated Pest Management, and Pharmacy Engagement.

This strategic shift from projects to specific initiatives will positively impact the Primary Care Plan. One key initiative that impacts the Primary Care Plan is the Access initiative. This workgroup was developed as the next step for the PCMH Workgroup, which focused on working with our PCP network to achieve PCMH Level 3 accredidation. This group has built upon the elements Standard 1 of the NCQA guidance (Patient-Centered Appointment Access)and asked its partners to share best practices and data around engagement of adult and pediatric patients that have not seena primary care provider in the past 12-18 months. The Access workgroup is also seeking to connect with community partners such as day care centers, nutrition programs,and substance-use centers. Community-based partners are already engaged with the populations they serve and are trusted referral resources. By partnering with CBOs, BHA PPS seeks to bring access to primary care to their patients through mobile vans and direct referrals.

BHA has also moved forward in our data mining and reporting efforts with the goal of providing PPS partners with that reflect both overall PPS performance as well as "Hub" or organization specific performance. These reports are developed from the MAPP data and is therefore delayed, yet it gives our partners and our PPS insight as to "high" and "low" performers in our network so we can target our resources and time appropriately. This will assist the PPS in spreading best practices and ensuring that dollars spent are going to provide targeted support towards improving performance going forward. The "hub-level"reports are also shared with the Clinical and Quality Committee and the targeted initiative workgroups to provide strategic insight and transparency to our activities.

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

- PPS' 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 Primary Care Practitioners (PCPs), as well as institution-based PCPs?

a. Describe the PPS' progress in addressing primary care capacity and needs from April 1, 2016 to March 31, 2017. Include efforts to extend hours and increase access to primary care services:

Bronx Health Access PPS continues to address primary care capacity, performance, and needs through the expansion of the number of PCMH Level 3 accredited sites and through the delivery of comprehensive, integrated, and culturally competent primary care services to patients with complex medical, behavioral health, and social needs.
BHA has contracted with Insight Management to provide hands-on technical assistance and support to sites seeking PCMH Level 3 Recognition. From April 1, 2016- March 31, 2017, over 200 providers have achieved Level 3 accreditation in our network. Many of these practices worked directly with the team at Insight to achieve this milestone and are now poised to deliver services that meet the highest level of care. These practices are also largely community-based Primary Care Practitioners (PCPs), which would not have had the infrastructure to work towards Level 3 accreditation without the support of the PPS. Insight's work with these community providers includes fundamentals such as identifying an electronic health record (EHR) to implement. A number of community PCPs have been in practice for decades and only been using paper charts. These providers required a lot of support and education. Insight then worked 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 access providers.
The expansion of available hours throughout our Primary care network will have a direct impact on our attributed population. Sites that are approved for PCMH Level 3 accreditation must demonstrate that they have extended office hours. The newly accredited sites in our network had to produce documents that reflected the expansion of clinic hours to their patients. One partner, Bronx Lebanon Hospital Center has added additional Saturday and evening hours for primary care services for both Adults and pediatric patients. Another key partner, Urban Health Plan, Inc. offers same-day, Saturday and walk-in appointments at 9 of its 10 FQHCs located throughout the South Bronx and local neighborhoods.

b. Describe the PPS' challenges from April 1, 2016 to March 31, 2017 with addressing primary care capacity needs:

The BHA PPS has used data as a key element in understanding out patient population and network. There are numerous gaps in the Access-related measures currently available from DOH and among our partners. Partners will largely have data available based on their assigned patient populations. Many of these patients are already engaged and seeking services. Based on our internal analysis of our network, a good portion of patients are not attributed to a PCP, meaning they have not sought primary care services in the past 18 months or more. Without additional information available on these patients (ie. zip code, race, gender, age), it has been challenging to determine concrete next steps to improve primary care capacity needs in our community.

Our network has also used Town Halls and other Stakeholder activities to interface with our community of providers and patients and better understand our primary care needs. The new political climate seems to be having an impact on primary care access and capacity. Patients in our community may not be documented which can be a barrier to seeking primary care. As more legislation and discussion centers around deportation and border control, we are learning from our partners that they are having difficulty getting patients to primary care appointments, both adult and children. This will have a direct impact on our attributed population's health and creates additional barriers to patient engagement.

We will continue to focus on supporting PCPs in our network and providing them the tools needed to deliver quality and culturally competent care.

c. Based on the PPS' progress and challenges addressing Fundamental 1 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 1 outlined in the final Primary Care Plan submitted in 2016?

Our PPS has expanded opportunities for training to PCPs and care team members as a strategic change to our Primary Care Plan submitted in 2016.

In efforts to improve service delivery and understanding of different patient populations, our network launched a Cultural Competence and Health Literacy (CCHL) Training Series in Fall 2016. These free trainings are open to all partners and were developed to strengthen knowledge, skills, and impact attitudes towards patients seen in our community. Topics offered to date include "Domestic Violence/Intimate Partner Violence Issues and Their Impact on the Developing Adolescent"; "Micro-Aggressions"; "Cultural Competence and Humility"; "Working with Families with Same Sex Parents"; and "Culturally-Informed Mental Health and Substance Abuse Prevention and Treatment Strategies for West African Immigrants". Trainings are delivered by known experts in the local community and there is time for interactive discussion, in addition to direct learning through lecture. Trainings were offered bi-monthly when the series was first launched but was changed to monthly in Winter 2017.

