



Community Care of Brooklyn Primary Care Plan

PPS Name: Maimonides Medical Center

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

Community Care of Brooklyn (CCB) has a multi-pronged approach to increase access to high quality primary care: 1) building a robust primary care network and assisting those PCPs who are practicing in Brooklyn to transform their practices to become more efficient, more effective, and culturally and linguistically competent to accommodate an increased patient load, and encouraging these providers to expand their office hours; 2) adding and leveraging existing resources to expand availability of primary care in the evening and on weekends; and 3) facilitating, monitoring, and evaluating the hospitals participating in the Value Based Payment Quality Improvement Program (VBPQIP) to ensure that these hospitals and their primary care networks are in a position to engage in value based contracting and that Brooklyn has a clinically integrated network, with an adequate number of PCPs.

Our approach to increase access to primary care has involved building a robust primary care provider network and supporting that network to achieve increased visit capacity. CCB began building its primary care network by identifying PCPs who have expressed a commitment to working with CCB and who have the highest volume of Medicaid patients. CCB currently has Master Services Agreements (MSAs) with five hospitals employing 400 PCPs, six Federally-Qualified Health Centers (FQHCs) employing 83 PCPs and two Independent Practice Associations (IPAs) with 74 affiliated PCPs. Deliverables, required reporting, and funding amounts are defined in schedules to the MSA ("Schedule Bs"), specific to primary care, that outline specific obligations, which focus on implementing the National Committee for Quality Assurance (NCQA) 2014 Patient-Centered Medical Home (PCMH) standards and five clinical DSRIP projects (asthma, cardiovascular disease, behavioral health integration, palliative care, Health Home At-Risk). CCB is providing funding to launch these projects as well as providing training and technical assistance as described in the response to Question 2.

In addition to relationships with institutionally-based physicians, CCB has executed 51 MSAs with signed Schedule Bs that account for 102 PCPs in community practices. CCB is committed to providing some level of PCMH transformation support to every practice with a MSA, with smaller practices receiving training and support through online resources. All of the actively engaged community practices with MSAs have been visited by at least one CCB program staff member, often with CCB leadership, to introduce the DSRIP program, CCB, and the specific projects applicable to primary care practices. In addition, a majority of these actively engaged community practices have completed a CCB Participant Survey, which was deployed in fall 2015 across the CCB network. CCB has identified another 500 PCPs who are currently not in the CCB network and anticipates adding another 100-200 PCPs during the current window for expanding the PPS network. CCB has made engagement of community-based PCPs a major priority both because we understand the central role of PCPs in an integrated delivery system and because 70% of the PCPs with MSAs with CCB are in community-based practices.

CCB's strategies to increase access through collaboration with existing PCPs across settings include: 1)



encouraging them to offer (or expand) evening and weekend hours and make same-day appointments available; and 2) providing training and technical assistance to improve the efficiency and effectiveness of primary care practices through PCMH transformation, including the addition of Health Coaches, to allow more primary care visits per day as described in response to Question 2.

CCB is increasing access to evening and weekend primary care by 1) promoting coordination with existing urgent care resources so that hours of availability are additive and not duplicative and 2) working with Participants that received capital funding to build after hours/urgent care services. CCB prioritized primary care and urgent care applications during the Capital Restructuring Finance Program review process. Wyckoff Heights Medical Center received capital funds to support opening of an urgent care center; Wyckoff, Maimonides Medical Center, and Kingsbook Jewish Medical Center received capital funding to enhance and expand their primary care clinic space; Interfaith Medical Center received funds to provide urgent care; and First MedCare, a Diagnostic & Treatment Center offering primary and some specialty care, received funding to expand and upgrade its site.

CCB is also addressing the need to address the shortage in primary care resources as part of its financial sustainability strategy. CCB is playing a key role in facilitating, monitoring, and evaluating the hospitals participating in the Value Based Payment Quality Improvement Program (VBPQIP) to ensure that these hospitals and their primary care networks are in a position to engage in broader delivery system transformation efforts. Financial sustainability requires increased access to both primary care and behavioral health services and a well-balanced provider network that works collaboratively to meet patients' needs.

