Primary Care Plan Update 2017

Advocate Community Providers

September 29, 2017

Introduction

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

Instructions

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

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

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Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

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

ACP's network grew from 1,200 to 1,656 Primary Care Providers (PCPs) due to aggressive outreach during network open enrollment. Four additional Physician Engagement (PE) Specialists were hired to meet the demands of the expanded network. Furthermore, a standalone PCMH department was established to assist primary care physicians during the PCMH practice accreditation process. During DY2, ACP assisted 173 providers in attaining 2014 PCMH level 3 certification. As of March 31, 2017, ACP has 297 PCMH-accredited practices.

ACP helped connect PCPs to Community-Based Organizations to fill social services gaps. ACP staff members were trained to conduct Stanford Model training and we introduced a comprehensive nutrition education initiative around the DASH nutrition plan. Community Health Workers (CHWs) helped disseminate patient education materials to improve health literacy. To address the issue of long wait times for patients, some offices hired NPs. ACP PE Specialists educated practices about the importance of coding and extracting data for DSRIP reporting purposes and VBP; PE Specialists are trained to pull data from various EMR systems, including MDLand and eCW. Scorecards were developed to show providers where they excel and where they are deficient.

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

- PPS' over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)
- How is the PPS working with community-based Primary Care Practitioners (PCPs), as well as institution-based PCPs?

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

To address primary care capacity and needs, ACP provided VBP and PCMH training and retraining at our primary care offices with a focus on the importance of extended hours, daily blocked hours, and weekend schedules to avoid ER visits and potential admissions. Through these trainings and staff support, the primary care physicians are becoming more knowledgeable about the VBP concept and its financial impact. ACP has 305 primary care physicians that offer weekend hours and 325 that offer walk-ins.

ACP also launched pilot programs with several CBOs to address service gaps. With CentersLink, we have an office-based, high-risk patient service linkage program in which we identify, assess, link, and follow-up to ensure timely warm hand-offs and patient safety. Services address medical, behavioral health, and social determinates of health.

In terms of financial sustainability, five practices responding to our survey indicated some kind of hardship. Through follow-up, however, it was determined that the practices are not in need of financial assistance.

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

Our Physician Engagement Specialists educated our provider network on the benefits of extending both weekday and weekend hours, including reductions in ER visits, hospital admissions and readmissions. Additionally, our teams familiarized our PCP network on the elements of value-based payments and the potential positive impact VBP can have on their practices.

As a result of ACP's efforts, we have 305 network PCPs that offer weekend hours and 325 PCPs that accept walk-ins. Also, numerous primary care physicians are hiring NPs to reduce overcrowding and wait time. The expansion of office hours and the additional of weekend hours increase patients' access to primary care and decrease the likelihood of patients seeking care in a hospital settings for conditions which can be addressed in an ambulatory setting. ACP is also collaborating with CBOs and leveraging their expertise to address patients' social needs while connecting the patients to PCPs.

While ACP continues to build capacity to expand access to care we will not completely address the need because most of ACP's PCPs are located in underserved areas. Many of the patients in our catchment area do not have access to local, culturally sensitive PCPs and those located nearby are over capacity. Therefore, some patients are forced to travel long distances to access primary care.

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

ACP Physician Engagement Specialists have been the liaison between PCMH vendors and provider offices, including scheduling appointments for vendors to meet with practices. PCMH practice transformations increased from 120 in 2016 to over 400 currently. ACP hired more staff to accommodate the growing needs of our network, such as training new and existing providers on DSRIP requirements. ACP reached out to providers to obtain consent forms for MDLand and eCW for data reporting purposes. ACP updated its master directory, including fields such as weekend and walk-in hours.

ACP created materials to meet our member needs. We increased our collaboration with CBO partners to more effectively engage patients and the community. Stanford Model workshops were conducted at both practices and CBO locations for easy accessibility. CHWs are closing access-to-care gaps by collaborating with providers and health plans which are sharing lists of non-utilizers. CHWs call and/or visit patients to schedule appointments.