Feedback from these trainings have been overwhelmingly positive, with attendees walking away with a greater awareness and understanding of the psycho-social and cultural issues that impact our network of patients. Attendee lists from these workshops reflects the diversity of our providers network with representation from nurses, medical assistants, primary care providers, substance abuse counselors, receptionists, community health workers, and patient case managers. Due of the continued positive feedback and strong attendance at the CCHL Trainings, additional trainings will be offered throughout 2017 and 2018.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
Bronx Health Access PPS has continued to provide support and engagement opportunities to our community-based primary care providers (PCPs) in a variety of ways. Data is a key element of any population-based approach. BHA PPS has built a strong connection to the Bronx Regional Health Information Organization (Bronx RHIO) and we actively encourage all community-based PCPs to enroll in the RHIO to support data sharing and to receive up-to-date information on patient utilization. Our Workforce Committee continues to empower all BHA PPS partners through training opportunities. Community PCPs and their staff have access to the opportunities such as Medical Assistant training, American Diabetes Association 2017 Primary Care Guidelines, and the CCHL training series. As mentioned previously, community-based PCPs are also working directly with Insight Management to achieve PCMH Level 3 accreditation. A number of providers have already been successful and we anticipate further success in these efforts Our Stakeholder Team continues to keep all partners engaged and aware of BHA PPS activities through the various events and publications. This team disseminates a newsletter which has the latest information on our network and activities. Community-based PCPs are also invited to our Town Hall, a face-to-face opportunity to engage with the PMO team, Project leads, and learn more about the work of the PPS. Our most recent Town Hall focused on the shift to value-based payment (VBP) and its impact on our various stakeholders, including community-based organizations, primary care practices, substance use/ behavioral health partners, and long-term care providers. The Stakeholder team is also working with PCP champions and our Workforce Committee to develop web-based learning opportunities for primary care providers. These opportunities would be open to all providers in our network, including community PCPs, and would also provide continuing medical education credits (CMEs).

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	247

e. Additional Information

Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:	388 (based on 2ai speed and scale)
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	299
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	N/A (none of the PCPs in our network are currently pursuing APC recognition)

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

- What are your PPS plans for working with Primary Care at the practice level, and how are you supporting practices to successfully achieve PCMH or APC recognition? (Resources could include collaboration, accreditation, incentives, training and staffing support, practice transformation support, central 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?

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

The PPS contracted with Insight Management to engage with participating community and institution-based PCMH eligible providers across our network. As part of our previously submitted Primary Care Plan, Insight is providing practice transformation support and technical assistance to providers across the six PCMH standard categories.

During the Spring of 2016 Insight performed an initial baseline assessment of our network providers and organized them into 4 waves for strategic implementation. This process was initially very successful and continues to be through March 2017 and beyond. From April 1, 2016 to March 31, 2017 approximately 200 providers achieved NCQA PCMH 2014 Level 3 certification. This was a combination of providers who had not previously been certified, had been certified at a lower level, or were certified Level 3 under the 2011 standards.

The PPS PCMH committee provides oversight of the project and carefully monitors the progress of each practice during regular status meetings with Insight Management.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

Some of the challenges in working with primary care practices include working with providers who are uncertain about changing the way they practice, assisting providers in acquiring a certified EHR that meets the PCMH and MU standards, and coordinating efforts to assist in practice transformation that didn't interfere with the provider's ability to conduct business.

We've been able to address these issues primarily by collaborating with the Stakeholders Committee. They have been very involved in the whole process and provide consistent support by serving as the liaison between each provider and Insight. They leverage well established relationships with providers in our network and they communicate regularly with each practice site. Whenever questions or issues arise they coordinate meetings with Insight's team to help address providers' concerns.

Insight is also very flexible and works closely with the practices to meet at a time that best suits their schedule. When necessary they also guide them through the process of upgrading their EHR or in some cases they help them acquire their first EHR.

c. Based on the PPS' progress and challenges addressing Fundamental 2 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 2 outlined in the final Primary Care Plan submitted in 2016?

There have been a few challenges, but overall the PPS' PCMH strategy has been very successful in terms of helping providers achieve PCMH 2014 Level 3 certification. We do plan to continue the strategy outlined in the final Primary Care Plan submitted in 2016, but we will continue to monitor the project's development and adjust as needed to ensure success.

