BPHC Primary Care Plan

August 2016

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

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

BPHC's primary care capacity

The New York State Department of Health (SDOH) has identified approximately 1,100 primary care providers (PCPs) among the providers that make up SBH Health System PPS, d.b.a. Bronx Partners for Healthy Communities (BPHC). Of that group, about 23% work primarily as specialists or hospitalists. Another approximately 23% deliver primary care, but for less than 16 hours per week. The average PCP working with BPHC's largest partner, Montefiore, is unlikely to deliver primary care on a full-time basis given that Montefiore is a large academic medical center.

With these considerations in mind, we roughly estimate that the BPHC network contains about 500 primary care practitioner full-time equivalents (FTEs). BPHC's seven largest primary care partners report that they currently provide primary care services to approximately 585,700 unique patients, regardless of payer-type. We assume that count includes the approximately 170,000 DSRIP Medicaid patients that were attributed to BPHC based on where they seek primary care. BPHC has an additional approximately 200,000 attributed DSRIP Medicaid patients that are non-users or non-users of primary care (those patients may seek primary care services outside of our PPS or not at all.) Once those non-users of primary care are brought into the system through population health management strategies and outreach, BPHC partners will have at most, about 785,700 unique patients requiring primary care services. Assuming panel sizes of 1,500 per 1 FTE PCP, BPHC's 500 PCP FTE s should be able to provide primary care services to the unique patients currently served *and* cover most of the additional demand created by drawing non-users into the system.

However, among BPHC's partners, PC capacity varies widely. Capacity does exist within some partner organizations, but with very limited access—some PCP panels are not technically full, but their over-burdened schedules limit their ability to treat more patients. Other partner organizations operate at the limit of their primary care capacity, with PCPs carrying full or oversized panels of patients. PCP patient panels in the PPS range from 700-2,350, with a current average panel size of 1,200.

Expanding primary care capacity to ensure the timely provision of required services

BPHC has adopted a strategy aimed at addressing both capacity and access issues through the expansion of visit types that encourage team-based care models outside the traditional PCP visit. Examples of such initiatives include: 1) the provision of blood pressure (BP) checks with a staff-member other than the PCP, and 2) increasing the spread of the IMPACT model, in which PCPs can rely on a depression care manager (DCM) to follow up patients between primary care visits to manage their depression. Both of these models offer a venue for follow-up and treatment outside of the traditional PCP visit, thereby creating additional capacity within PCP schedules.

These approaches leverage the talents and abilities of a multidisciplinary team to more efficiently improve the quality of hypertension and depression care for patients. In the team-based care model promoted by BPHC, each team includes the patient, the patient's PCP, and other team members such as nurses, medical assistants, pharmacists, dietitians, social workers, and community health workers. Team members provide process support and share responsibilities for the provision of hypertension and depression care to complement the activities of the primary care provider. These responsibilities include

medication management, adherence support, patient follow-up, and health coaching for self-management.

The BP checks and depression care management models both represent a departure from the traditional primary care model that, in addition to enhancing patient access to primary care services, improve the patient's experience and health outcomes. In traditional models of PC, when patients with uncontrolled hypertension or mild to moderate depression have their medications adjusted they are told to return to their healthcare provider for a scheduled visit in three months. Patients require an average of three iterative medication changes, therefore in the traditional model patients would require 9-12 months to achieve blood pressure or depression control. When blood pressure and PHQ9/symptom checks occur with greater frequency, patients can achieve blood pressure or depression control within 6-16 weeks—a win-win for quality of care and access.

To further improve access to primary care, BPHC has embarked on train-the-trainer program to improve coaching for practice transformation. A healthcare transformation consulting group has trained site-based DSRIP Program Directors, as well as Project Management Staff from the Central Services Organization on crucial elements of transformation, including: panel management, continuity of care, leveraging care team members, pre-visit planning, and others.

Even with these strategies in place, BPHC's network may still face a capacity deficit: there may not be enough PCPs to cover the population even once alternative visit opportunities and other transformation strategies have been leveraged. In the short term BPHC has encouraged its partners to hire additional PCPs, both physicians and NPs, and/or physician extenders (Physician Assistants). BPHC's longer-term strategy includes leveraging SBH Health System's new relationship with the Sophie Davis School of Biomedical Education/ CUNY School of Medicine to recruit underrepresented minorities into medicine, increase medical services in historically underserved areas, and increase the availability of primary care physicians.