As part of ACP's CCHL strategy, staff was deployed to conduct environmental assessments that provide a starting point for a robust health literacy plan. The assessment evaluates patient navigation, print communication, verbal communication to patients, use of technology, staff, and policies and procedures surrounding cultural competency and health literacy issues. Post-assessment, ACP provides resources, support, and training to increase physician and staff skills toward the goal of increasing quality of care, patient satisfaction, and patient empowerment.

ACP is confident that our PCMH goals will be met; as of November 2017 ACP's PCMH transformation is as follows:
- PCMH commitment = 662
- Currently PCMH certified = 613
- Currently in progress = 80

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:	
ACP trained and educated PCPs on ACP projects (e.g., Cardiovascular, Asthma, Diabetes, tobacco cessation). While pulling data during reporting periods, ACP PE Specialists educated providers on the importance of proper reporting and coding. ACP also provided a list of ICD10 codes and CPT codes to ensure proper coding for reporting purposes. PE Specialists coordinated with ACP vendors and provider offices on PCMH certification. PE Specialists also coordinated with providers on the non-utilizer access-to-care project, securing lists and permission for CHWs to contact patients on behalf of the office to schedule an appointment.	
Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	553

e. Additional Information

Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:	913
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	297
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	0

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

- What are your PPS plans for working with Primary Care at the practice level, and how are you supporting practices to successfully achieve PCMH or APC recognition? (Resources could include collaboration, accreditation, incentives, training and staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.)
- How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

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

Between April 1, 2016 and March 31, 2017, 173 ACP providers achieved PCMH Level 3 certification for 248 providers.

ACP contracted with four vendors, which have experience working with ACP network practices. These vendors provide comprehensive, linguistically and culturally appropriate turnkey services with onsite implementation and training for transformation, including follow up and the preparation, submission, and tracking of the certification application. Services are provided in a chronological, streamlined, and flowcharted process that begins with a gap analysis to determine the provider's needs followed by construction and implementation of a customized work plan that includes training staff on continued practice transformation. These vendors are: Insight Management – 315 sites, CCACO – 100 sites, Precision Quality – 14 sites, HQ Analytics – 9 sites, and Independent Vendors – 50 sites.

ACP has implemented several training modules which enhance staff credentials and serve to promote patient compliance and performance. These trainings include Stanford model certifications for Diabetes and Chronic Disease. Additionally, ACP contracted with the American Lung Association to train staff as trainers in Smoking Cessation programs.

ACP developed and identified training courses to upload to its workforce portal, HWapps, which are accessible to all ACP and network partner employees. These courses include workshops trainings and materials on cultural competency and health literacy, Teach Back technique, and others. Additionally, we have made available all of our DOH approved clinical protocols and project implementation materials on the ACP website.

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

Some providers are reluctant to begin the transformation process due to their perception that PCMH will increase their staffing, expenses, workloads, and reporting requirements. This is especially true of smaller practices and those still using paper charts. Some providers are nearing retirement and don't see the value in migrating their patient data to an electronic database.

ACP providers and their staffs speak many languages in order to serve large immigrant patient populations in New York City. These languages include English, Spanish, Mandarin, Cantonese, French, Urdu, Hindi, Bangla, Punjabi, Russian, Arabic, and Hebrew. ACP has continued to improve workforce and vendor capability to provide linguistically and culturally appropriate patient materials and staff training. Finding vendor employees who are proficient in practice transformation as well as culturally and linguistically competent has proven to be key.

Lastly, there is a timeline for conversion to 2014 PCMH standards and the 2017 standards are not approved as a viable alternative to the 2014 standards.

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

ACP employed a team approach to address providers' transformation needs. Our PCMH, Physician Engagement, Project Management Office, and Community Health Workers are collaborating and working more synergistically.

