NEW YORK STATE OF OPPORTUNITY. Department of Health

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DOH REVIEW AND EXECUTIVE SUMMARY OF PPS PRIMARY CARE PLAN DECEMBER, 2016

PPS: ST. BARNABAS PPS/BRONX PARTNERS FOR HEALTY COMMUNITIES (BPHC)

BPHC serves the Bronx along with 3 other PPS. BPHC has 170,000 attributed Medicaid members. PPS governance and network includes FQHCs, community physician IPA, St. Barnabas Hospital (PPS lead) and Montefiore Medical Center. PPS has innovative project management approach where PPS has funded project directors to work with their largest primary care practices that account for 97% of attributed Medicaid members. As of summer 2016, 35% of BPHC primary care partners had attained 2014 PCMH Level 3 accreditation. PPS has developed a Community of Practice learning collaborative where partners discuss best practices for practice transformation.

Overall Assessment: An excellent primary care plan that demonstrates overall strategy for addressing primary care practice transformation and active implementation of strategy. No details provided on dollars to be flowed to primary care, neither flowed to date nor planned.

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

- DOH has listed 1,100 primary care providers in the PPS network. PPS estimates these to equate to approximately 500 primary care FTEs due to other roles, and assignments as part of the PPS' largest partner, Montefiore, an academic medical center. PPS has identified approximately 200,000 non-users of primary care and have calculated that with population health management strategies and outreach, and panel size per FTE, current BPHC primary care capacity will be able to manage the primary care services needed for this population.
- Capacity and access will be maximized by team-based care where other staff and professionals will provide services to the patients.
- Practice transformation coaching by the project staff who work with the practices.
- Continue recruitment of PC staff; work with CUNY School of Medicine as part of pipeline.
- Partners developed a Comprehensive Clinical Operations Plan (COP) toolkit that promotes high standards of quality care and improve clinical integration broad enough to be adaptable to hospital and community based partner settings.

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

- BPHC has retained 12 practice transformation vendors for work with their primary care practices to achieve PCMH or APC. Of 120 authorized sites, 76 pap assessments returned to identify specific practice needs for targeted assistance.
- As of July 2016, 23 sites achieved PCMH 2014 level 3 - equal to 35% of identified PCPs.
- Encourage team based care with nurses, medical assistants, pharmacists, dietitians, social workers and community health workers for hypertension, medication management, and depression care managers with goal to reduce control period down to 6-16 week period.
- Investigating PCMH models for school based health centers, mobile clinics, PACE programs and long term care centers.

- PPS has created a Community of Practice to build and share best practices, collaborate with experts on PCMH transformation and ideally transfer knowledge and experience to other population health initiatives, and developed the Clinical Operations Plan mentioned in #1.
- Focus on care coordination training for workforce in different roles as part of team-based care as part of practice transformation. Such training and applied skills should also help staff to address SDH and access these community-based services for patients.

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

- Care transition and care connections via a closed loop referral system outlined in COP.
- ED navigator ties back to Primary Care Provider.
- Extending CBO accountability when warm handoff referral to non- co-located providers.
- Plan for interconnectivity for alerts and messaging,
- Planning for embedded care coordinators within PC teams throughout PPS
- Development of a Care Coordination Management System
- Seven largest PC practices are represented on Governance committees and workgroups
- Bronx United IPA a group of community-based independent practices one of the largest partners engaged

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

- Twofold VBP readiness strategy: 1) sustain and standardize PCMH infrastructure and expand capacity at local level 2) centralized shared services for system development, governance, financial and network management, interconnectivity, contracting, population health and risk analysis, analytic services.
- Engaged consultant for VBP modeling, contractual readiness and 1:1 interviews with partners.

FUNDAMENTAL #5: How does your PPS's funds flow support your Primary Care strategies?

- Largest primary care partners serving 97% of attributed patients were funded to hire DSRIP Project Directors if implementing 7+ projects.
- Start-up funds to build care coordination and population health capacity provider and PCMH with technical assistance vendor support
- Hospital based teams to develop care transition planning with PCPs
- Community based independent PCPs engaged
- CBO and BH Organizations to support innovations to address social determinants of health and integration of behavioral health/primary care.

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

- 348 PCPs participating in Project 3ai: 99-Model 1; 7-Model 2; 32-Model 3; 205-Models 1&3.
- Hiring Depression care managers and a Psychiatric Consultant
- COPs have specific sections on integration of BH/PC allowing for site adaptation
- Contracted with Institute for Family Health to provider training and TA on Collaborative Care, Problem Solving Treatment, Psychopharmacology and Screenings.
- Working with GNYHA and NYC DOHMH on SBIRT training.
- Clinical community linkages emphasized
- Convened "Engaging Behavioral Health Leadership" group working on engagement with community based behavioral providers to develop capacity, interventions, screenings, performance, funds flow and linkage to patient's primary care practitioner.