Expanding PCMH and improving performance across the network

BPHC is working with community-based PCPs and institution-based PCPs, with tailored approaches to improve primary care across the range of settings these PCPs represent. BPHC provides Patient-Centered Medical Home transformation support through dedicated technical assistants (TAs), spanning over 115 primary care sites (additional details can be found in the following section). Additional support will be provided for Meaningful Use (MU), as part of a package of IT interventions for providers that have yet to achieve QE connectivity. With the help of NYC DOHMH's Primary Care Information Project (PCIP), BPHC has performed an MU gap assessment that includes all BPHC providers. The gap assessment examined physician eligibility and status within the MU process. A work plan is currently under development based on the assessment results, prioritizing physicians that have yet to begin the program. The work plan includes other IT infrastructure improvements, such as EHR implementation, RHIO connectivity and encounter notification systems deployment.

In an effort to improve clinical integration and promote a high standard quality of care across the PPS, BPHC partners engaged in a participatory process to develop a comprehensive Clinical Operations Plan (COP), which acts as a toolkit for DSRIP implementation. The COP includes narrative explanations, suggested workflows, and policies and procedures broad enough to be adapted to a variety of settings, from hospital-based primary care to a single practitioner. BPHC's CME Course Director, Dr. Robert Morrow, MD, who also sits on the Quality and Care Innovation Sub-Committee (QCIS), is an independent

primary care physician, and has been instrumental in guiding BPHC's implementation plans to include small and solo independent primary care practices.

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

Working with primary care at the practice level

BPHC has undertaken a process to ensure all eligible providers meet Patient-Centered Medical Home (PCMH) Level 3 2014 recognition, where possible, and the PPS is well-positioned to deploy Advance Primary Care (APC) once guidance is released surrounding that program. During the summer of 2015, BPHC issued a Letter of Intent (LOI) request to over 30 technical assistance (TA) groups to help BPHC members transform their practices. After a selection process, twelve TAs became approved BPHC vendors. At the same time, BPHC profiled its member organizations; those with large numbers of primary care providers (PCPs) were guided by BPHC in a matching process with the TAs. Each organization was matched with two to three TAs, based on their organizational profile, and had the opportunity to select one group to work with. In addition to the PCP matching, one TA group was retained by the Central Services Organization to help manage the administration of program logistics.

Standardized gap assessment tools were created by BPHC and used by the TAs to assess PCMH readiness at authorized practice locations. To date, over 120 PC practice locations have been authorized with 76 gap assessments returned. The TAs work with the sites to address the identified gaps and provide coaching in the application process. As of July 2016, this effort resulted in 23 locations achieving PCMH 2014 Level 3 recognition, accounting for roughly 35% of our SDOH identified PCPs. A summary of progress to date is provided below:

	Practice / Site	No. PCPs @ Site	Gap Analyses Done?	Work Plans Done?	Application Submitted?	PCMH 2014 L3 Received	Clinicians Recognized
SBH Health System	6	67	1	1	1	1	21
Union CHC	3	12	3	3	0	0	0
Independent Practices	10	21	4	4	1	1	2
Acacia Network	5	17	3	3	3	3	7
Morris Heights HC	5	16	5	5	3	3	26
Bronx IPA	20	33	11	1	1	2	14
Montefiore - MMG	22	266	22	22	11	9	179
Montefiore - Voluntary	43	60	27	20	0	0	0
Montefiore - Faculty	2	15	0	0	0	0	0
Institute for Family Health	4	28	0	0	0	4	28
	120	**535**	**76**	**59**	**20**	**23**	**277**

The eight TA consulting groups were invited to be a part of a Community of Practice, which BPHC has organized to build and establish best practices, collaborate with experts on PCMH transformation, and ideally transfer the experience and knowledge to other population health initiatives. Within this group BPHC has shared the Clinical Operations Plan (COP)—described in Section One of this document—which defines how members will provide DSRIP-related services to patients in a standardized, efficient, reliable way. The consultants and the practices with which they are working have also been provided

information and tools (such as cross-walks and suggested disease-specific interventions) specifically designed to guide the implementation of PCMH in concert with DSRIP requirements and goals.