ACP also hired a Community Engagement Specialist for the South Asian community who is building relationships and improving our ability to serve dozens of providers from this community. Two ACP employees are fluent in Urdu, Bangla, Hindi, and Punjabi, enabling access to the providers and their staff.

ACP also leveraged our IPAs to provide outreach about PCMH timelines. The trusted nature of the IPA's relationship with their physicians allowed us to identify "champion physicians" who are able to influence other IPA physician members to begin the PCMH transformation process. ACP has been involved in IPA meetings at which these champion physicians support PCMH and rally other physicians.

Separately, ACP focused on those physicians who are still using paper medical charts to encourage them to convert to an EHR. ACP determined that it is beneficial to address having an EHR system in place and migrating patient clinical data prior to beginning the PCMH transformation process.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
ACP's PCMH team took the following actions to approach the work stream for transformations: Readiness assessments, gap analysis, workflow mapping, and support. ACP worked extensively with EMR vendors (MDLand and eCW) to provide additional support to providers in successfully installing EMR services and connecting these systems to better report project and quality requirements. ACP proactively purchased PCMH survey tools for practices pursuing transformation and certification so as to meet deadlines for the 2014 standards. The deadline to purchase survey tools to pursue Level 3 certification was March 31, 2017. The careful linguistically and culturally appropriate connection of specific community providers and PCMH vendors has proven to be effective. A dedicated team member has been assigned to serve South Asian providers and their staffs to ensure effective communication with the PCMH vendor. ACP provided substantial consulting support to providers who wish to transform their practices. Initial meetings are key. A member of the ACP's PCMH or Physician Engagement teams is present at every initial meeting. A weekly "problem" list of providers is reviewed by the VP of PCMH Implementation with each of the four vendors (Insight Management, CCACO, Precision Quality and HQ Analytics) and all providers stalled in the process are either contacted or personally visited by ACP's PCMH team. "Champion physicians" were enlisted to encourage their peers to transform.

e. Additional Questions:

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

Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:	438
Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:	175

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

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

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

Number of Engaged Primary Care Practitioners	936

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

Progress in centralizing IT functions includes meeting key milestones with partners such as Optimus, eCW, MDLand, and Arcadia. These provide the connectivity, data exchange, centralization, and reporting necessary between PCPs and partners. Additionally ACP has contracted with Salesforce to better manage partner support activities and availability.

Optimus is ACP's centralized technology solution through which claims and EHR data is stored, and operations support is provided. Optimus provides technical expertise and support for DSRIP and the transition to VBP. EHR data from eCW, MDLand, and other sources is securely stored for visibility of quality metrics and patient engagement. Arcadia, a population health engine, also processes this data and provides trend and gap analyses so ACP staff may determine resources from secondary and tertiary service providers. Optimus is the centralized connectivity tool for the ACP network with the RHIO, which will provide timely event notifications to all partners.

ACP's care management provides support and coordinates between PCPs and community partners to ensure that services are provided efficiently. ACP staff contacts patients to resolve care gaps, supports physicians in process and workflow development and addressing barriers to care. Utilization, trend, and gap reports allow PCPs to understand patient needs and efficiently manage referral patterns

ACP's partner organization, Rapid Care Solutions, receives admit/discharge alerts from several of ACP's high volume hospitals and health plans and implements the Coleman model of Care Transitions in a timely manner. Furthermore, RCS communicates with the PCPs to alert them of event notifications and follow up activities.

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

The ability to routinely capture health plan data is a challenge. Some health plans, where ACP's legacy IPA partners have current VBP arrangements, provide raw data regularly, while others provide final reports and some do not provide any information. Systems have been developed where raw data is consumed, processed, and reported; however, it is often difficult to conduct the same processes with final plan reports. Plans that do not provide any information remain outstanding. Ongoing conversations are in place to address data gaps.