One area of potential strategic change is in training opportunities related to primary care practices. The Workforce Committee has successfully implemented staff training plans and strategies targeted to primary care providers and front-line staff to help ensure practice and workforce transformation. There are trainings and technical assistance programs available through the 1199 SEIU Training and Education Fund, but not as many partners as anticipated have taken advantage of these free opportunities. We continue to look for ways to engage people with these trainings.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
The strategy we have found to be most effective is the “warm handoff” between our Stakeholders Committee and our contracted vendor. Our approach has been to initially send out a communication from the PPS to each PCP site explaining who Insight is and why we are working with them. Then a designated Stakeholder Manager would be personally in touch with each partner and facilitate the “warm handoff” for ease of transition. This helped build trust and establish accountability. We found it allowed Insight to get in the door and begin work more quickly which was especially important for practices that we felt required more hands on intervention in order to achieve PCMH Level 3. We found that beginning the work as early as possible was key.

e. Additional Questions:

Is the PPS contracting with any vendor(s) for PCMH recognition assistance? ☒Yes ☐No

Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:	375
Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:	7

Is the PPS contracting with any vendor(s) for electronic health record (EHR) transformation assistance?
☒Yes ☐No

Fundamental 3: What is the PPS' 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' governance committees and structure, and your clinical quality committees?

Number of Engaged Primary Care Practitioners	319

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards implementing an integrated delivery system with Primary Care playing a central role. Be sure you address efforts to strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services:

As described in the initial submission of the Primary Care Plan, the PPS is implementing an IT Care Coordination Clearinghouse, which will connect high utilizing patients to services within the PPS. The clearinghouse is live at the lead hospital and is in the final stages of development at the Bronx RHIO. For example, the Clearinghouse allows for bottom up referrals to the Health Home, which is a meaningful linkage.

In addition to the IT Care Coordination Clearinghouse, the projects continue with implementation, linking patients to secondary and tertiary services. The Asthma project, since the original Primary Care Plan submission, has begun to linking high risk patients to pharmacists for medication management. This linkage will occur across all projects, though the PPS is prioritizing the Asthma project. In addition, the Asthma project has begun linking patients to Integrated Pest Management (IPM). This service offers patients hone visits offered by a professional pest management company. The PPS believes this should result in less asthma related ED and IP visits as pests will not be present in the home.

The PPS has also been collaborating with the Health Home, which is comprised of many Care Management Agencies (CMAs) (some of which are CBOs). One of the collaborations offers CMAs the opportunity to make referrals into the PPS project initiatives. This allows for meaningful linkages to services these patients may not have otherwise received.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in implementing an integrated delivery system with Primary Care playing a central role:

As with many PPS, the MCOs will not provide the PPS with the data needed to improve quality. One concept of the clearinghouse included providing the missing services of patients (ie. HEDIS measures) who are in need of receiving care and pushing this information to the RHIO. The RHIO would push this information to providers for pre-visit planning and at the point of care. To date, no MCO is willing to provide the PPS or RHIO with a member's missing services. To further compound this issue, the PCP-based organization who contract with the MCO, who receive the missing services from the MCOs, are very hesitant to share the missing services with the RHIO. Agreements in place between the PCP organization and MCO indicate PCP based organization cannot share this information. This has been a major challenge.

Outside of the MCO challenge, the PPS has smoothly implemented fundamental 3 as described in the initial submission.

c. Based on the PPS' progress and challenges addressing Fundamental 3 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 3 outlined in the final Primary Care Plan submitted in 2016?

As described in the above challenge, the PPS's original vision and scope of the IT Care Coordination clearinghouse has had major roadblocks with receiving data from MCOs. With that, the PPS has adjusted the scope and has begun to build out much of the clearinghouse functionality in local EMRs as the issues described above are mitigated with this approach. This includes crosswalking MCO Missing services data with clinical data.

Additionally, some of the items discussed in Fundamental 3, section A (above) were added scope to address the challenges. This includes the Integrated Pest Management. This was identified as a need after the primary care plan was submitted.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices with implementing EHRs and reaching Meaningful Use Stage 2:

The PPS continues to implement the plan described in the Primary care plan. There has no change to the plan previously submitted.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices to connect to Regional Health Information Organizations (RHIO)/Qualified Entities (QE) and the State Health Information Network of New York (SHIN-NY):

RHIO has attended Townhall meeting, where all providers are invited. Additionally, the PPS has met individually with Primary Care Provider organizations to discuss the benefits of the RHIO. The PPS has also offered education to individual providers on the programs available to offset the costs of connecting to the Health Information Exchange. This was included in the PPS newsletters. For already-connected providers, the PPS and RHIO are meeting with organizations to increase the use of the RHIO by demonstrating the various products the RHIO offers. The PPS believe as providers see the value of the RHIO, other providers within their organization and outside of their organization will increase their use/uptake of the RHIO.

The PPS is focusing on the development at the Bronx RHIO level, so participating providers can see the value of joining the RHIO. The major Bronx hospitals are connected to the Bronx RHIO, providing many data feeds, which offers value to primary care providers. These major hospitals continue to push data, which PCP based organizations need.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	329

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	358, 72.7% (358 out of 492)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	333, 67.7% (333 out of 492)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	25, 5.5% (25 out of 492)

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

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

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards VBP Readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan:

The PPS strategy in Value Based Payment, as documented in the VBP Support Plan, was to train PCPs, CBOs, and Behavioral Health providers on Value Based Payment. The PPS' plan was to build off each training session, beginning with a "101" session for all providers. The PPS contracted with MTAC to provide training to providers at the PPS Townhall. The PPS held breakout sessions for facilitated discussions on VBP. After the session, the PPS collected feedback from the participants for subsequent sessions.