To achieve maximum patient impact, the PPS's largest PC sites have been prioritized in BPHC's PCMH efforts; nonetheless work is ongoing to provide needed support to the remaining practices. BPHC is preparing for APC implementation by educating its members on the forthcoming model, and identifying partners for whom the model will be most relevant in order to assist them in fully leveraging existing statewide technical assistance resources. Efforts are also underway to evaluate PCMH potential for school-based health centers (SBHC), mobile health clinics, PACE programs, long-term care centers, and others.

Workforce support in tandem

BPHC provides a number of resources to its members to support workforce transformation in parallel to practice transformation. Programs currently underway include: a 60-hour *Care Coordinator Training* developed in conjunction with the Primary Care Development Corporation (PCDC); a *Certified Clinical Medical Assistant (CCMA) Training* for medical assistants and medical office assistants developed in conjunction with Hostos Community College, resulting in CCMA certification; and, *Registered Nurse Supervisory Training,* which includes both the *Care Coordinator Training* and a *Supervising Care Coordinators Program* developed by the National Institute for Behavior Health. All members of the primary care team, including the PCPs, will receive a training program entitled, *Essentials of Care Coordination*.

The *Care Coordinator Training* includes the following components: 1) 44 hours of Comprehensive Care Coordinator training, designed and delivered by PCDC; 2) eight hours of Motivational Interviewing training, designed and delivered by the National Council for Behavioral Health; and 3) eight hours of training on Care Management for SMI/Substance Users delivered by various subject matter experts. The *Registered Nurse Supervisory Training* is for Nurse Care Management Supervisors, who will participate in the training with the Care Coordinators and receive an additional two-day training on supervision, delivered by the National Council for Behavioral Health. The Comprehensive Care Coordinator training, which makes up the core of the instruction, includes the following modules: Intro to New Models of Care, Working in Interdisciplinary Teams, Person-Centeredness, Communication and Health Literacy, Chronic Disease and Social Determinants of Health, Assessment, Care Planning and Care Management, Transitions of Care and Closed Loop Referrals, Cultural Competence, Ethics and Professional Boundaries, Quality Improvement, Community Orientation, Health IT, and Documentation and Confidentiality. The Essentials of Care Coordination training aims to provide basic training for staff members who work with care coordinators to ensure a basic understanding of care coordination and its purpose, the role of the care coordinator and how to work with them as part of a team, and how values and bias can affect our work.

By expanding care coordination as part of a team-based primary care model, BPHC seeks to transform the delivery of care and the patient experience, particularly for high risk and high needs patients, and to ensure patients gain access to community-based services that address the social determinants of health.

Utilizing existing statewide TA resources

To support primary care initiatives, existing statewide resources for technical assistance are being leveraged. Five staff members have been trained in Salient Interactive Miner (SIM) offered by the State

and continue to work on their competencies. When opportunities arise, BPHC staff members proactively engage in additional trainings, attend webinars, and participate in seminars to build DSRIP implementation capacity. BPHC also uses the MAPP analytics platform extensively in planning and reporting on our primary care activity and its consequences. The members of the PPS are always looking for more training opportunities, additional MAPP licenses, standard Salient reports, and ways to identify behavioral health visits in Salient. We are also looking forward to possibly receiving a data model for Medicaid claims data so that each PPS would not have to develop their own, as well as access to Medicaid eligibility files to incorporate our data, and access to the Health Home (HH) referral portal in order to determine which patients are HH-enrolled at any given time.

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

Primary care acts as the lynchpin of an integrated delivery system (IDS). The PCP has always served as the glue among various medical specialists. In an IDS, the PCP serves as the glue for a wider group of care providers: medical and behavioral health specialists, hospital-based providers, community-based social service providers, various care managers and care coordinators, and of course, at the center, the patient and their primary caregiver(s).

Care transitions, connections, and coordination

BPHC's strategy emphasizes the facilitation of care transitions and care connections throughout the care continuum—from primary care through secondary and tertiary services—and includes closed loop referral tracking. Targeted care coordination for high-risk patients will reduce care fragmentation and improve the quality of our patients' care, health and experience with the medical system. BPHC's Clinical Operations Plan (COP) includes policies and procedures around "closed loop" order and referral tracking to foster well-managed patient transitions among various healthcare providers and settings, and assure that patients "get where they're going." A referral from an ED Navigator back to a patient's PCP is one piece, but BPHC is adding accountability by holding the ED Care Triage Program accountable for tracking that referral back to the PCP and ensuring patients are rescheduled and redirected as needed.

