Primary Care Plan Update 2017

Community Care of Brooklyn

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.

From the launch of New York State Delivery System Reform Incentive Payment (DSRIP) program activities, Community Care of Brooklyn (CCB) committed to using the standards from the National Committee for Quality Assurance 2014 Patient-Centered Medical Home recognition program as a framework through which to implement interventions associated with DSRIP projects. In DSRIP demonstration year 2, CCB began exploring the integration of New York State's Advanced Primary Care (APC) model into its overall primary care strategy. CCB expects to engage partner organizations in demonstration year 3 and advocate for the transition of partner organizations from NCQA 2014 PCMH recognition to APC recognition, which will enhance the strategies outlined in CCB's final Primary Care Plan that was submitted in 2016.

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:

CCB worked with 5 hospitals, including those participating in the Value Based Payment Quality Improvement Program (VBPQIP), 6 Federally Qualified Health Centers (FQHCs), and 2 Independent Practice Associations; which together employed more than 550 PCPs. CCB also increased its active engagement of primary care providers to 237 community-based PCPs, an increase from 102 PCPs highlighted in the 2016 CCB Primary Care Plan. CCB's growing network of primary care providers worked on assessing patient access and primary care capacity in addition to transforming practice sites from traditional practices to patient-centered medical homes (PCMHs), improving performance and training the workforce to efficiently and effectively meet patients' needs.

CCB further developed and provided Health Coach resources to primary care practices, and saw great impact, especially among community-based practices where providers are often challenged in finding sufficient time to work with patients on self-management goal setting and connecting patients to local and community-based resources. By embedding Health Coaches directly in primary care practices, CCB has increased the capacity of practices to work with more patients in need of extra time and support. Since April 1, 2016, CCB provided training for 80 health coaches and integrated them across CCB partner primary care sites.

All community- and institution-based primary care practices with a Schedule B that had not achieved NCQA 2014 PCMH recognition were paired with a PCMH technical assistance (TA) organization, which helped CCB partners with onsite technical assistance and coaching to achieve NCQA PCMH recognition. An important part of the PCMH TA organizations' work was to help each practice to improve capacity, by implementing same-day appointments, assisting practices in assessing patient need for late or weekend hours and helping practices to initiate changes in office hours to meet patient needs.

CCB continued to work with partner organizations that received capital funding to implement after hours/urgent care services. Building on the strong work of our community engagement committee, CCB supported development activities for a second Participatory Action Research project.

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

For several partner organizations in economically distressed communities where large numbers of patients are struggling with multiple social determinants of health, recruitment of primary care providers has been a key challenge to improving primary care capacity. One of those organizations had 3 vacant primary care provider positions, which when filled, could mean the ability for that organization to manage an additional 3,500 patients.

Finding clinical backup support has also been a challenge for many of our partner organizations. Several FQHCs and small, community-based practices have expressed a need for backup pharmacy and behavioral health services for curbside consultations, which would enable those practices to manage care efficiently for their patients.

In a network of CCB's size and reach, it is inevitable to have varying levels of engagement. While 1,152 community- and institution-based primary care providers expressed interests in DSRIP objectives and remaining connected to CCB, only 237 community-based providers and their practices fully engaged with CCB through contracting to implement program interventions and practice transformation activities in demonstration year 2.

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?

Community Care of Brooklyn (CCB) initiated conversations with chief medical officers and administrative leadership at several partner organizations that have had challenges in the recruitment of primary care providers. Together, CCB and its partners are developing an intervention to support provider recruitment activities. We expect to launch a pilot in demonstration year 3. While no changes have been made to Fundamental 1 of CCB's final Primary Care Plan submitted in 2016, CCB anticipates its efforts to improve primary care provider recruitment among partner organizations will increase capacity and access to primary care services.

Similarly, while no strategic changes have been made to Fundamental 1 of the final Primary care Plan with respect to CCB's work to develop clinical backup services by March 31, 2017, CCB expects to continue its development activities in this area in demonstration year 3. We plan to pilot clinical backup services in psychiatry by the last quarter of demonstration year 3. After learning from the pilot and implementing any changes, we will launch additional clinical backup services in cardiology and pharmacy in early demonstration year 4. These clinical backup services should yield improvement in capacity to manage a wider range of patient issues in the primary care setting.