Other challenges, such as paper providers and costly integration costs (i.e., Practice Fusion EHR), are being addressed by using the practice management/billing systems to extract relevant data; however, this approach is not as robust as data extracts directly from the EHR.

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

ACP has not changed the fundamentals of its strategy, but some aspects of design have changed, such as:

• Arcadia Health Solutions, a population health vendor, has taken a more defined role in analytics and data processing.
• Additional support products are being utilized from eCW, including Healow, a patient scheduling platform, and SQL extracts that were not in the original design. Healow allows for direct access to the PCP's scheduling platform to facilitate appointments. SQL extracts allow us to form relational databases from an otherwise transactional EHR system for data analysis and reporting.
• Utilization of practice management or billing systems as a workaround for cost-prohibitive EHRs or paper providers to systematically gather data.

These key design changes, along with others, do not inherently change ACP's strategy but better fit the overall strategy of connectivity and integration of the PCPs within ACP.

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

ACP facilitated achievement of Meaningful Use Stage 2 requirements through various initiatives directly from DSRIP requirements as well as practice transformation efforts. ACP's funding and facilitation of PCMH and educational efforts have allowed PCPs to maximize EHR functionality to improve workflows and processes. ACP's focus on reporting and documentation requirements that target quality-based preventive medicine ensures continuity of these developed workflows and processes.

• ACP trained and educated physicians with EHRs on appropriate ways to capture Meaningful Use Stage 2 requirements and incorporate within the practice workflow.
• Some of DSRIP's core requirements, such as the focus on patient education and cultural competencies that require capturing specific demographic information, fulfill some requirements of Meaningful Use Stage 2.
• PCMH requirements address some of Meaningful Use Stage 2 objectives.
• EHR vendor partnerships at the ACP level have ensured all providers have access to required tools.
• Options are provided to PCPs currently on paper health records.

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

ACP has had on-going conversations with RHIOs to establish centralized connectivity as well as distribution of clinical event notifications (CENs) when network PCP patients visit the ER or are admitted to the hospital. In preparation, work plans have been developed and executed with high-volume EHRs to create dedicated hubs to connect with RHIOs. ECW and MDLand completed development of ACP hubs which are required for RHIO connectivity. Other EHRs have capabilities as well and are handled individually. Additionally, consent capabilities have been modified in eCW and MDLand to reflect the latest requirements from the Department of Health.

ACP contracted with Optimus Health Analytics to provide the centralized connectivity with independent physician practices to make the connection to the Bronx RHIO. ACP has obtained consents from the PCPs for this connectivity through the deployment of PE staff. ACP PEs have collected system information of each EMR to set connectivity parameters for each practice as appropriate. As of November, 2017, hundreds of consents have been obtained and Optimus is developing the connectivity working with the different EMRs, HL7 interfaces, web based platforms and other systems.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	13

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	50%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	0%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	100%

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

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

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

From April 2016 to March 2017, ACP leveraged its IPA partnerships to survey and analyze its providers' level of participation and contracts, as well as readiness to undertake value-based arrangements. Analyses included financial, IT, and process-based, determining past quality and performance. As a result, ~300 physicians were selected to initiate VBP pilots through SOMOS IPA.

Evaluating practice needs:

I. Analysis of financial activity related to patient cost identified a lack of post-hospital follow-up due to lack of timely event notification that would allow the provider to identify and connect with the patient for continuity of care and intervention, preventing avoidable rehospitalization.

II. ACP/SOMOS's IT survey revealed a lack of connectivity among practices and their partners, lack of population health platform usage, and the need for greater IT supports.

III. Leveraging existing IPA connections, ACP/SOMOS conducted analysis of MCO provider-based quality and performance scores showing several providers attaining adequate percentile targets with HEDIS, QARR, and adequate coding for proper risk adjustments for patients. However, many providers were not sufficiently educated on the parameters and metrics, or proper coding for claims-based reporting and monitoring.