The same level of accountability is required when referrals are generated from the primary care practice. While PCMH Level 3 2014 certification requires primary care practices to track medical specialty referrals, BPHC is extending this accountability to referrals to community-based organizations (CBOs), as well. BPHC recognizes that without stable housing, for example, a patient cannot prioritize control of their chronic medical condition, and that the referral to a CBO specializing in housing assistance may be as or even more important than a referral to a medical specialist. All BPHC members are responsible for ensuring an appropriate referral tracking mechanism is in place when patients transition between points of care and that all referrals are tracked to completion. BPHC places particular attention on warm and timely hand-offs between non co-located providers.

To ensure closed-loop referral tracking, the PPS will facilitate relationships and connectivity between PCPs, hospitals (EDs and inpatient), specialists, health homes, CBOs, and other providers. These relationships will be aided by data sharing and clinical interoperability capacities, including standardized workflow and protocols, staff and partner role definitions, and strategies such as event notification, clinical messaging and other protocols that support care transitions across settings. These systems will ensure the flow of information between providers and the success of referrals, thereby preventing patients from getting "lost in the system." Ensuring coordinated care transitions from the hospital

setting to primary care and other needed services plays an essential role in BPHC's clinical integration strategy. BPHC seeks to fortify linkages between primary care and other members of the IDS by embedding dedicated care coordinators within primary care teams throughout the PPS. Care coordination staff in PC sites enhance team-based care through participation in huddles and case conferences, by visiting patients admitted to the hospital, and by managing connections to care beyond the clinical setting. We are also creating coordinated care teams across primary care and behavioral health partners through our work in Primary Care and Behavioral Health Integration (all three models.)

Primary care in the BPHC governance structure
Our seven largest primary care organization partners are heavily represented in our governance committees (Executive Committee [EC], Quality Care and Innovation Subcommittee [QCIS], Finance and Sustainability Subcommittee [F&SS], IT Subcommittee [IT] and Workforce Subcommittee) and on our seven clinical quality workgroups that report up to the QCIS. All seven primary care partners are represented in our Clinical Leadership Forum, as well. One of our largest seven primary care partners is Bronx United IPA (BUIPA), a group of community-based independent practices. Their practices range from solo and two-partner practices, to a group of 11 PCPs. BUIPA has been incredibly engaged with BPHC from almost its inception: The Executive Director of BUIPA sits on the EC, their Medical Director is part of the Clinical Leadership Forum, and their practitioners sit on the QCIS and F&SS. We also have representation from independent private practitioners in our governance and clinical quality structure. Representation is displayed in the table below.

Committee/Workgroup	Name and Title	Organization
(Sub)committee		
EC	Eric Appelbaum, DO, Associate Medical Director (oversees ambulatory care)	SBH Health System (SBH)
EC	Debbian Fletcher-Blake, NP, COO	Morris Heights Health Center FQHC (MHHC)
EC	Maxine Golub, Senior VP, Planning and Development	Institute for Family Health FQHC (IFH)
EC	Pamela Mattel, COO	Acacia Network FQHC (Acacia)
EC	Douglas York, CEO	Union Community Health Center FQHC (UCHC)
QCIS	David Collymore, MD, CMO	Acacia
QCIS	Frank Maselli, MD	Bronx United IPA (BUIPA)
QCIS	Kenneth Jones, MD, Interim Medical Director	MHHC
QCIS	Robert Morrow, MD	Morrow O'Connor Everyone Practice (Private practice)
QCIS	Vanessa Pratomo, MD, ACO Quality Improvement and Chronic Care Management	Montefiore Care Management Organization (MCMO)
QCIS	Edward Telzak, MD, Chief of Medicine (oversees Adult Medicine including Primary Care)	SBH
F&SS	Denise Nunez, MD, Owner and Medical Director	Divino Nino Pediatrics (private practice)
F&SS	Max Francois, MD	BUIPA
F&SS	Carol Bouton, VP for Business Development	IFH