Additionally, the PPS has contracted with Columbia University to aid CBOs with program evaluation. This was also outlined in the VBP support implementation plan. This program will work with CBOs to create methods to track their internal programs, which will allow CBOs to demonstrate value to MCOs and PCP organizations.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working towards VBP Readiness among the PPS' primary care providers:

Since the PPS is not a contracting entity, MCOs will not discuss specifics of VBP agreements nor offer data such as missing services to the PPS or RHIO. Since VBP readiness is dependent on improving clinical quality, this has been a large barrier to VBP readiness. This required the PPS to shift the strategy of a centralized development (for example, cross walking missing services and clinical data) to a more local IT development at the PCP organization level. This development is not ideal, however since the MCOs will not provide the PPS or RHIO with the missing services data (since the PPS is not a contracting entity), this was the only path forward. This is the largest barrier the PPS has faced in VBP Readiness.

c. Based on the PPS' progress and challenges addressing Fundamental 4 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 4 outlined in the final Primary Care Plan submitted in 2016?

There have been no changes to the plan that was submitted in 2016. The challenges existed before 2016, so no changes were required.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers to engage Managed Care Organizations (MCOs) for VBP contracting:

Since PPSs are not contracting entities, the PPS is limited to encourage providers and MCO's to make connections and contact rather than facilitate conversations. With this in mind, the PPS invited MCOs to every TownHall and encourages PCP-based organizations to connect with the payers. Additionally, the PPS holds meetings with MCOs and providers to develop workflows. These connections help PCPs develop connections with MCOs throughout the PPS. Additionally, the Finance Committee will often discuss contracting strategies PCPs can take with MCOs.

This is in addition to the VBP education sessions the PPS holds (outlined above) for each provider type.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers in levels 2 & 3 VBP arrangements to address social determinants of health and engage Tier 1 Community-Based Organizations (CBOs):

In order to support Primary Care Providers in Level 2 and 3 agreements to address social determents using Tier 1 CBO's, the PPS created a RFP for CBOs. The RFP is called the "CBO Grant Opportunities Fund." The CBO Fund's goal was aimed to help CBOs migrate to value based payment. The PPS received approval from the Finance and Steering Committee and released the RFP for up to $1,000,000 total in DY3. The PPS received 6 responses from CBOs within the PPS. After ranking the 6 proposals, all projects and applications were funded at 100% of their eligible amount with approval from the PMO, Finance, and Steering Committee.

This RFP asked CBOs to partner and receive referrals from PCP based organization in the PPS. The goal was to broker relationships between CBOs and PCPs. Additionally, the PPS is working with these CBO organizations to track patients that receive the service from the CBO. The PPS will then use the data to track the effectiveness of the CBO intervention. The PPS will share this data with PCP based organizations. The goal is when PCP-based organizations are contracting, the CBOs will have the data on their efficacy, which will make the contracting conversation easier as the CBOs will have already shown their value.

f. Additional Questions

Is the PPS planning to form a contracting entity (e.g. ACO Certificate of Authority)? ☐Yes ☐No ☐N/A

…If yes, has it been granted? ☒Yes ☐No

Has the PPS provided technical assistance to primary care partners planning to form a contracting entity (e.g. ACO or IPA)? ☐Yes ☒No

…If yes, describe: Click or tap here to enter text.

Fundamental 5: How does your PPS' funds flow support your Primary Care strategies?

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

a. Describe how the funds flow model(s) support(s) primary care in the PPS network:

The Funds Flow model has a dedicated funding stream to Primary Care Providers in its methodology. The PPS funds flow model includes buckets for each provider type. Each project determines the importance of each provider type for their project. Some projects has a large portion of the funding flowing through PCPs, while others have more modest allocations. This methodology is specific to performance payment distributions (not all PPS distributions).

The PPS also makes distributions to PCPs in the form of implementation dollars. These implementation dollars are developed locally at the project and clinical initiative level with approval from the finance and steering committees. Since projects are mostly primary care driven (with a few exceptions), most implementation dollars spent go to primary care providers/PCP based organizations.

The PPS also has centralized expenses, which support PCP's. These include workforce training funding, PCMH funding for initiatives, as well as centralized IT funding. This includes Analytics and RHIO development funds. These are not reported as distributions to partners, but rather centralized expenses.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$10,212,379.20	**100%**
Primary Care Provider	$5,990,465	58.6%
Hospital-Ambulatory Care	$0 (Lead Entity PCP's are employed at its FQHC)	0%
Federally Qualified Health Centers (FQHCs)	$5,883,105	57.6%
Primary Care Practitioners	$107,360	1.05%
PMO Spending to support Primary Care	$5,216,909 (includes Workforce and PCMH spend)	(Reported in outside bucket from the $10M above)

c. Based on the PPS' progress and challenges addressing DSRIP performance from April 1, 2016 to March 31, 2017, what strategic changes have been made to the funds flow model outlined in the final Primary Care Plan submitted in 2016?