To explore an innovative approach to assessing needs, improving performance and developing action plans, CCB is partnering with the Massachusetts Institute of Technology (MIT) to engage in Participatory Action Research (PAR) as the model for community engagement with an initial pilot focused on cardiovascular disease (CVD) in Central Brooklyn. In collaboration with its Community Engagement Committee, CCB created a workgroup that includes key CBOs and stakeholders from those neighborhoods, including local union representation and local PCPs, FQHCs and hospital-based primary care clinics. PAR is a well-studied model that seeks to engage communities in partnership with academia to study and identify solutions to community needs. The Workgroup is focused on a pilot project to map community resources in two zip codes representing the Bedford Stuyvesant and Brownsville neighborhoods. MIT has provided graduate students to lead the PAR project and supervise college students from Medgar Evers College and a group of local high school students. The goal is to conduct key stakeholder interviews and community resource mapping through youth engagement, with a focus on better understanding the resources and barriers for community members as they pursue healthy lifestyle choices that can promote improved cardiovascular health. The initial report of findings, recommendations and suggestions for next steps will be available in the fall of 2016. CCB plans to replicate the PAR in other Brooklyn communities, focusing on topics prioritized by those communities.



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

CCB has a varied and extensive array of training and technical assistance supports available to PCPs. The largest effort is focused on PCMH transformation in hospital clinics, FQHCs, IPAs and community-based practices. CCB established a PCMH Workgroup with PCPs and primary care office staff to discuss and prioritize the necessary types of support. The Workgroup agreed that a significant level of technical assistance, training and resources were needed and that the assistance should begin early in DY2, initially focused on the practices that work with the largest number of Medicaid beneficiaries. It is expected that over 400 PCPs in more than 55 locations will be engaged in PCMH transformation over the next 12 months, potentially impacting more than 250,000 Medicaid beneficiaries.

To appropriately address the unique needs of primary care practices across CCB's vast network by the DSRIP DY3 deadline, CCB is contracting with four organizations, all of whom have significant experience assisting providers seeking to meet NCQA PCMH standards: the Primary Care Development Corporation (PCDC), the NYC Department of Health and Mental Hygiene's Primary Care Information Project (PCIP), CMS Solutions, and Health Team Works. Contracts have been finalized with three of these organizations. All three have received individual, half-day on-boarding and orientation sessions conducted by CCB staff and work has begun at 40 sites. The PCMH vendor's contracts require them to provide detailed, hands-on, in-person assistance in completing NCQA applications and implementing the necessary changes in practice training and workflow to achieve NCQA 2014 Level 3 recognition. These PCMH vendors will provide on-site training in hospitals, FQHCs, IPAs and community practices, as well as centralized training on topics such as performance improvement, team huddles and registry use. CCB is in the process of finalizing a contract with the fourth PCMH vendor, Health Team Works, which will provide a "virtual" resource via webinars and telephone calls to smaller primary care practices.

CCB's Chief of Clinical Programs and Network Development is a NCQA PCMH Certified Content Expert, with experience helping primary care teams transform their practices into patient-centered medical homes. CCB has also hired a Director of PCMH Transformation, with significant PCMH coaching and project management experience, to oversee the PCMH vendors and, along with other members of CCB's program staff, to provide assistance directly to the practices.

Support in integrating behavioral health services into primary care is another major area of technical assistance and training for PCPs. CCB has contracted with the Institute for Family Health (IFH) to provide training and technical support to PCPs to implement Behavioral Health Integration (BHI). To date, IFH has provided training on collaborative care and integrating behavioral health services into primary care practices for five CCB hospitals and six FQHCs and provided training webinars and telephonic and on-site technical assistance for both hospitals and FQHCs. CCB's Associate Medical Director, who is a psychiatrist, also provides significant on-site and telephonic technical assistance and training.

In addition to the PCMH and BHI training supplied by contracted vendors, CCB has multiple training activities in place to support primary care expansion and practice and workforce transformation. The largest effort involves training Health Coaches who will work in PCMHs to coordinate services provided to patients between primary care visits (e.g., visits to medical specialists; community-based services for housing, nutrition, exercise support and testing); assist in the development of care plans and establishment of self-management goals; and support PCMH clinical staff with patient education. Additionally, care management agencies are providing Health Coaches for small, community-based practices that do not have the patient panels to support a full-time Health Coach.