Committee/Workgroup	Name and Title	Organization
F&SS	David White, VP of Finance	MHHC
F&SS	Mary Harnett, CFO	UCHC
IT	Helen Dao, Director of Quality Assurance	UCHC
IT	Elizabeth Lever, Director of Business Planning and Development	IFH
IT	Edgardo Nieves, VP of Systems and Communication	MHHC
IT	Anthony Ramirez, Assistant Director MIS	Acacia
IT	Jeeny Job, DO, CMIO	SBH
Workforce	Katrina Jones, Director of Human Resources	Acacia
Clinical Quality Work Groups		
Asthma	Rajan Gurunathan, Internist – Divisional Director, (Oversees Adult Internal Medicine including Primary Care)	SBH
Asthma	Marina Reznik, MD, Pediatrician	Montefiore Medical Center (MMC)
Asthma	Howard Slomko, MD, Pediatrician	MHHC
CVD/Diabetes	Akwuba Uche, MD	MHHC
CVD/Diabetes	Eric Appelbaum, DO, Associate Medical Director (oversees ambulatory care)	SBH Health System (SBH)
CVD/Diabetes	David Collymore, MD, CMO	Acacia
CVD/Diabetes	Christine McGeough, Clinical Director of Diabetes, Nutrition and Wellness	IFH
CVD/Diabetes	Vanessa Pratomo, MD, ACO Quality Improvement and Chronic Care Management	MCMO
CVD/Diabetes	Eric Gayle, MD, Regional Medical Director	IFH
ED Care Triage and Care Transitions to prevent 30 day readmissions (ED/CT)	Rajan Gurunathan, Internist – Divisional Director, (Oversees Adult Internal Medicine including Primary Care)	SBH
ED/CT	Eva Paulino, Program Director BASICS Esperanza PROS	Acacia
Health Home at Risk (HHAR)	Theresa Barona, Clinical Director, Ambulatory Care	SBH
HHAR	Helen Dao, Director of Quality Assurance	UCHC
HHAR	Eric Gayle, MD, Regional Medical Director	IFH
HHAR	Alexandria Massey, Director of Nursing	MHHC
HIV	Edward Telzak, MD, Chief of Medicine (oversees Adult Medicine including HIV Primary Care)	SBH
HIV	Ralph Belloise, Director of HIV (includes outpatient HIV primary care services)	SBH
HIV	Donna Futterman, Director of Adolescent AIDS Program (includes outpatient HIV primary care services)	MMC
HIV	Barry Zingman, MD, Medical Director, HIV services, including HIV Primary Care	MMC
HIV	Steven Levine, MD, HIV Medical Director	IFH
HIV	Rebecca Green, Regional Director of COMPASS	IFH
Mental Health & Substance Use (MHSA)	Dr. David Appel, Director, Pediatric Behavioral Health Services	MMC
MHSA	Caroline Davis, Director of Teen Services (Outpatient,	SBH

Committee/Workgroup	Name and Title	Organization
	Primary Care Based)	
MHSA	Paolo Pina, MD, Assistant Director, Pediatrics Department	SBH
Primary Care Behavioral Health Integration (PCBH)	Vincent Renda, MSW	Acacia
PCBH	Mildred Casiano, MSW	UCHC
PCBH	Alissa Mallow, LCSW, Director of Social Work (including Primary Care-Based services)	MMC
PCBH	Virna Little, SVP, Psychosocial Services and Community Affairs and BPHC Trainer of IMPACT model for PCBH integration	IFH

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

In order to help primary care providers in our PPS improve their readiness to participate in VBP payment arrangements, BPHC has adopted a strategy designed to 1) build infrastructure to sustain medical home operations and expand service capacity at the local practice level, and 2) develop centralized, shared services through the BPHC Central Services Organization (CSO) for system development, network relations, interconnectivity, and analytics services at the system level. We believe that this complement of strategies can best serve and position BPHC's primary care providers to operate effective and productively in a VBP environment.

Local level: medical home infrastructure and capacity expansion

As a central component to the first part of our strategy, BPHC provided DSRIP funding to promote practice transformation and support achievement of NCQA PCMH recognition, as described in Section Two of this document. BPCH has engaged clinical practice leadership to guide development, adoption and implementation of standardized protocols and best practices—culminating in the creation of the Clinical Operations Plan (COP)—leading our PPS to the achievement of a shared practice model across primary care practices and the establishment of robust medical home operations at the local level.

