Primary Care Plan Update 2017

Bronx Partners for Healthy Communities

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.

We have not made any strategic changes since our final Primary Care Plan in 2016. 1) Our primary care partners continue to expand visit types that encourage team-based care models outside the traditional primary care provider (PCP) visit, such as 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. We continue to provide coaching for crucial elements of practice transformation, including: panel management, continuity of care, leveraging care team members, pre-visit planning; and Bronx Partners for Healthy Communities (BPHC) continues to encourage its partners to hire additional PCPs, both physicians and NPs, and/or physician extenders where needed.

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:

As stated above, primary care partners have created access by exploiting visits with team members other than PCPs. All seven of our largest primary care partners, who account for 97% of our primary care footprint, have instituted provision of blood pressure checks with a staff-member other than the PCP, and six of the seven have implemented the IMPACT model. In addition, our primary care partners have extended hours to include evening and weekend hours: SBH Health System's Ambulatory Care Medicine and Pediatric Clinics are now each open one day a week until 7PM and their Bronx Park Pediatric practice is also open one evening a week; Acacia now has two locations (RVHC and Casa Maria) open every weeknight until 6:30PM, one location (Claremont) open twice a week until 7PM and every other Saturday from 9-5PM, and a fourth location (LCDS) open every Saturday from 9-5PM; Morris Heights Health Center expanded hours until 8PM weekdays and expanded hours on Sundays. Primary care partners have also hired additional primary care providers: SBH Health System hired a new adult primary care physician and one of Bronx United Independent Practice Association's practices (Dr. Emili) hired a Nurse Practitioner. SBH Health System has expanded walk-in availability, allowing daily walk-in patients throughout the day for each PCP; SBH Health System has also added two care transitions sessions per week, to give open access to patients after ED visits and Inpatient stays at the same time as improving access for primary care providers.

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

Given the national shortage of primary care practitioners (PCPs), recruitment of qualified PCPs remains a challenge for our primary care partners.

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?

We have not made any changes in our strategy. BPHC's long-term strategy still 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 providers.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:	
BPHC continues to provide Patient-Centered Medical Home transformation support to our community-based primary care providers (PCPs) through dedicated technical assistance (TA), spanning over 148 primary care sites (additional details can be found in the following section). We also arrange introductory meetings between community-based PCPs and the Bronx RHIO to engage these PCPs in RHIO connectivity and encounter notification systems deployment. In addition, we have invited community providers to participate in our planning and governance committees so that they may introduce their perspective on care delivery and help direct BPHC's performance improvement strategy. Finally we have also supported one of our leading IPA to explore incentive payment strategies to promote improved coordination practices. From July 2016 to present, Bronx United IPA incentivized their PCPs to participate in care conferences, to submit proxy performance metrics, and to participate in trainings on evidence based medical management of patients with chronic disease, all aimed at improving patient outcomes. This strategy is being expanded in DY3, with a pay-for- performance improvement program available to more community based primary care practitioners.	
Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	277

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:	554
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	337
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	29

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:

Bronx Partners for Healthy Communities (BPHC) has continued to support all eligible providers in pursuing PCMH 2014 Level 3 and Advanced Primary Care (APC). BPHC extended contracts with five technical assistance consultant (TA) groups to facilitate on site coaching and PCMH support and identified a preferred TA for APC support. During DY2, 14 sites were added to PCMH TA contracts and an APC pilot was launched with six sites. The plans BPHC made during DY2 for the support of 42 School Based Health Centers (SBHC) toward PCMH 2017, are currently under way with pilot programs at six sites. During DY2, at least 25 practices received PCMH 2014 Level 3 designation with 277 providers. Also, during this time period, BPHC has continued to explore ways to best incent and provide support to the remaining Montefiore Independent Practice Association (MIPA) providers and Bronx United Independent Practice Association (BUIPA) providers which account for the bulk of unresolved practices.

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:

There are three major challenges to working with providers to meet NCQA PCMH 2014 Level 3 or APC milestones:

1. Categorization of PCPs – SDOH identified a number of providers as PCPs which work as specialists or as PCPs but in settings which would not be able to pursue transformation (nursing homes, urgent care, PACE program, etc). Without those providers achieving PCMH or APC, BPHC will not be able to reach the required 100% participation for IDS.