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

1. As a non-profit DSRIP PPS, ACP is not a legal contracting entity with the capacity to enter into any type of risk contract. As a result, ACP is not able to organize primary care providers to enter into contracts with any type of reimbursement model with MCOs.

2. Many practices are not able to perform at the VBP level due to lack of understanding and implementation of the performance requirements.

3. Independent Primary Care Providers lack the connectivity required to ensure timely notifications and interventions.

4. Lack of HIE infrastructure creates difficulties in attaining and gauging performance metrics.

5. ACP/SOMOS has identified a need for greater care coordination and care management amongst its primary care providers for better care and better outcomes.

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

1. ACP, an entity formed by IPAs, established its VBP initiatives through SOMOS IPA, which was formed by ACP's founding IPA members. ACP, as a non-profit PPS, does not have the legal capacity to enter into risk contracts that SOMOS IPA has.
2. ACP provides PCPs assistance in contracting with SOMOS IPA:
• Establishing the relationship between PCP and SOMOS.
• Educating PCPs in VBP models of care and performance monitoring.
• Providing financial modeling help in order for PCPs to understand financial risks and benefits.
• Organizing and sponsoring meetings in which the PCPs meet the SOMOS IPA leadership and have a forum for their questions to be addressed and contracts to be discussed and signed.
• Deploy PE staff to the practices to provide one on one VBP education, answer questions and assist with contracting with SOMOS IPA.
3. Connectivity: ACP/SOMOS is developing appropriate HIE functionality for timely event notification and intervention.
4. ACP/SOMOS will monitor performance and compliance with measures through claims data provided by Optimus Health Analytics:
• CPT, HCPCS, and ICD codes that gauge performance and direct toward value achievement.
• Healthcare expenses at a per patient and per provider level.
• Patient risk scores and healthcare gaps per practice.
• Services provided post event notification and preventive measures.
• ACP/SOMOS has developed Individual scorecards and system-wide dashboards for monthly performance monitoring using up-to-date EMR data that's actionable.
• Scorecards measures include HEDIS, Quality, access-to-care, and population health.
• Clinical and claims-based information is analyzed and correlated.

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

SOMOS IPA applied for participation in the NYS VBP Pilot program and was approved at the end of 2016. By March 31, 2017, SOMOS IPA had entered into VBP level 2 arrangements with 6 MCOs. Contracts have been submitted for final NYS DOH review and approval. The roll out of the VBP initiatives will pave the way for a staged transition of the network.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers in levels 2 & 3 VBP arrangements to address social determinants of health and engage Tier 1 Community-Based Organizations (CBOs):
ACP/SOMOS has reviewed Tier 1 CBOs to determine availability of services for patients we serve. Meetings were held in February and March 2017 with CBOs (including meal delivery services, housing and home care) to discuss participation through SOMOS IPA in a VBP-type arrangement to ensure services to at-risk patients. ACP/SOMOS has letters of intent with several CBOs to collaborate in the SOMOS network for VBP models.

f. Additional Questions

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

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

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

…If yes, describe: ACP, as a non-profit PPS, does not have the legal capacity to enter into risk contracts. To facilitate VBP for our providers, ACP's founding IPA members formed SOMOS IPA which includes ~300 physicians to initiate VBP pilots. SOMOS IPA, which has entered into VBP level 2 arrangements with six MCOs.

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

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

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

ACP funds flow model(s) have been designed to attract, retain, and reward participation of our provider network partners. As a primary care-centric PPS, ACP's funds flow formulae have focused on compensating our primary care providers for their participation in DSRIP and in our selected DSRIP projects. For DY1, ACP's funds flow model used attribution and engagement metrics as the basis for determining payments to primary care practices. DY1 funds flows to network providers totaled $27.4 million, with $17.9 million of that amount going to our primary care partners. The balance of the funds flows went to hospital partners ($5.7 million), specialist physicians ($1.3 million), as well as Behavioral Health providers, Nursing Homes, Pharmacies, Hospice, CBOs, and Others.