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CCB is working with the New York Alliance for Careers in Healthcare (NYACH) and with CUNY-Kingsborough Community College to train Medical Assistants (MAs) and other MA-level staff members to become Health Coaches to work at primary care sites. Upon completion of the program, trainees will receive 4 college credits. Two initial cohorts, totaling 40 students, will complete training by September 1 and work as Health Coaches in those settings. A third cohort of MAs will begin health coach training in September.

CCB has contracted with 1199SEIU Training and Education Fund (TEF) to deliver care coordination training for cohorts of 15-20 care managers, care coordinators, transitional care nurses and managers. The training covers topics such as patient goal setting, lay patient education, and motivational interviewing. To date, four cohorts of CCB Participant staff have completed the training, a fifth cohort is taking the training now, and a sixth cohort is scheduled to start in September.

Provider education will include a course on Healthcare Reform/DSRIP 101 to be offered by TEF In September that will be made available to all staff, including clinicians. CCB has developed an educational program that includes VBP and has already been offered to CBO's and primary care organizations. CCB will continue to roll out this VBP orientation, expanding both the content and the audience. Cultural Competency/Health Literacy training, consistent with CLAS standards, will be provided to both PCPs and their office staff. CCB is convening disease-specific, physician-centered workgroups for asthma, palliative care and the other clinical projects, and has developed clinical operations plans using evidence-based guidelines for all projects. These workgroups will meet this fall to solicit provider feedback on any additional training and technical assistance resources needed for each of the clinical initiatives.

Another training service that CCB offers is training on our web-based collaborative care plan (part of the care coordination platform GSI Health Coordinator – the Dashboard), that CCB is integrating into many of its clinical initiatives. The Dashboard is used to coordinate care and create collaborative, community-wide care plans that can be shared across organizations for their common patients. CCB currently has records for over 66,000 patients in the Dashboard, many of whom have care plans that have been created at multiple points during the patients' history with CCB and/or the Brooklyn Health Home. CCB staff train primary care practice staff via in-person and webinar trainings to use the Dashboard to document care plans and meet project reporting requirements.

Another support for practice transformation is the Maimonides Central Services Organization (CSO) that supports all of CCB's efforts. Currently the CSO offers a helpline for providers with questions about DSRIP projects or requirements; a newsletter highlighting current status of the projects and announcing borough-wide DSRIP-related activities and resources; and an arrangement to provide Health Coaches to small practices through contracts with two care management agencies. The CSO will very soon offer back-up telepsychiatry and pharmacy support.

Taking advantage of existing NYS training and technical assistance resources, CCB arranged for its Participants' staff to attend a full day of care coordination training provided by Greater New York Hospital Association with funding from the NYS Healthcare Workforce Retraining Initiative. Over 100 staff working in CCB Participant organizations attended these sessions, including staff from adult and pediatric primary care sites and several Health Home Care Management Agencies. Four of CCB's participating FQHCs were selected to participate in NYS's Collaborative Care Medicaid program to implement the IMPACT model. These sites will receive training, technical assistance and payments from state resources. CCB will continue to identify opportunities to leverage and coordinate our efforts with existing and new statewide initiatives.



3. CCB's strategy for how primary care will play a central role in an integrated delivery system

CCB is committed to designing an integrated delivery system with PCPs playing a central role in providing and coordinating patient care. CCB's leadership in the Maimonides CSO includes three PCP physician champions, who, together with other members of the CCB team, have developed a comprehensive strategy to ensure the central role of primary care in Brooklyn. The CSO's Chief Executive Officer is an Internist who has served as the Chief Medical Officer of a major academic medical center and as Chief of Clinical Integration at Maimonides. CCB's Chief Medical Officer is an Internist who ran a highly successful primary and specialty ambulatory care center in Manhattan that was an early adopter of the PCMH model. The Chief of Clinical Programs and Network Development has consulted to multiple organizations committed to transforming their practices into medical homes/medical neighborhoods and has substantial background in workforce development in primary care settings. In addition, individuals who are primary care providers and/ or manage the delivery of primary care services are well represented on our Governance committees.