2. APC Program Not Fully Developed – As of the end of DY2, APC had not been fully formed and ready to roll out. Commercial providers were not participating and the application/review process has not materialized. Many SDOH identified BPHC PCPs do not see Medicaid patients or have small Medicaid panels. These providers are waiting for APC. Without APC it is unlikely they will have the financial incentive to pursue practice transformation.

3. Small Practices Are Disadvantaged – Small practices are often disadvantaged in that they do not have adequate scale to pursue PCMH/APC. There isn't back office support, ability to understand, prioritize and react to changes in payment schemes, and a small enough Medicaid population where they are not as motivated to change. Even with full TA support, it is difficult for these practices to "pass the test," let alone achieve any measure of transformation.

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?

There is no strategic change. BPHC had about 80% of our eligible providers working toward or achieving PCMH 2014 Level 3 recognition as of March 31, 2017. Of the remaining providers, 75% are part of either Montefiore IPA or Bronx United IPA. These providers have loose governance structures and individually often do not see many Medicaid patients. For the IPAs, two contracts are being developed to offer additional financial support to make practice transformation more attractive for smaller independent practices and to create structure around that support. We also continue to look for ways to support advance primary care models. For example, we are supporting interconnectivity and providing analytics on the shared data, funding care coordinators and subsidizing care coordination management system platform. We are advocating and working with NCQA to broaden their eligibility requirements so that more provider settings can be considered for PCMH recognition. Specifically, we have supported members to work with NCQA to have School Based Health Centers (SBHCs) recognized as PCMH eligible sites. Due to this effort SBHCs are now eligible and BPHC is currently supporting TA activity at SBHC sites for two of our major provider organizations. In light of Advance Primary Care (APC) program being still in flux, we are exploring ways to support BPHC primary care practices towards PCMH 2017. We are also using positioning the resources made available for APC implementation to reinforce various advance primary care tenets such as referral management and empanelment.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
Collaborative planning at the individual provider and site level, between BPHC and individual members, was the critical component of our strategy which has led to our success. BPHC attributed all primary care providers (PCPs) to locations and organizations where they work. BPHC then worked with those organizations to determine each providers' eligibility to participate in practice transformation programs and the level of support each site would need to meet the requirements of the programs. At the same time, BPHC developed relationships and contracts with TAs with broad expertise and specialties to aid the organizations in transformations. Through a collaborative process, we were able to match TAs and organizations based on TA's expertise and needs of organization. By methodically approaching each provider and site with a flexible array of support packages we were able to help over 80% of our eligible PCPs toward practice transformation.

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:	170
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:	243

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	722

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:

During DY2, we implemented a shared care coordination management system, GSI Health and vetted multiple Referral Management Systems (RMSs). We have had multiple providers (primary, secondary, and tertiary) link to GSI Health and the Bronx RHIO. In an integrated delivery system (IDS), the primary care provider (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). GSI users include those that are primary care-based, hospital-based, behavioral health-based and community-based. Those same providers also are connected to the Bronx RHIO.

BPHC's strategy continues to emphasize 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. During this period BPHC launched our ED Care Triage Program at SBH Health System and Montefiore (five emergency departments) and those navigators are accountable for tracking referrals back to the PCP and ensuring patients are rescheduled and redirected as needed. During this time period, our seven largest primary care partners (accounting for 97% of our primary care footprint) embedded dedicated care coordinators, depression care managers and community health workers 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.

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 greatest challenge is the competing priorities that our primary care providers (PCPs) face: Many of our PPS partners are also part of other networks, each trying to figure out its place in various integrated delivery systems (IDSs): Each IDS may require use of its own platform(s), and the primary care partner must decide which integrated delivery systems to engage with as engaging with multiple platforms (care coordination platforms, referral management systems, reporting systems) may be both cost-prohibitive and operationally inefficient.

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?