The formulae for funds flow distributions for DY2 are being finalized, with distribution of funds to follow shortly. DY2 formulae will shift the focus from attribution and engagement to performance, in alignment with project milestones. In DY3, Physicians, Hospitals and Other partners will continue to be able to earn incentive payments if performance on metrics is achieved. All ACP providers are being trained and incentivized to succeed in a managed Medicaid environment where appropriate utilization is encouraged, and performance, quality, and outcomes are tracked and rewarded.

Additional funds flow to support Primary Care consists of dollars distributed for PCMH certification and funds allotted and paid for IT infrastructure and connectivity:
• PCMH: $4,803,090 (14.1%)
• IT Infrastructure: $2,034,643 (6%)

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$34,027,464	**100%**
Primary Care Provider	$17,891,271	52.6%
Hospital-Ambulatory Care	$5,741,242	16.9%
Federally Qualified Health Centers (FQHCs)	$508,487	1.5%
Primary Care Practitioners	$11,641,542	34.2%
PMO Spending to support Primary Care	$9,298,460	27.3%

c. Based on the PPS' progress and challenges addressing DSRIP performance from April 1, 2016 to March 31, 2017, what strategic changes have been made to the funds flow model outlined in the final Primary Care Plan submitted in 2016?
During the time period April 1, 2016 to March 31, 2017, ACP did not make changes to the funds flow model, and distributed DY1 funds (including Equity Program funds) consistent with our initial attribution and engagement formulae. As ACP prepares to distribute DY2 funds, we continue to work on finalizing our restructured funds flow formulae to reward our network providers, especially our primary care practices, for achieving performance and quality metrics that will determine our success in earning available DSRIP funds during the balance of the program. ACP is working diligently to ensure that funds are distributed fairly and promptly to all network partners, with a particular emphasis on our primary care physicians. To move ACP's network from current state to future state, we are focusing our funds flow distributions on outcome measures, quality measures, and patient satisfaction measures linked closely to those contained in VBP contracts.

d. Additional Questions

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

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

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

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

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

1. Trained ~200 practices to administer validated depression screening tool (PHQ2/9) embedded in the practice's EMR. Engaged physicians and their staff on implementation of protocols for patients who score above threshold. Also instructed on proper coding of screening and referrals. Provided consulting psychiatrists for physicians who to treat patients themselves to consult on psychotropic medications.

2. Engaged with NYC DOHMH to place licensed masters-level clinical social workers in eligible practices and supported practices through application process. NYC DOHMH placed 13 Mental Health Service Corps (MHSC) social workers in ACP practices to receive warm real-time handoffs. MHSC clinicians provide patient counseling and referrals to community-based organizations as appropriate.

3. Contracted with community-based mental and Health Homes to receive referrals for patients who need intensive care management and are HARP eligible, and to provide information back to the PCP.

4. Supported a large ACP practice that is one of 11 NY sites engaged in a NYS Health Foundation research study under Dr. Henry Cheng aimed at identifying opportunities and challenges for community primary care practices to integrate behavioral health into their work protocols.

5. ACP Physician Engagement and Project Management staff encouraged practices to adhere to HEDIS behavioral health measures (e.g., ensure that children prescribed ADHD medications have follow-up appointments within stipulated time frames).

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

1. Our PCP practices are on various EHR platforms. Not all practices have trained Medical Assistants who can support screening and triaging of patients.

2. Massing data from 600+ practices on multiple platforms has been difficult. Establishing a means to analyze this data and report it back to the PCP to achieve performance corrections has been challenging.

3. For practices that do not have an on-site behavioral health professional, providing appropriate referral resources can be a challenge, especially for patients who require specific linguistic and/or cultural capacity.