For primary care providers not actively engaged with CCB through an executed Schedule B and not otherwise receiving PCMH technical assistance, CCB believed it was still very important to invest in PCMH technical assistance for these providers and their practices. CCB offered them access to an online PCMH technical assistance organization that provided assessment tools, videos, tip sheets and resources specific to PCMH standards. CCB complemented that online resource by developing a graduate-level internship program to provide coaching and project management support to practices to be launched at the end of quarter 1 of demonstration year 3.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
More than 70% of Community Care of Brooklyn's (CCB's) engaged primary care providers (PCPs) have been community-based PCPs. Given that high percentage and the central role of primary care in an integrated delivery system, CCB made engagement of community-based PCPs a priority. In demonstration year 2, CCB's clinical leadership and program team members met in person with primary care teams from over 150 primary care sites that did not have a contract. Following in-person meetings, CCB talked with providers by telephone and had additional in-person meetings as needed. In addition to offering these practices a range of resources that CCB has developed to support practice transformation, performance and quality improvement, workforce development, CCB also reviewed centralized resources, including a dedicated program team, performance reports, support line, newsletter, and web-based PCMH technical assistance. Follow-up conversations, both in person and by telephone, has led to engagement and contracting with many of those sites. Contracts in demonstration year 2 have included payments for meeting targets, program implementation and performance.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	237

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:	1288
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	288
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:

Community Care of Brooklyn (CCB) committed to working with primary care practices to achieve medical home transformation. Between April 1, 2016 and March 31, 2017, CCB contracted with four different organizations with expertise in National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition to provide medical home transformation technical assistance to all primary care practices in CCB's network that had not yet been recognized by NCQA. Additionally, we provided financial support to one of our IPAs with in-house NCQA PCMH Certified Content Experts (CCEs) to enable them to deliver PCMH coaching and assistance to their IPA practices in the CCB network. Between April 1, 2016 and March 31, 2017 we paired over 80 practice sites with a PCMH technical assistance organization.

We emphasized and promoted medical home transformation as the overarching framework within which our DSRIP primary care projects are executed. All practices we engage and that receive DSRIP funding are expected to actively work towards achieving NCQA PCMH 2014 Level 3 recognition.

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:

A significant portion of the primary care providers in CCB's network are solo-practitioners who often work in very leanly staffed offices. They struggle with dedicating the time and human resources that are essential for PCMH project planning. Furthermore, they have little time available to participate in training, as every minute spent in training is often a minute not spent on patient care. Despite these challenges, many of the small primary care practices in our network, with the help of our PCMH technical assistance organizations, have demonstrated tenacity and creativity in developing strategies to dedicate the time required for successful medical home transformation. Additionally, in recognition of the challenges all primary care practices experience in training participation, our PPS provides training stipends to help offset the costs of sending staff and providers to training.

Small primary care practices are more likely to have little or no prior exposure to or knowledge of the patient-centered medical home model. Although this does not prevent them from being successful with medical home transformation, we have noted that this knowledge gap often means that they are slower to adopt its standards.

Lastly, electronic medical record capability has been a challenge for primary care practices, including medium and large-sized practices. Reporting and electronic tracking are key components of both the NCQA PCMH 2014 model and the Advanced Primary Care model. Some of the practices undergoing PCMH transformation are using EMRs with limited reporting capability, posing challenges in being able to meet some of the medical home requirements.

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?

Plans to develop additional training resources for primary care providers were initiated in demonstration year 2. There was some focus on opportunities to customize trainings around practice transformation in small, community-based practices. Community Care of Brooklyn also collaborated with the New York City Department of Small Business Services to identify community-based providers to participate in a small pilot training program taught by New York University professors using a business education and development curriculum. The pilot cohort will participate in 13 sessions over 7 months; the first session will launch in March 2018. At the end of the pilot in October 2018, we will assess the program and program outcomes, and plan for full implementation across the CCB network in demonstration year 4.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
Community Care of Brooklyn found that providing both remote and in-person technical assistance was the most effective way to help practices successfully transform. Practices, particularly those that are small and leanly staffed, need a practice transformation partner who can guide them through the process. Practices are most likely to stay on track when they receive some face-to-face coaching and guidance. Another effective strategy we used was mandating that practices agree to PCMH transformation as a requirement for participating in our DSRIP projects and receiving funding via our contracting process. Not only did we set the expectation early on that PCMH transformation was a requirement for funding, we also emphasized the alignment between PCMH transformation and the creation of a strong, integrated delivery system in Brooklyn that would achieve the "triple aim." As a PPS, we also stressed the benefits of PCMH transformation for the practice and their patients. We created a summary document about PCMH, which we use in all initial meetings with primary care practices. We also work with our PCMH technical assistance organizations to help the practices align PCMH requirements with DSRIP reporting requirements.