The CCB team's exceptional background in building integrated delivery systems and redesigning the practice of primary care enables them to design a delivery system built on the foundation of the patient's relationship with his or her primary care physician. The team acknowledges that PCPs must transform their practices to become more efficient, effective and patient-centered and encourage individuals to be responsible for the healthy lifestyles necessary to avoid chronic conditions, or, at least, to minimize the most negative effects of chronic illnesses. Other changes to the current fragmented and siloed care delivery system required for the integration and coordination of all health services include the need to: 1) establish workflows and procedures to promote communication and referral linkages between PCPs and other care providers; 2) enable complete and timely health information exchange among PCPs, other providers, patients and caregivers; 3) increase access to primary care services on weekends and evenings; and 4) provide care coordination services for high-risk patients.

CCB is undertaking multiple activities to promote PCP connectivity with other health care providers and with community-based social service providers. Data sharing is being promoted by providing participants with access to the Dashboard, CCB's web-based care coordination platform. This is the same care coordination platform that is used by the Brooklyn Health Home and CCB to create community-wide care plans that can be shared across multiple organizations. The community wide care plan model allows for multiple providers to document patient goals, coordinate multiple aspects of patients' care, and facilitate communication among providers via secure direct messaging and event notifications.

CCB participants are encouraged to join Healthix, our Regional Health Information Organization (RHIO), to gain access to data on their consented patients and receive alerts when their patients are admitted or discharged from a hospital or Emergency Department. Patient-level clinical data in Healthix is available to Participants via an electronic interface between Healthix and the Dashboard. Through in-person and webinar trainings, CCB trains primary care practice staff to document care plans and meet project-reporting requirements.

As noted in the response to Question 1, CCB is increasing access to evening and weekend primary care by 1) promoting coordination with existing urgent care resources so that hours of availability are additive and not duplicative and 2) working with our participant organizations to build after hours/urgent care services. Multiple CCB Participants, including Wyckoff, Maimonides, Interfaith, Kingsbook and First MedCare, received funds to add urgent care and/or expand their primary care space.

Rather than approaching DSRIP in project-specific silos, CCB views the PCMH model as the foundation for the



achievement of programmatic goals. All of the DSRIP projects being implemented by CCB involve PCPs and are geared toward a collaborative care model, which envisions teams of health care providers in all settings and at all levels of care, working together with the patients and their caregivers to improve health outcomes and increase patient satisfaction. Collaborative care seeks to avoid fragmented care, duplicative testing, overprescribing, and potentially preventable use of inpatient, nursing facility, ED and other care that is not “in the right place, at the right time.” The PCP is at the center of the model, serving as the patient’s main caregiver and advocate and coordinating the care delivered by other parties.

CCB’s Care Transitions, ED Triage and Health Home at-Risk projects all promote the central role of primary care physicians in the integrated delivery system. In the ED Care Triage project, ED staff members are required to make follow-up appointments for patients with their PCPs, acknowledging the pivotal role of the PCP in coordinating patient care. Similarly, the Care Transitions project requires hospital staff to develop 30-day post-discharge care plans and share those care plans with the patients’ PCPs, again acknowledging the central role of PCPs. In the Health Home-at-Risk project, the intervention is being delivered in the primary care setting.

Health Coaches, a key new member of the primary care team, will help to identify and intervene in situations where, without some action, patients are at risk for escalation to Health Home-level services. Health Coaches will support patients using motivational interviewing techniques, identifying patients’ readiness to change and assisting patients with creating achievable self-management goals. Between visits, Health Coaches will follow up on patients’ progress toward achieving their goals and report back to the primary care teams. PCPs can refer patients with chronic conditions to Health Homes that can then provide care coordination services that are incorporated into an overall care plan. These activities support PCPs who do not have the time or resources to coordinate the social services that many high risk Medicaid patients need to improve or maintain their health.