4. Classical IMPACT model assumes a behavioral health clinician is embedded in the practice and a "warm handoff" occurs. With 600 practices across the city it is clear this is challenging. As an alternative, and with the concurrence of NYS OMH and the AIMS Center, the originator of the IMPACT model, we developed an alternative model in some practices where off-site clinical entities that themselves are downstream providers to Health Homes interfaced with clinical practices to receive "virtual" warm handoffs, to intake the patient, provide short-term counseling, and refer as necessary for longer-term behavioral health services and other psychosocial services that meet patient need.

c. From April 1, 2016 to March 31, 2017, describe the PPS' challenges to integrating Primary Care and Behavioral Health specific to regulatory issues:

ACP did not apply for any regulatory waivers. One challenge, however, has been the need for C.F.R. 42 consent, which greatly limits the PCPs' ability to obtain information on patient compliance and outcome even when it is the PCP who has referred the patient. Care managers and Care coordinators cannot obtain proper data to monitor patient progress.

Through our participation with Dr. Henry Chung's Montefiore Care Management Behavioral Health Framework Integration Project, we have developed referral relationships with Article 31 (OMH) and Article 32 (OASAS) clinics in neighborhoods near our PCP "hot spots" across all boroughs ACP serves. These agencies (significantly Long Island Consultation Center (LICC), Bleuler Psychotherapy Center Inc., Mental Health Providers of Western Queens, Metropolitan Center of Mental Health, and many others) have agreed to accept ACP PCP referrals and prioritize initial intakes within 10 working days. The accepting BH clinics have resources that are culturally competent to address the linguistic and cultural needs of ACP's diverse patients.

Recognizing the shortage of behavioral health providers to accept warm handoffs, ACP is providing training to all medical assistants within the PCP practices, as the PCP agrees to, to not only perform screening on the different EMR platforms, but also to accept warm handoffs and follow the patients through care management protocols to achieve compliance of PCP's treatment plan and coordinate with community providers as necessary. This will also be useful in providing culturally appropriate care management and care coordination.

ACP has entered into contracts with psychiatrists and BH providers of the major cultural background that it serves.

A major challenge is the HIE platform that can support the information received from different platforms, but look forward to addressing this through our contract with Optimus and Arcadia which will bring all of the information to a centralized, monitorable platform.

d. Based on the PPS' progress and challenges addressing Fundamental 6 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 6 outlined in the final Primary Care Plan submitted in 2016?

Classical IMPACT model assumes a behavioral health clinician is embedded in the practice and a "warm handoff" occurs. With 600 practices across the city it is clear this is challenging. For some practices we therefore changed our strategy. As an alternative, and with the concurrence of NYS OMH and the AIMS Center, the originator of the IMPACT model, we developed an alternative model in some practices where off-site clinical entities that themselves are downstream providers to Health Homes interfaced with clinical practices to receive "virtual" warm handoffs, to intake the patient, provide short-term counseling, and refer as necessary for longer-term behavioral health services and other psychosocial services that meet patient need.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	6	3	3
Model 2	6	3	3
Model 3 IMPACT	600	523	77

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

☒Alcohol Use screening
☒ Billing for Integrated Care
☒ Collaborative Care for Depression, i.e. IMPACT model
☒ Depression screening
☒ EHR Integration
☒ Health Homes
☒ Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
☒ Mental Health First Aid
☒ Outcomes Measurement
☒ Patient Consent and Privacy regulations specific to Behavioral Health populations
☒ Person-Centered Care
☒ Peer Services
☒ Population Health
☐ PSYCKES
☒ Quality Improvement Processes
☐ Regulatory Issues
☒ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
☐ Serious Mental Illness
☒ Tobacco Cessation
☐ Trauma Informed Care
☒ Other Mental Health screening (please specify): GAD 7
☐ Other Substance Use screening (please specify): Click or tap here to enter text.
☐ Other

Describe:

Click or tap here to enter text.

GLOSSARY OF TERMS

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

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

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

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

Primary Care Practice: Individual sites providing primary care services

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

Primary Care Provider: Entity providing primary care services

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