The only change to the funds flow model is an increase in spending for clinical initiatives. These clinical initiatives are funded outside of the project workgroup budget and Performance Distribution model. The clinical initiatives mirror projects, however are focused specifically on performance measures, which is slightly different than project workgroup work. Project workgroup work is more disease specific, while the clinical initatives are HEDIS measure specific based.

Additionally, since the original Primary Care Plan submission, the PPS has made an additional $7,000,000 performance distribution.

d. Additional Questions

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving PCMH or APC recognition? ☐Yes ☒No

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving defined performance measurement targets? ☐Yes ☒No

Fundamental 6: How is the PPS progressing toward integrating Primary Care and Behavioral Health (BH) (building beyond what is reported for Project 3.a.i. within the quarterly report)?

- Including both collaborative care and the development of needed community-based providers.

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i. within the quarterly report):

As reported in the DSRIP Community Needs Assessment (CNA), patients in the South Bronx suffer disproportionately from co-occurring (comorbid) medical and psychiatric, and/or chemical dependency diagnoses. Beyond progress on Project 3ai, for which we are currently on ahead of our performance goals in terms of meeting actively engaged members and the implementation of behavioral health screenings in the primary care setting, our network is working across multiple projects to improve care for patients with primary care and behavioral health needs.

Under Project 2ai, the "Clearinghouse" was launched in Spring 2016 to increase IT interoperability and care coordination throughout our network. Through the "Clearinghouse", Health Home and Health Home at Risk Care coordinators are alerted to patient's admissions in the ED/IP settings, in addition to information such as their MCO PCP, health home and health home at risk eligibility and enrollment status. Having this information allows teams to engage patients at the point of care and provide more comprehensive services. Our network of providers can also contact the "Clearinghouse" for a "top-down" referral, or similar vetting when the patient is encountered in the field.

Under Project 2biv, a team of care transitions nurses have been embedded on BLHC medical units to reduce readmissions. In January 2017, a care coordination nurse from this team was embedded in the Behavioral Health ED and Inpatient units to better integrate primary care in discharge planning and follow-up. BLHC has also implemented a HRSA grant which expands training and staffing in our FQHCs to provide substance use screening and support. Two sites are actively screening patients for substance use and connecting them to follow-up care as a result of this grant.

Under Project 2biv, interdisciplinary care teams at Urban Health Plan and BLHC are meeting regularly to review cases identified as "high-risk". Many of these patients are identified as frequent utilizers of the ED and have both BH and PC needs.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health (not including regulatory issues):

Challenges to the integration of primary care and behavioral health services include creating a cultural shift amongst providers to integrate Primary Care and Behavioral Health, documentation and coding, and cultural diversity. Traditionally in primary care, staff make outside referrals for Behavioral Health instead of actively managing patients with behavioral health in the same setting. In addition to training and working collaboratively with new care team members, such as depression care managers, new screenings and documentation also need to be completed. This may impact current workflows and cycle times. To alleviate some of these challenges, the PPS has secured the Institute of Family Health as a technical assistance provider for Integration of Primary Care and Behavioral Health. In this role, IFH has provided coaching, training, and helped to facilitate discussions around workflow redesign and the rationale for this shift in care delivery. Providers across the network have been very pleased with the support of IFH and we have seen significant progress in the implementation of project 3ai.

To make the integration of care financially viable, new documentation procedures with the billing and IT departments have to be created that accurately and seamlessly allow for coding and increased reimbursement for the newly implemented care models. This has been challenging as there are often institutional barriers that must be eliminated or circumvented to implement these changes.

Lastly, staffing to meet the needs of primary care and behavioral health integration in our diverse community has been challenging. There are a limited number of LCSWs and other behavioral health providers that are also bi-lingual. We strive to provide cultural competent services and providing services in the patient's primary language is one way we seek to meet this goal. We will continue to work with local colleges and universities to recruit staff that meet the language needs of our network. Our Workforce Committee also continues to provide training to increase the cultural competency and language skills of staff in our network.

c. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health specific to regulatory issues:
n/a
d. Based on the PPS' progress and challenges addressing Fundamental 6 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 6 outlined in the final Primary Care Plan submitted in 2016?
No strategic changes have been made to Fundamental #6. The PPS's current strategy is working well and we will continue our efforts in this area.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	11	1	6
Model 2	Number	Number	Number
Model 3 IMPACT	11	1	3

f. Please check all trainings that the PPS provides directly, or supports partners in delivering, to Primary Care Providers for Behavioral Health Integration within DSRIP projects from April 1, 2016 to March 31, 2017:

☒Alcohol Use screening
☐ Billing for Integrated Care
☒ Collaborative Care for Depression, i.e. IMPACT model
☒ Depression screening
☐ EHR Integration
☐ Health Homes
☒ Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
☐ Mental Health First Aid
☐ Outcomes Measurement
☐ Patient Consent and Privacy regulations specific to Behavioral Health populations
☐ Person-Centered Care
☐ Peer Services
☐ Population Health
☐ PSYCKES
☐ Quality Improvement Processes
☐ Regulatory Issues
☒ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
☐ Serious Mental Illness
☐ Tobacco Cessation
☐ Trauma Informed Care
☒ Other Mental Health screening (please specify): Depression Screening and warm handoff, Registrar Role in IMPACT referrals, Problem-solving Treatment (PST) Didactic Training, Assessing and Managing Suicide Risk, DCM Boot Camp, Advanced Boot Camp for DCMs, Psychopharmacotherapy for PCPS,
☒ Other Substance Use screening (please specify): Motivational Interviewing, Bupenophrine Learning Community Substance Use in Adults and Adolescents, Funding Medication-Assisted Treatment
☐ Other

Describe:

Click or tap here to enter text.

GLOSSARY OF TERMS

Community-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is not employed by a hospital or hospital-system

Engaged Provider: Providers reported in PIT/PIT-Replacement as engaged on at least one project

Institution-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is employed by a hospital or hospital-system

PPS-defined Network: Provider Network in the MAPP DSRIP PPS Network Tool filtered to Practitioner-Primary Care Provider (PCP) for Provider Category or PPS-defined Provider Category

Primary Care Practice: Individual sites providing primary care services

Primary Care Practitioner (PCP): Individual practitioner providing primary care services

Primary Care Provider: Entity providing primary care services

RHIO/QE Connectivity: Providers sharing data with RHIO/QE or have an active BAA in place with the RHIO/QE

The Following has been Appended:

Thank you for the submission of the Bronx Health Access Primary Care Plan Update (Update) submitted on September 29, 2017. A panel consisting of staff from the Department of Health's Office of Health Insurance Programs and Office of Quality and Patient Safety has reviewed the Update and has provided feedback. Our goal was to assure that the Updates were complete in demonstrating progress toward implementation of strategies outlined in the Primary Care Plan.

Updates will be posted for public comment on or about December 1. With this in mind, the Department offers the following recommendations for areas of the Bronx Health Access Primary Care Plan Update to be considered for enhancement or revision. The comments are provided to guide the PPS toward an Update for public review that demonstrates a comprehensive implementation of primary care strategies to enable DSRIP success.

For each fundamental checked below, provide additional detail on the PPS' progress using the following recommendations as guidance, and include information on strategy implementation and results:
☐ 1 ☒ 2 ☐ 3 ☒ 4 ☐ 6

Fundamental 2: Consider including additional detail on the progress of engagement of PCPs through Insight Management and the activities of Insight Management for practice transformation

Description of PCMH Services, Expertise in Transformation, EMR Experience and Expertise, Gap Analysis, Engagement

Insight's experience with practice transformation goes well beyond just understanding the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) standards and how to prepare supporting documents. We also understand the challenges and obstacles, as well as the rewards associated with true practice transformation. Our approach to achieving practice transformation is highly customized and focuses on the specific needs of each practice. Insight works collaboratively with practices to assess their needs and create a fully customized plan to achieve real practice transformation.

Our team is well versed in process, people, and technology change. We apply proven approaches to accomplish transformation; improve outcomes; and enhance patient, staff, and provider satisfaction while bending the cost curve. We accomplish this by engaging staff and system leaders through on-site visits, Webinars, and conference calls, and by following a detailed project plan for the transformation team. Most of all, however, we use a hands on, at the practice site, one on one practice training and transformation model. Often, practices attempt transforming their practice before making an accurate assessment to identify roadblocks and obstacles. This can be frustrating and result in wasting time, money, and resources.

Insight digs deep to understand what is needed before the work to achieve practice transformation can begin. These questions cover history, goals, priorities, resource availability, health information technology capabilities, strengths, and potential obstacles. Based on the information we collect; a customized proposal is developed. If situations change at any point and more guidance is needed, we re-visit the proposal and provide updates for review and approval. An example of this may include adding on-site training sessions or adding tasks originally slated to be completed by practice staff members.

A common pitfall is not taking a thorough, objective view of the site. When asked if a site does provide one of the PCMH factors, a common response is, "Of course we do." However, they often lack necessary policies or procedures, or supporting documentation. It is imperative to have a non-affiliated person objectively view, analyze, and guide the assessment and planning process.

Each Practice is analyzed in the following manner:

- **GAP ANALYSIS –** Our first step is an **on-site gap analysis**. We observe and analyze workflow and staff roles, explore electronic medical record (EMR) functionality and reporting capabilities, speak with providers and key staff, and meet with the transformation team. This analysis reveals both glaring gaps and subtle changes that the practice might not notice—that need to be included in the transformation work plan. We present the Gap Analysis in both quantitative (NCQA PCMH points achievable) and qualitative (a narrative analysis of clinical, operational and EMR strengths and weaknesses, proficiencies, and deficiencies)

- **WE DEVELOP A CUSTOMIZED WORK PLAN --**Recommendations and a work plan structure is created to close the identified gaps. The work plan includes timelines, areas of concentration, remedial actions required, training schedules, goals, and outcome tracking mechanisms

- **WE IMPLEMENT THE PLAN --**The transformation team reviews the work plan, sets deadlines, and organizes responsible parties assigned to specific tasks so that the team is working cohesively toward site transformation goals. For sites with limited resources, PCMH Advisory Services can plan, organize, and facilitate team meetings; manage the project plan; and provide summary reports, based on your needs.