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:	250
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:	16

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	1,152

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:

Community Care of Brooklyn (CCB) continues to develop an integrated delivery system with primary care playing a central role in providing and coordinating patient care. In demonstration year 2, CCB increased provider engagement and delivered a range of resources to support the redesign of primary care practices, patient engagement activities and care team trainings focused on improving care team communication and coordination of services for patients across the care continuum.

To facilitate communication and care coordination among providers across the care continuum, especially for providers managing patients with complex medical and psychosocial needs, CCB provided training to care team members in hospitals, FQHCs, and community practices on using the GSI HealthCoordinator ("Dashboard"), an Internet-based care coordination platform that is connected to Healthix, the local Regional Health Information Organization. Access to the Dashboard enabled members of the care team to all contribute to a common care plan and receive real-time updates on the patient's progress toward goals as well as alerts on emergency department and hospital admissions and discharges.

In-service and training sessions on communication, care coordination and care transitions along with case conferences for key staff members, including transitional care nurses, transitional care managers, emergency department navigators, health coaches, behavioral care managers and supervisors have helped to improve communication across the care continuum.

Twenty-seven partner Primary Care Providers have participated in CCB governance committees. They offered valuable insight, expertise and guidance, which helped CCB to develop interventions that improve access, communication, care coordination and care transitions.

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:

Engaging hundreds of primary care providers, most of whom were in small community practices, and in various stages of readiness for practice transformation was an early challenge. Many practices were still using paper charts which created obstacles in retrieving information and data for population health management. Most primary care practices faced communication issues connecting with secondary and tertiary providers as well as community-based service providers about common patients. Though many people may have been working with a patient, they were working in silos making the management of the patient difficult.

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?

Community Care of Brooklyn made no changes to strategies highlighted in Fundamental 3 of the final Primary Care Plan submitted in 2016, but we did accelerate the timeline for training on the GSI HealthCoordinator and team trainings around communication to act on communication issues observed across partner sites.

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:

Community Care of Brooklyn (CCB) retained patient-centered medical home technical assistance organizations to support practice transformation efforts in all CCB engaged primary care organizations. An important part of that work has been assessing the use and maximization of EHRs as well as leveraging PCMH elements to meet Meaningful Use Stage 2 standards.

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):

Community Care of Brooklyn (CCB) collaborated with Healthix, our Regional Health Information Organization, to develop a strategy to engage and connect CCB partner organizations currently not connected to Healthix. In demonstration year 2, CCB identified partner organizations that were not connected to Healthix but used an electronic health record compatible with RHIO connectivity. Plans were developed for early demonstration year 3 to launch an engagement strategy with those partner organizations. Through a series of follow-up sessions, Healthix and CCB will guide partner organizations through the process of connecting to the RHIO.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	637

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	27 (14%)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	17 (9%)
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	10 (5%)

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:

In the CCB VBP Needs Assessment, four areas of need were identified across the PPS network, all of which apply to primary care:

- Area #1: Provide training and education to increase Participants' (partner organizations and practices) understanding of VBP concepts and terminology.
- Area #2: Support Participants' efforts to increase the quality and effectiveness of their services to effectively manage a population of patients.
- Area #3: Encourage additional data connectivity among PPS network partners.
- Area #4: Increase the number of Participants and percentage of revenue associated with a Level 1 or higher VBP arrangement.

CCB's VBP Support Implementation Plan was designed to address these areas of need, specifically committing to: 1) provide VBP training and education to partners, including providing at least two sessions per DY for PCPs, 2) provide technical assistance to PCPs for the transition to PCMH and APC, 3) increasing PCP connectivity to the online care management platform and RHIO, and 4) support the development of VBP arrangements, including the HARP VBP Pilot, and development of a PPS successor/contracting entity. All of these activities are currently underway with the goal of developing and supporting an integrated delivery system that is comprised of a network of high-quality and efficient primary care providers.

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

The CCB network includes about 1,000 partner organizations, representing thousands of providers. CCB's PCP partner practices are of varying size, complexity, corporate structure, services, and familiarity with VBP concepts. These providers operate in the context of a rapidly shifting healthcare delivery landscape in Brooklyn. There are a multiplicity of activities and programs aimed at our network practices promoting the pursuit of the "triple aim." Most efforts are segmented by payor and/or topic area for engagement, and as a result, there is no single solution for primary care that could provide a comprehensive and coordinated approach to delivery system transformation.