While this work was guided centrally, these initiatives have been driven by local effort and have local accountability to:

- improve access and promote continuity of care between acute care settings and primary care providers;
- standardize screening, interventions and evidenced-based protocols to identify at-risk patients and improve management of chronic conditions;
- achieve tighter collaboration with Health Homes and coordination of services to help reduce, and whenever possible prevent, avoidable use of emergency and inpatient care;
- develop more effective integration between primary care and behavioral health services within provider organizations; and
- establish population health management strategies, including processes for empanelment and preventive care screening and monitoring.

System level: centralized services and network development

In parallel to strategies for building robust primary care at the local level, BPHC has also provided its primary care practices an overarching array of services at the system and PPS level to help support VBP readiness. Most specifically BPHC's system level services have focused on providing support for functions in the following domains:

- Clinical and care management
- Network management
- Financial management
- Governance and organization
- Analytics and information

In addition to driving adoption of uniform clinical protocols and standards for chronic care management, BPHC has worked to select and develop a care coordination management system (CCMS) to serve primary care providers and other member organizations of the PPS. The CCMS will be a critical tool, facilitating the tracking of patient activities toward meeting their health goals and carrying out their care plans. While in the last stages of the selection process, BPHC has worked with its primary care member organizations to establish use cases that will guide customization, implementation and adoption of the CCMS. We have also worked to establish core data sets for care planning across PPS providers to ensure that providers will be able to track patients and interventions even if they use an alternative CCMS interfaced with the Bronx RHIO. Implementation of a CCMS platform will ensure that primary care providers will be able to: identify and manage high risk and rising risk patients on their panel using a standardized framework with predictable, evidenced-based and measurable interventions; have access to screening tools for identifying and assessing social determinants of health in targeted populations; and track cross-cutting and interdisciplinary patient engagement strategies and measures of success. The CCMS is a system level tool fundamental for improving capability of primary care providers to manage care of patients in VBP arrangements.

BPHC has initiated network management services that are beginning to create profiles of member organizations within the PPS, identify service needs and gaps, and create new linkages, referral protocols and communication pathways to help primary care providers better access community-based social and behavioral health services for their patients. A PPS Resource Directory is under development to put this information at the fingertips of primary care practices and member organizations across the PPS. Network management profiling and analysis are used by BPHC to identify primary care practice engagement in programs and services available through BPHC and to determine which practices need additional support to meet PCMH and MU standards.

The contracting processes established by BPHC with its primary care provider organizations in DY1 have established a foundation for fund distribution based on deliverables, set to evolve into a performance-based and ultimately a risk-based payment model. BPHC is using the contracting process to incent and educate its primary care providers on the ways in which the basis of fund distribution will progress over the course of the DSRIP and how their flow of funds will be driven by the care interventions, patient tracking and care management activities generated by their practices.

Finally, as more primary care providers are being linked to the Bronx RHIO, BPHC is working with IT and QA staff to ensure that the HIE is leveraged beyond only connectivity, so that a productive, bi-directional and reliable exchange of clinical data can be generated and sustained. This is a system-level service critical to our providers' ability to effectively participate and succeed in VBP arrangements. It requires

the identification and definition of data elements foundational to risk stratification, population profiling and tracking, performance reporting and population health management. In order to take full advantage of the system-wide data that these advances generate, BPHC will coordinate and drive the effort to design and populate centralized patient registries. Furthermore, BPHC will continue to facilitate the change management and workflow redesign required to establish the flow of data from hospitals to primary care providers on ED visits and patient admissions and discharges—in the form of alerts and reports transmitted through the RHIO—in order to ensure appropriate follow-up care.

While offering ongoing education on quality and performance improvement, BPHC analytics will also provide an ongoing stream of performance and utilization reports to identify system level trends, as well as conduct ad hoc analyses to identify new outliers and at-risk cohorts in the population under our care. Monitoring our attributed population at both the primary care provider panel level and at the PPS population level will ensure that primary care providers are informed about gaps in care and can improve their performance and the health outcomes of the patients on their panels.

While these functions are in place to help ready and engage primary care providers for VBP contracting arrangements, BPHC is taking several steps to further assess the various components, functions and services that will need to be developed and/or enhanced going forward. These components include, but are not limited to, evaluating existing infrastructure and processes for governance and legal structures, financial management, network management and provider relations, and analytics. In particular the preparatory needs of, and VBP impact on non-hospital providers, such as FQHCs and independent primary care providers, will need to be further explored. BPHC will also need to determine which Medicaid Managed Care entities have the ability to best administer VBP contracting across such varied primary care settings.