PCMH is serious business. It is an environment that must be established, reinforced, and become the new way for a practice to operate. We will help staff, providers, and patients so that they are active, and knowledgeable in how PCMH works on a daily basis. We do this in the following manner:

- **ENVIRONMENTAL CHANGES—**Insight develops a plan to support this environmental transformation by creating awareness, providing education and the methods to reinforce permanent changes over time, and building a desire to be a part of something better.

- **TEAMWORK—**Work team development and facilitation focuses on staff, process, and technology. Starting to work in team-based structures can be challenging for some.

- **EVERYONE HAS A ROLE --** Being a contributing member of a team begins with having clear roles and responsibilities. Insight works with practice leaders to refine job descriptions to reflect PCMH concepts and ensure that each staff member is working within the full scope of his or her license or skill. We can provide a full continuum of training, including in-person, via Webinars, or through train-the-trainer approaches, depending on the practice's needs.

Fundamental 4: Consider including a detail on the progress and implementation of the contract with MTAC and Columbia University.

The PPS strategy in Value Based Payment, as documented in the VBP Support Plan, was to train PCPs, CBOs, and Behavioral Health providers on Value Based Payment. The PPS' plan was to build off each training session, beginning with a "101" session for all providers. The PPS contracted with MTAC to provide training to providers at the PPS Townhall. The PPS held breakout sessions for facilitated discussions on VBP. After the session, the PPS collected feedback from the participants for subsequent sessions.

Additionally, the PPS has contracted with Columbia University to aid CBOs with program evaluation. This was also outlined in the VBP support implementation plan. This program will work with CBOs to create methods to track their internal programs, which will allow CBOs to demonstrate value to MCOs and PCP organizations. The first training to take place at the Columbia Community Partnership for Health on October 20th. Due to an overwhelming response, an additional training is planned for November 20th. Following training, individual support to CBOs and BHA partner agencies interested in developing evaluation plans will be provided by Research Scientist Dr. Angela Aidala and her team of students and colleagues.

For each fundamental checked below, in question "c", provide additional detail on the strategic changes the PPS has made to address the Primary Care Plan using the following recommendation as guidance, and include explanations for changes and expected impact or outcomes:

☒ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☒

Fundamental 1: Consider including additional detail on the strategies to address challenges to training for primary care physicians and care team members.

To reduce the burden of coming to training, the Stakeholder Engagement Workgroup PCP champions have decided to launch a webinar series. The champions identified 4 priority topics and will work in collaboration with the Workforce Committee to offer live web-based events that will be recorded and posted on HWApps for future viewing . To encourage participation by providers and care team members, the PCP champions requested that all the webinars offer Continuing Medical Education (CME) credits. The first webinar was launched this month and focused on Integration of Primary Care and Behavioral Health and offered credits for both providers and social workers.

Fundamental 2: Consider including more detail on how the PPS believes community-based PCPs will be able to implement local EHR

A crucial necessity of true PCMH transformation, is a fully integrated EHR system. Although many NY providers added EHR's in order to meet e-prescribing requirements, many never fully integrated their system's full functionality. Insight Management, in conjunction with the practice's EHR provider, help the practice fully embrace all the modules available. This allows the practice to implement Quality Improvement based on actual practice reporting in order to meet the needs of their patient population.

Fundamental 6: Consider including additional detail on the progress and implementation of IFH's efforts to influence a cultural shift among providers, and the progress and implementation of the new documentation procedures with billing and IT departments.

In this role, IFH has provided coaching, training, and helped to facilitate discussions around workflow redesign and the rationale for this shift in care delivery. Providers across the network have been very pleased with the support of IFH. In addition to IFH workshops and webinars, internal clinic leadership also facilitates discussions around challenges, teambuilding, evolving roles. This allows for a more concrete discussion of culture of change and expectations.

To make the integration of care financially viable, new documentation procedures with the billing and IT departments have to be created that accurately and seamlessly allow for coding and increased reimbursement for the newly implemented care models. This has been challenging as there are often institutional barriers that must be eliminated or circumvented to implement these changes. There continue to be regular meetings between providers, billing department, and IT department team members to identify, and pilot solutions.

Completed data tables were not submitted, information may be inaccurate, or misalignment with submitted narrative and/or DSRIP goals has been identified for the following fundamentals. Where values are not applicable, write 'N/A':

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Fundamental 3: Consider including clarification on the nature of RHIO connection and participation of providers, with additional detail on the strategies to address gaps in RHIO functionality and use.