CCB planning efforts related to the formation of a PPS successor/contracting entity have taken into account the critical importance of primary care providers in the integrated delivery system. Plans have also factored in PCPs' limited ability to set aside the time needed to develop subject matter expertise in all areas of payment and delivery transformation, including negotiating VBP contracts with multiple MCOs. CCB intends for the new entity in development to provide significant coordinated assistance across partners, including primary care practices, to both enter into and, more importantly, succeed under VBP arrangements.

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?

CCB's strategies to support PCP participation in VBP remain consistent with the 2016 Primary Care Plan as well as the VBP Support Implementation Plan. PCMH transformation activities, as described earlier, will increase PCPs' attractiveness to MCOs for VBP contracting.

One of the areas of greatest progress since the last update is the PPS' efforts related to transformation planning. CCB's Sustainability Planning Workgroup, which reports to the CCB Finance Committee and CCB Executive Committee, has provided significant leadership for the PPS's vision for clinical integration and formation of a PPS successor/contracting entity, which is expected to be operational in early 2018.

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:

In addition to the initiatives mentioned previously that aim to increase attractiveness of PCPs to MCOs for VBP contracting, CCB is also engaging with MCOs through participation in the HARP VBP Pilot and the VBPQIP initiative, both of which affect primary care providers in our network.

Effective January 2017, Maimonides Medical Center, acting as VBP Contractor, is participating in a HARP VBP Pilot with Healthfirst. Many CCB network partners, including primary care providers, are included as downstream HARP Pilot Network Service Providers. The Maimonides CSO will provide support to the HARP Network Service Providers, including data analysis and care management oversight across CCB network partners engaged to manage the assigned HARP members.

CCB has since 2015 played a significant role in the VBP Quality Improvement Program (VBP QIP) initiative. As of April 2017, CCB is paired with four MCOs (Affinity, Fidelis, Healthfirst, and United) and four safety net hospitals (Brookdale Hospital Medical Center, Interfaith Medical Center, Kingsbrook Jewish Medical Center, and Wyckoff Heights Medical Center). Among other things, VBPQIP requires that by April 1, 2018, each participating safety net hospital establish Level 1 or greater VBP arrangements that cover at least 80% of its Medicaid managed care revenue (including revenue from its primary care clinics). CCB is providing education and assistance on VBP to the VBPQIP hospitals and facilitating conversations with MCOs on opportunities for VBP arrangements, many of which are built on a foundation of primary care attribution (such as the Total Cost for the General Population VBP model).

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):

As described earlier, targeted training and education will be provided to PCPs across the PPS network on requirements related to VBP, including requirements related to addressing the social determinants of health and engaging CBOs. CCB is leveraging its experience working with a network of social service and CBOs to identify, evaluate, and promote promising interventions to address social determinants of health, as well as engage Tier 1 CBOs. One example is that CCB has partnered with The New York Legal Assistance Group (NYLAG), a Tier 1 CBO, to expand an existing legal assistance clinic model to serve patients engaged with our network partners. The legal clinic, held at one of our partner CBO sites in downtown Brooklyn, provides patients with legal assistance services to address a variety of social determinants of health. CCB will continue to promote CBO partnerships and interventions aimed at improving social determinants of health across the network to help providers meet requirements for VBP contracting, but more importantly to support patients' overall health and well-being.

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: CCB has provided technical assistance to Primary Care Providers in connection with work on the development of a PPS successor/contracting entity. Primary care providers entities/practices will play a prominent role in the emerging entity and will be critical to the success of a clinically integrated network serving patients throughout Brooklyn.

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:

Supporting primary care—both in the form of technical assistance and direct financial support— remains a key focus of CCB's overall approach to delivery system transformation. As of March 31, 2017, CCB had distributed almost $10 million in funding, or a total of about 23% of total PPS funds flow, either directly to or in support of primary care providers in the CCB network: $6 million to primary care providers, almost $1 million in PMO spending, and an additional $3 million in spending to other partner types (not shown in the table below). However, this total underrepresents the total funds allocated for primary care as additional spending has been committed beyond these totals for future reporting periods and for activities that support all CCB partner types, not just primary care.

Funding amounts shown in the table below include funding for PCPs to participate in CCB project interventions, such as health coaches, behavioral health integration, pre-visit planning, and PCMH transformation. The PMO total includes spending for primary care/behavioral health integration training provided by the Institute for Family Health, four contracted PCMH vendors for PCMH training and technical assistance, and DSRIP data reporting integration for FQHCs.