CCB staff members promote PCP participation in DSRIP initiatives by meeting with PCPs in their offices; encouraging PCPs to participate in CCB committees and workgroups; and attending medical staff meetings in the hospitals, IPAs and FQHCs to discuss DSRIP activities and clarify CCB’s intention to reinforce the central role of PCPs in the health care delivery system. CCB has established a PCMH Workgroup that includes PCPs employed by hospitals, FQHCs, and IPAs as well as physicians in community practices. The purpose of the workgroup is to help prioritize gaps and needed resources, collaborate on innovations, identify best practices and interventions for practice-based projects and agree on clinical guidelines and protocols. PCPs are members of the Care Delivery and Quality Committee, one of CCB’s governance committees.

The critical role of primary care in our integrated delivery system is also being reinforced as part of CCB’s financial sustainability strategy. As part of this strategy, CCB plays a key role in facilitating, monitoring, and evaluating the hospitals participating in the Value Based Payment Quality Improvement Program (VBPQIP) to ensure that these hospitals and their primary care networks are in a position to engage in broader delivery system transformation efforts. Financial sustainability requires increased access to both primary care and behavioral health services and a well-balanced provider network that works collaboratively to meet patients’ needs. The clinically integrated network being designed for Brooklyn will be sustainable, maintain care in as-local-as-possible settings, have centers of excellence for clinical services, and place primary care as the foundation upon which all secondary and tertiary care is structured.



4. CCB's strategy to enable primary care to participate effectively in Value-Based Payments

New York State has created a value-based payment (VBP) Roadmap to transition Medicaid reimbursement from a fee-for-service, “pay-for-volume,” model to provider reimbursement based on outcomes. CCB is committed to enhancing the attractiveness of its PCPs to Managed Care Organizations (MCOs) offering VBP arrangements by helping primary care practices increase the quality and effectiveness of their services and by providing training on the current reimbursement landscape so that PCPs understand the changes that are necessary for participation in the emerging reimbursement models.

MCOs are interested in contracting with primary care practices that have NCQA Level 3 PCMH recognition and with organizations (hospitals, FQHCs and IPAs) that have strong clinical networks, including a robust primary care base. MCOs seek primary care practices that can provide high quality, evidence-based patient care; provide documentation that they meet national health prevention screening guidelines; have patient panels with low rates of potentially preventable hospital admissions and ED visits; and utilize care coordination to avoid duplicative diagnostic testing and reduce overuse and misuse of medications. MCOs evaluate the strength of primary care practices or the primary care component of the organization's network by assessing the availability of timely appointments, same-day appointments and evening and weekend coverage; the level of patient satisfaction, scores on quality indicators (e.g. HEDIS and NQF metrics); deployment of meaningful-use certified EHRs; and use of regional health information organizations to coordinate care and share information with other entities caring for their patients.

CCB's overall strategy to enable primary care providers to participate in VBP is to 1) increase PCPs' understanding of the reimbursement environment, including VBP and how practices can position themselves to succeed in that environment; and 2) increase the attractiveness of primary care practices to MCOs by assisting them in achieving MCO standards for access, preventive screening, quality of care, and patient outcomes and patient satisfaction. CCB will also be working with its provider network to explore various options to form contracting entities (IPA, ACO, etc.) that would include PCPs in developing and sustaining value-based contracting arrangements.

CCB leadership and staff have visited all of the hospitals, FQHCs, IPAs and over 100 community-based primary care practices to discuss DSRIP and CCB and to solicit input from providers as to the assistance they need to enable their participation in VBP. PCPs have requested assistance in managing their relationships with MCOs; achieving NCQA PCMH Level 3 recognition; obtaining and using electronic medical record systems; and accessing available resources for care coordination, training and technical assistance.

Working with its Training Lead, the 1199SEIU Training and Education Fund (TEF), CCB has developed an entire menu of trainings, including many topics that are particularly important for PCPs and their staff to understand and to be successful in VBP arrangements. Examples of training topics for PCPs and staff that are closely linked to VBP participation and success are: DSRIP 101 for providers (which will cover current and future medical care reimbursement models, including various types of VBP arrangements); Use of Registries and CCB's web-based care coordination platform (which can be used by practices to coordinate patient care and report mandated metrics); and Performance Improvement (which is a tool primary care practices need to understand and use to continuously improve the efficiency and effectiveness of their services). CCB is also offering a specific orientation to VBP that has already been attended by CBOs and primary care organizations. CCB will continue to roll out this VBP orientation, expanding both the content and the audience.