The PPS is strongly encouraging PPS partners to fully adopt the BronxRHIO by using many strategies. For the clinicians, the RHIO/PPS is training providers on the system to demonstrate use cases where the RHIO can positively affect their workflows. For example, when a new patient is seen by a Primary Care Providers, the training focuses on how using the BronxRHIO's provider portal can produce useful information for the Primary Care Providers on the history of the patient. In other scenarios, the RHIO/PPS trains providers on subscription services, so the Primary Care Providers will receive an alert when the patient is seen in a Bronx based ED or Inpatient unit. Through these granular examples, the PPS and RHIO have seen increased use and adoption of the RHIO as demonstrated in the PCP Plan filings and MAPP reporting.

For each question listed below, provide additional detail on the PPS' progress using the noted recommendations as guidance:

Fundamental #2, question d: Please provide additional information on success with strategies supporting PCMH or APC transformation, particularly in providing education, technical assistance, and EHR/ HIE infrastructure. Please clarify the linkage between PCMH transformation and how it addresses identified challenges within the PPS network, and include strategies to address limited engagement in 1199 TEF PCP and Frontline focused trainings

Another important component of PCMH recognition is ongoing quality improvement. We work with site leaders to identify focus areas, develop quality improvement plans. We will also guide the site in creating effective site-level and provider-level performance statements that reflect the clinical and patient experience goals of the site or system.

We have found the above methodology to be very successful in not only transforming practices into fully functional medical homes, but also in meeting NCQA's rigorous standards in order to achieve Level 3 certification as a Patient Centered Medical Home. For BHA PPS, we have successfully engaged and transformed over 75 practices, which include the following practice types:

- Federally Qualified Health Centers (FQHC)
- Small Multi-sites (fewer than 5 locations)
- Large Multi-sites (greater than 5 locations)
- Multi-specialty practices
- Small Primary Care practices (fewer than 5 providers)
- Independent Primary Care providers (solo-providers)

Strategies to address limited engagement in 1199 TEF PCP and Frontline focused trainings include:

- Increasing the advertising effort (i.e. additional email blasts, website updates, and personal reminders about the availability of such trainings)
- Additional follow-up with practices that have indicated a need for training, even if they have previously been unresponsive
- Expand the offerings and availability of trainings (i.e. additional online and in-person trainings.)

Fundamental #3, question e: Please provide additional information on the progression of strategies to assist primary care practices to connect to the RHIOs/QEs/SHI-NY. Consider including additional detail on how the PPS is encouraging providers to join and actively participate in the Bronx RHIO, including how the PPS is incentivizing providers to do so.

The PPS and RHIO are seeing an increased use and adoption of the Bronx RHIO throughout DSRIP. The value add of the RHIO has increased adoption as providers recognize the value of the Bronx RHIO's functionality. The PPS has found that demonstrating specific use cases to providers of the RHIO is the most effective way to increase adoption.

In regards to the question about incentivizing providers to connect, as far as implementation incentives, there is already an existing funding stream available so the PPS is consciously/deliberately not duplicating adoption incentives to providers. If these funding streams are no longer available, the PPS will reconsider this strategy. With this being said the PPS is offering performance incentives and believes that the use the RHIO plays a crucial role in achieving these performance measures.

Fundamental #4, question e: Please provide additional information on the supportive services the PPS has provided to primary care providers for engaging Community-Based Organizations for VBP contracting. Consider including

clarification on the PPS strategy to support, specifically, primary care providers through VBP education and additional details on the nature of the educational initiatives.

As outlined in the submission, the PPS has created a CBO Grant Opportunities Fund. The CBO Fund's goal was aimed to help CBOs migrate to value based payment. With this being said, RFP asked CBOs to partner and receive referrals from Primary Care Provider based organization in the PPS. The PPS is tracking these referrals and working with Primary Care Providers to analyze this data specifically for reducing hospital admissions and unnecessary ED visits. This is part of a VBP training effort to aid partnerships between Primary Care Providers and CBOs to demonstrate the value add when partnering with CBOs.

Fundamental #5, question a: Please provide additional information on the funds flow model as it supports primary care in the PPS network. Include details on the primary care transformation and enhancement activities that the funds flow is supporting as well as the level of primary care provider engagement it has created. Consider including some additional detail from the original PC Plan on the performance payment distribution, funds flow to primary care physicians and the linkage of performance distribution payments to DSRIP primary care goals.

The PPS has made sizable investments into PCMH adoption, Centralized IT Services for PCP members, and workforce training. The PCMH adoption included using an external vendor to work with PCP based organizations on achieving PCMH adoption. This investment has garnered great interest by partnering PCP based organizations and has additionally brought some of the peripheral PCP partners into the fold of additional projects. Additionally, workforce training produced (and continues to produce) collaborations with PCP partnering organizations as their workforce redeployment/training efforts can be offered through the workforce fund. The PPS outreached to PCP based groups to identify training needs and as a result, the PPS offered EMR training and frontline staff trainings for select PCP based organizations. These investments directly benefited the PCP organizations.