In May 2016, BPHC engaged Manatt Health Solutions to assist with VBP planning efforts. The engagement's objective is to assist BPHC with VBP modeling and understanding the various contractual arrangements that may be used. Additionally, and central to this assessment, are one-on-one interviews with our primary care provider organizations to determine their VBP readiness and ascertain the types of technical support and services they need to engage successfully in VBP arrangements.

5. How does your PPS's funds flow support your Primary Care strategies? What resources are being expended by your PPS to support PCPs in DSRIP?

Support for primary care has played a central role in BPHC's fund distribution strategy. During DY1 and DY2 the release of funds has been structured around a series of waves, reflecting PPS priorities and supporting member organizations in their implementation of DSRIP projects. These priorities include: ensuring a robust primary care foundation exists across the PPS, supporting patient-centered medical home (PCMH) transformation, and fostering a system-wide care coordination infrastructure. The strategically designed staged approach to distributing funds aims to align local capacity for implementation with BPHC's focus on deliverables that require early adoption in order to meet DSRIP targets, while simultaneously garnering broad participation from member organizations and ensuring support for community-based organizations.

Financial support for primary care practice transformation

BPHC's early funding distribution strategy aimed to build operational capability and the foundational skillsets necessary for the implementation of medical homes and DSRIP required projects and initiatives.

An initial outlay supported the hire of DSRIP Project Directors (DPDs) by the major primary care partner organizations who had committed to implement more than seven projects each, and who together provide services to 97% of the PPS's attributed patients. Beginning in mid-DY1 (October 2015), BPHC distributed funds to support PCMH Technical Assistance (TA) vendor services to facilitate the PCMH application process and medical home transformation. These funds seek to assist the approximately 1,000 BPHC primary care providers (PCPs) identified by SDOH to achieve PCMH 2014 Level 3 recognition. As described in Section Two of this document, the actual selection of TA vendors was driven by PCP practices that were asked to interview and select the PCMH TA vendors of their choice from a pool of vetted and highly qualified experts recruited by BPHC CSO. Once the practices selected their preferred TAs, work began to produce primary care gap analyses and PCMH project plans, which the practices had to approve before the CSO proceeded with the development of contract agreements for PCMH implementation.

Around the same time, BPHC launched a round of funding distribution designed to provide start-up funds for building primary care, care coordination and population health management capacity. BPHC established a Request for Information for Clinical Integration ("RFI") process that offered primary care organizations an opportunity to describe their funding gaps in relation to the primary care delivery, care coordination service models, and population health management processes adopted by the PPS through BPHC's governance structure, as well as those required to achieve PCMH. Member organizations that together represented more than 97% of BPHC attribution—including federally qualified health centers (FQHCs), independent practice association (IPA) and hospital-based primary care settings—were invited to complete the RFI.

By encouraging practices to highlight their priority needs, BPHC sought to ensure that resources and capability factors beyond patient attribution would be used to determine how funds would be distributed. In sum, this wave of funding distribution was developed and informed by both attribution size, which reflected the scale of member organizations, and the RFI process that helped us better understand the gap between current capability and resources needed by partners to implement recommended models of care developed during our planning process and meet required results.

Financial support for the primary care continuum

The next wave of funds flow was designed to support activities at either end of the primary care continuum. First, this wave aims to support hospital-based teams to develop and manage effective patient transitions from emergency departments and in-patient services to community-based primary care and other required services. Second, this wave seeks to ensure that community-based independent primary care providers have access to support services and systems to assist with their transformation and achievement of PCMH 2014 Level 3 recognition.

The last wave of distribution designed for DY1-DY2 period provides support to community-based social services and behavioral health organization, providing critical opportunities for supporting innovative approaches for addressing social determinants of health, expanding capacity of community-based behavioral health services, as well as promoting innovative approaches for developing effective integration of services between primary care practices and mental health and substance use providers.

6. How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)? This would include both collaborative care and the development of needed community-based providers.

BPHC aims to develop an integrated delivery system that reduces the care fragmentation that so often contributes to poor population health outcomes. We believe that the creation of pathways for connection and collaboration between primary care and both behavioral health and social service providers is critical to achieving that goal. To this end, BPHC has developed strategies to meaningfully engage community-based behavioral health and social service providers in its DSRIP initiatives.