CCB envisions at least eight types of resources and support that will better position PCPs to participate effectively in VBP agreements: 1) allocation of funds for implementation of specific projects defined in Master Services Agreements and Schedule Bs signed with individual physician practices, IPAs, hospitals and FQHCs; 2) significant levels of technical assistance in achieving NCQA PCMH Level 3 recognition and behavioral health integration, using both vendors and CCB staff with expertise in these areas; 3) varied training opportunities to increase practice performance; 4) allocation of funds and training support for care coordination (Health Coaches) who can assist PCPs in reducing potentially preventable hospital admissions and ED visits, avoiding duplicative diagnostic testing, reducing overuse and misuse of medications and helping them build relationships with specialty and community-based providers of social services to ensure a smoother, more coordinated continuum of patient care; 5) funding and training support for CCB's web-based care coordination platform, the Dashboard, to support development and sharing of care plans across providers and support transitions of care; 6) access to centralized resources that can provide important services on a shared basis, including access to part-time Health Coaches for smaller practices, back-up telepsychiatry, and access to pharmacists to assist PCPs in resolving medication issues and; 7) capital funding for several CCB providers and hospitals to enhance space in which primary care is provided and provide urgent care and evening and weekend primary care coverage; and 8) allocation of funds and training support for managing behavioral health conditions, including depression, anxiety, alcohol and substance misuse, all of which have been demonstrated to negatively impact overall physical health and utilization of emergency and acute care services.

As detailed in the response to Question 5, CCB has already committed over \$11 million to directly implement its strategy for primary care; however, many other centralized resources and other efforts contribute to the success of primary care providers in our network that are not quantified in this total. Funds are being allocated to implement specific projects and to provide the necessary training and technical assistance to make those project implementations successful. Examples of CCB activities that support participation of primary care practices in VBP include:

- Over 400 PCPs in over 55 locations are receiving support to achieve NCQA PCMH Level 3 recognition, from expert vendors and CCB staff, which will make those practices more attractive to MCOs and increase the likelihood that the practices will meet MCO standards and expectations;
- Centralized support which currently includes a Participant support line, a newsletter promoting DSRIP projects and resources, and an arrangement to provide Health Coaches to small practices through contracts with two care management agencies, which is continuing to expand and will eventually include services more directly linked to VBP arrangements, including training on strategies to optimize coding/billing practices; and
- CCB's Chief of Clinical Programs and Network Development is providing support to a large IPA to further strengthen its existing staff and infrastructure to expand its performance improvement initiatives associated with successful VBP arrangements.

Funding received by multiple hospital and FQHC sites through the Capital Restructuring Financing Program (CRFP) will support projects and programs likely to increase the attractiveness of some of the primary care locations to MCOs implementing VBP contracts.

5. How CCB’s funds flow supports primary care strategies

As of August 24, 2016, CCB has committed more than \$11 million and distributed nearly \$3 million in funds to directly support primary care strategies. These funds represent payments directly to primary care practices to date to supplement staff and payments to vendors providing technical assistance and training exclusively to primary care practices. We expect that additional commitments will be made in the future directly related to primary care. Additionally, it can be argued that many of CCB’s other efforts also contribute to the success of primary care providers in our network (see list below).