Other CCB partner types have received funding to provide direct support for primary care strategies. Some examples of this funding include payments to the MJHS Institute for Innovations in Palliative Care to provide primary care training, three partners to provide asthma home-based assessments and care management services, and care management agencies to hire health coaches that are paired with smaller primary care practices.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	**$42,804,072.69**	**100%**
Primary Care Provider	$6,040,988.32	14%
Hospital-Ambulatory Care	$1,352,130.81	3%
Federally Qualified Health Centers (FQHCs)	$1,962,327.89	5%
Primary Care Practitioners	$2,726,529.62	6%
PMO Spending to support Primary Care	$922,390.86	2%

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?

CCB's initial contracting efforts with primary care providers were primarily focused on standing up the CCB primary care transformation model and initiating DSRIP reporting related to actively engaged patients. Since then, the second round of primary care contracting built on and continued earlier activities but included additional performance-based approaches, using payment incentives and bonus payments as levers to encourage additional movement on DSRIP and other related performance metrics. CCB is monitoring providers' performance on all DSRIP measures, but is especially focused on measures of access, medication management and reconciliation, tobacco cessation, as CCB has committed funding to primary care providers that show specified improvements on these areas over time. The alignment of funding in partner contracts to specific process and outcome measures should help drive further improvement in DSRIP performance in primary care practices.

Additionally, during this time period, CCB issued over $300,000 in bonus payments to primary care providers in support of PCPs' contributions in DY1. Examples of DY1 contributions included reporting/meeting targets relating to actively engaged patients and completing required CCB surveys. While bonuses were paid during this time period based on achievement of actively engaged targets, future bonus payments may be paid to providers based on performance on DSRIP quality metrics, achieving PCMH recognition, and meeting contracting-specific quality measure targets.

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):

CCB continues to implement Project 3.a.i., with our focus on Model 3 and behavioral health integration into primary care practices. CCB is working to integrate physical and population health strategies into behavioral health practices. CCB will contract with Article 31 practices for the upcoming demonstration year to implement a model that includes using health coaches in mental health settings.

CCB has begun using peers with addiction experience to facilitate engagement of patients with addiction disorders who present to hospitals and primary care. Initial steps involve embedding peers in emergency departments and hospitals, who can engage patients and facilitate linkage to behavioral health services and primary care. CCB is embedding peers in primary care in demonstration year 3, to facilitate screening for alcohol and substance misuse and abuse, and engagement of those who screen positive for such problems.

CCB continues to utilize network Health Homes to facilitate coordination of behavioral health and primary care, with the plan to have health coaches in both primary care and behavioral health settings play a pivotal coordination role for the practices and care management agencies.

CCB is expanding the range of screening for behavioral health conditions to include screening for anxiety, trauma, alcohol, and substance misuse and abuse. The additional resources of social workers, health coaches, and peers will allow primary care to manage more effectively low complexity behavioral health conditions. CCB is also proceeding with its HARP pilot, which focuses on managing a high-risk population with both behavioral and physical health conditions.

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

A continuing challenge to integrating primary care and behavioral health is the shortage of mental health providers. While collaborative care allows an individual psychiatrist to cover ten times as many patients as s/he could treat individually, there are operational and logistical challenges to implementing a model that requires fractions of an FTE of a psychiatrist to provide backup at any given primary care practice. While telepsychiatry allows for greater flexibility to address this problem, there are operational and logistical challenges in adopting telepsychiatry at primary care practices.

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

Regulatory issues provide some challenges to integrating primary care and behavioral health. One significant challenge relates to sustainability of behavioral health resources embedded in primary care. There are currently significant impediments to sustaining clinical resources of a social worker and consulting psychiatrist in primary care settings that do not have an integrated license. Additional challenges relate to providers' concerns about the lack of integration at the State level between the State Department of Health, Office of Mental Health, and Office of Alcoholism and Substance Abuse Services. Providers in primary care have expressed concerns about the need to navigate 3 State-level agencies in order to achieve behavioral health integration into primary care.

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?

CCB is embracing the regulatory relief around telehealth and telepsychiatry to facilitate implementation of behavioral health integration into primary care practices. Telehealth solutions are critical to the expansion of collaborative care into small provider practices in Brooklyn given the scale of resources needed at a small provider site. With the challenges in implementing telehealth solutions to support behavioral health integration, CCB is exploring how it can implement a centralized telehealth resource that will be available to providers at small practices and any primary care provider that faces challenges in implementing their own local telehealth resources.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	5	5	0
Model 2	10	10	0
Model 3 IMPACT	15	15	0

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): Click or tap here to enter text.
☐ 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