Integrating primary care and behavioral health

There are presently a total of 348 PCPs participating in BPHC's implementation of project 3.a.i, Integration of Primary Care and Behavioral Health. Of the 348 PCPs, 99 are participating in Model 1, the co-location of behavioral health into primary care; 7 in Model 2, co-location of primary care into behavioral health; 32 in Model 3, the IMPACT Model of collaborative care; and 205 are participating in both Models 1 and 3. This project presents the opportunity to create greater PCP capacity by tapping into behavioral health resources that can address both mental health conditions and social determinants that may be exacerbating physical and behavioral health conditions of patients. In particular, the IMPACT Model embeds a Depression Care Manager (DCM) within the primary care practices, who can conduct population health management, provide short-term counseling, and provide some care coordination activities. The IMPACT Model also includes a Psychiatric Consultant who regularly consults on patients in depression care with the PCP and DCM, including guidance around medication management and escalating care for patients not responding to treatment. When PHQ-9 assessments are more frequent, patients can achieve depression control within 6-16 weeks, improving health outcomes and patient experience. All of the models include training the frontline staff on intake and screening methods, also improving PCP capacity by reducing the amount of time spent on screenings.

In order to ensure partner organizations understand and meet the project requirements for project 3ai, BPHC has produced a comprehensive Clinical Operations Plan (COP) with sections specific to integration of primary care and behavioral health, and has also contracted with Institute for Family Health (IFH) to provide trainings and technical assistance (TA) to all participants. Foundational trainings include, but are not limited to: Introduction to Collaborative Care, Problem-solving Treatment, Psychopharmacology, and Screenings (focused on PHQ 2/9). The COP clearly outlines processes and strategies for implementing the co-location and IMPACT collaborative care models. It has been produced in a way that allows organizations to adapt the materials to their own policies and procedures. IFH works closely with a BPHC Project Management Director (PMD) to assess organizational and site-specific training and TA needs. In addition to maintaining regular communication with DSRIP Program Directors (DPDs) at the organizations, IFH and the BPHC CSO are collaboratively producing an implementation assessment tool to measure progress towards implementation and identify additional training and TA needs before milestones are due. Additionally, BPHC has been in discussion with the Greater New York Hospital Association (GNYHA) and NYC Department of Health & Mental Hygiene (DOHMH) to develop plans around training and supporting implementation of the Screening, Brief Intervention, Referral, and Treatment (SBIRT) method of addressing substance use in the primary care setting. Practices will also receive training in population health management, so as to identify patients at-risk or lost to care for depression. Finally, BPHC has placed an emphasis on clinical-community linkages and making non-clinical referrals to community-based resources that can help address social determinants.

Development of community-based providers

BPHC has convened an "Engaging Behavioral Health Leadership" group, a space for our major community-based behavioral health leaders to meet and discuss how to engage community-based behavioral health providers in DSRIP. Members include Debbie Pantin (VIP Community Services), John Kastan (The Jewish Board), Andrew Cleek (McSilver Institute for Poverty Policy and Research at NYU), David Woodlock (Institute for Community Living), Doug Apple (Samaritan Village), and Pam Mattel (Acacia Network). The group is currently creating criteria to prioritize interventions and flow funds to facilitate capacity for CBOs to improve performance on metrics pertaining to populations with behavioral health conditions. Focus is on standardizing screenings across the community-based behavioral health providers and linking their patients to primary care. In mid-September BPHC will host a kick-off breakfast, inviting all community-based behavioral health organizations in the PPS to attend. The kick-off will lay out our strategy, and also offer a space to obtain input from the provider organizations. From there, a request for proposals (RFP) for training and technical assistance to those committed to participating in this program will be developed and distributed. The trainings will cover how to administer the standardized screenings, and technical assistance will be provided to aid organizations in adapting and adopting workflows and other processes, as needed.

The BPHC Community Engagement Group has also considered and developed criteria and a Request for Proposals (RFP) offering CBOs an opportunity to participate in funded programs to improve the community's health care navigation skills and health literacy. As described in Section Five, BPHC's final wave of funds distribution for the DY1-DY2 period will provide support to community-based social services and behavioral health organizations to expand innovative approaches for addressing social determinants of health, enhance organizational capacity, and connect patients to primary care providers and other members of the integrated delivery system.