Commitment and distribution amounts by type of entity are as follows:

Funds Directly Supporting Primary Care	Amount Committed	Amount Distributed
Hospital / Article 28 primary care clinics	\$1,393,667	\$450,167
FQHCs	\$1,736,500	\$541,833
IPAs	\$1,411,155	\$632,139
Community-based PCPs	\$1,087,436	\$336,496
Vendors of training and technical assistance exclusively for primary care	\$5,648,648	\$768,333
Total, as of August 24, 2016	\$11,277,406	\$2,728,969

As noted earlier, CCB executes Master Services Agreements with all of its network participants and includes schedules (“Schedule B”) that detail the contracted entities’ responsibilities, reporting requirements, and funds available. Funds are committed and distributed only after Schedule Bs are in place and following contracting and compliance reviews. Distributed and committed funds to date cover expenses that include:

- Funds for PCPs to participate in CCB projects and deliver interventions
- Funds to primary care practices to hire Health Coaches
- Funds to care management agencies to hire Health Coaches (used for small practices that “share” a full-time Coach)
- Payments to MJHS Institute for Innovations in Palliative Care to provide primary care team training that includes continuing education credits, to conduct case conferences and patient education development
- Payment to air.nyc and Wyckoff asthma programs to provide home-based self-management services that include trigger identification, review of asthma action plans, and connection of patients to social support services. These asthma programs will provide feedback to the patient’s primary care provider and



specialists to support care coordination efforts.

- Payments to three contracted PCMH vendors for training and technical assistance support to hospitals, FQHCs, IPAs and community-based practices to achieve NCQA 2014 Level 3 recognition.
- Payments to the Institute for Family Health for training and technical assistance to support implementation of behavioral health integration models.

Additional expenditures made on behalf of the CCB's primary care strategies that are not reflected in the above totals include:

- Funding to provide access to CCB's web-based care coordination platform, the Dashboard, to all Participants, and associated staff training and support in use of the platform;
- Funding and technical assistance provided, at no cost, to CCB by state initiatives (The NYS Healthcare Workforce Retraining Fund and NYS Collaborative Care Medicaid program) for training and implementation of the IMPACT model, respectively;
- Expenses associated with at least 6 FTEs employed by CCB staff who are providing technical assistance and training to primary care sites; and
- Funding to 1199SEIU Training and Education Fund to manage a portfolio of training programs, many for primary care team members.

CCB Participants also received Capital Restructuring Financing Program (CRFP) awards that support primary care strategies. In total, eleven CCB projects were awarded for a total of \$93.8 million, of which many awards support and expand CCB's primary care capacity. As described in the response to Question 2, capital applications were prepared with technical assistance from CCB, and CCB prioritized primary care and urgent care funding applications during the process.

6. How CCB is progressing toward integrating primary care and behavioral health

CCB is implementing initiatives to integrate primary care and behavioral health in multiple settings throughout its network. CCB's Associate Medical Director is a psychiatrist who serves as the physician champion for these initiatives, including both implementation of Project 3.a.i and other efforts in inpatient and community settings.

CCB is participating in all three models of Project 3.a.i, Integration of Primary Care and Behavioral Health. Model 1 is integrating behavioral health into primary care, Model 2 is integrating primary care into behavioral health, and Model 3 is implementing the collaborative care/IMPACT model. CCB's broad range of activities aimed at integrating primary care and behavioral health include: 1) assisting its primary care practices in implementing Models 1 and 3 by providing the necessary technical assistance, training and staff resources; 2) providing technical assistance and support to Article 31 Participants already implementing Model 2 using SAMHSA grants and assisting other Article 31 Participants to achieve some degree of primary care and behavioral health integration; 3) providing a care coordination platform (the Dashboard) to facilitate communication between primary care, behavioral health providers, and Health Homes; 4) addressing behavioral health integration in the Care Transition and ED Care Triage projects; 5) working with other PPS on a population-based school health initiative; 6) collaborating with the NYC Mayor's Office to implement a model of community-based depression screening and referrals; 7) implementing a Medicaid Accelerated Exchange (MAX) program at Interfaith Medical Center; and 8) implementing a Health and Recovery Plan (HARP) VBP pilot at Maimonides Medical Center.

CCB has contracted with the Institute for Family Health (IFH) to provide training and technical assistance to sites participating in Project 3.a.i. To date, IFH has provided training and technical assistance on collaborative care/IMPACT and integration of behavioral health services into a primary care setting for 5 CCB hospitals and 6 FQHCs. IFH trainings and technical assistance have been delivered via in-person meetings, webinars, and telephonically. Four of CCB's FQHCs have recently been selected to participate in the NYS Collaborative Care Medicaid program and will receive a per-member-per-month payment to provide care through the IMPACT model and receive training and technical assistance from the NYS Collaborative Care Initiative. CCB will begin implementation of IMPACT in smaller practices in 2017, and IFH is committed to providing training and technical assistance to these practices.

The Associate Medical Director and CCB program managers supplement the training and technical assistance provided by IFH. CCB staff members are helping Article 28 sites evaluate partnerships with Article 31 facilities or community providers in close geographic proximity, given the shortage of mental health resources in Brooklyn. CCB staff members are reaching out to Article 31 entities to begin planning to implement medical monitoring and screenings, and develop linkages to primary care through Health Homes, as initial steps towards BHI. Article 31s implementing Model 2 will use patient registries to track indicators of physical wellness, including blood pressures and measures of diabetes control, and will provide preventive health screenings, patient education on physical wellness, and provide peer supports and groups focused on wellness, healthy lifestyle choices, and exercise.

CCB is working with primary care and behavioral health providers to increase collaboration around specific patients. This process is facilitated by the common use of the Dashboard for coordinated care plans and by CCB's close relationship with its two partner health homes: Brooklyn Health Home (BHH) and Coordinated Behavioral Care (CBC). Our health home partners provide care coordination to many patients that require both medical and behavioral health services, facilitated by their use of the Dashboard.



One of the major challenges in integrating behavioral health into primary care is the shortage of mental health providers. The collaborative care model addresses this shortage of mental health providers by allowing psychiatrists to impact a 10-fold increase in patients suffering with depression and mental health issues compared with traditional, direct care by psychiatrists. CCB is facilitating the use of telepsychiatry as part of implementation of IMPACT and behavioral health co-location into primary care settings when a psychiatrist is not available to provide services to these sites. CCB is considering the need for making behavioral health resources available telephonically through a centralized resource for its entire network to assist small primary care practices in achieving BHI.

CCB is addressing BHI through its Care Transitions and ED Care Triage projects. The Care Transitions project monitors and provides telephonic care management support to patients over the 30 days post-discharge period for patients determined to be at risk for readmission. This includes identification of patients with behavioral health issues admitted for medical or surgical reasons and acknowledges the need for BH support in the transitional care plan, as needed. An overarching focus of the Care Transitions project is to connect all patients with two or more chronic conditions, or a diagnosis of serious mental illness (SMI) or HIV, to partner Health Homes for care management services. Health home care managers focus on coordinating behavioral health and physical health services for all enrolled patients.

CCB is also implementing Critical Time Intervention (CTI), an evidence-based best practice that provides intensive, time-limited case management for individuals with SMI and high utilization (three or more ED visits or hospital admissions within the prior six months). These individuals will be enrolled in Health Homes, but will initially transition from the hospital or ED through CTI, with step down to health home care management after nine months of participating in CTI.

CCB participated in the first round of the state's Medicaid Accelerated Exchange (MAX) program, which focused on super-utilizers. CCB included Interfaith Medical Center and Catholic Charities' Health Home care management agency as part of its MAX project, and embedded a Health Home outreach coordinator from Catholic Charities at Interfaith. The project focused on super utilizers with the diagnosis of SMI, with the goal of engaging these individuals more effectively with Health Home care management services as part of the transition from hospital to the community.

Maimonides Medical Center is working with the state and several MCOs to design and implement a HARP pilot that incorporates VBP instead of a fee-for-service reimbursement and will promote BHI. The pilot builds on Maimonides' success with a federal grant focused on the health home population.

In collaboration with three other PPS (One City Health, Bronx Health Care Partners and Bronx Access), the Jewish Board for Child and Family Services and the New York Academy of Medicine, CCB is engaged in a population health project supporting BHI. The initiative involves partnering with 100 schools to provide coaching to the schools and staff on early identification of behavioral health issues, preventive health interventions to target at children at risk for developing behavioral health problems, and facilitate linkage to behavioral health providers in the community when indicated. CCB is involved with a NYC-wide effort led by the Mayor's Office to replicate a University of California, Los Angeles model that engages CBOs around community-based depression screening using PHQ-2 and PHQ-9 and establishing referral networks for individuals who screen positive.