There have been no strategic changes. We have engaged GSI Health as our care coordination management platform, but are creating a direct interface with the Bronx RHIO so that care plans developed in GSI will also be housed in the HIE. We are not requiring partners to use GSI, although we recommend it; we require only that they connect with and pass 21 data elements, including their care plans, into the Bronx RHIO. This requirement levels the playing field as all practitioners can gain access to the Bronx RHIO regardless of the other platforms they may use.

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:

A detailed review of our PPS primary care practices (PCPs) revealed that 99.6% of PCPs have implemented EHRs with vendors prepared to take those EHRs to MU Stage 2. We continue to explore solutions for the remaining 0.4% of PCPs who do not yet have EHRs with MU Stage 2 capability.

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):

Bronx RHIO is a QE and a member of the BPHC. There is also a large contract between the two organizations for Bronx RHIO's assistance connecting BPHC member organizations. BPHC prioritized our efforts on primary care providers (PCPs) and ranked them in terms of number of Medicaid patients. By the start of DY2, all seven of our largest PCPs (covering 97% of our primary care footprint) expanded or upgraded connections to the RHIO to include additional labs, care plans, and diagnosis. During DY2, we prioritized 1) expanding data sets and improving the quality of the data coming into the RHIO, 2) developing new reports and registries, and 3) implementing processes for the use of these reports. Additionally our Workforce Development group prepared trainings to help improve consent collection. The remaining PCPs are being targeted for engagement and HIE connectivity is a requirement of all PCPs in DY2 and moving forward.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	499

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	687, 94%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	427, 58%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	260, 35%

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:

To help PCPs in our PPS improve their readiness for VBP payment arrangements, BPHC adopted a strategy designed to 1) sustain PCMH operations and expand service capacity at the local practice level, and 2) develop centralized services through the BPHC Central Services Organization (CSO) for system development, network relations, interconnectivity, and analytics. This complement of strategies will position BPHC's PCPs to operate effectively in a VBP environment.

In DY2, with Manatt, a healthcare consultancy, BPHC analyzed the structures and capabilities of Montefiore ACO and the features of the VBP Innovator Pilot program that SBH and MMC are pursuing together. At the same time, the Executive Committee (EC) and Finance and Sustainability Subcommittee (FSC) undertook efforts to familiarize member organizations with the DSRIP requirements around VBP contracting. Manatt explored leveraging our partners' varied experiences and structures to prepare them for future VBP arrangements. Planners have formalized a number of options for BPHC organizations to implement VBP arrangements. BPHC completed the Financial Sustainability survey that further investigated PCPs' ability to participate in VBP, and BPHC planned a VBP three course training.

Discussions about performance-based contracting were held with the FSC as part of our DY3 Budget Planning discussion as well as with the EC. PCPs, among others, were invited to help BPHC close the three remaining months of the MY3 period with a strong performance. BPHC prioritized DSRIP measures in this short-term and offered a payment incentive for closing care gaps linked to those measures before the end of MY3. This "Sprint" was launched March 2017 after it was presented to and supported by the FSC and the EC. Results from the Sprint Program have helped inform the overall methodology for distributing performance funds to providers in our PPS during DY3/MY4. We are calling the longer-time frame for this performance-based distribution the "Marathon," a precursor to VBP contracts for risk and outcomes achieved.

In DY2, BPHC began to submit and review Equity Infrastructure Program (EIP) reports with our paired managed care organizations (MCOs) and reached out to MCOs' quality assurance leads to begin a process for reviewing BPHC performance on Equity Performance metrics. The review of these contracts helps create a mechanism for central PCP performance review of claims data and dissemination of these reports. This is a precursor to PCPs receiving feedback based on claims data and acting on it, as they will under VBP.

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

BPHC recognized that VBP readiness relies heavily on access to clinical and process data reflecting actual utilization of services by attributed patients. The challenge was to ensure that data was both more complete and more standardized so that we could generate more reliable performance reports. BPHC worked at identifying and addressing incomplete data and data gaps within the PPS HIE in several ways. BPHC continued to promote the BronxRHIO and in addition to helping primary care providers (PCPs) connect to the Bronx RHIO, BPHC also worked to connect behavioral health providers to the RHIO. In the Spring of 2017, BPHC launched a community behavioral health provider initiative which provided incentives and funding toward interconnectivity with the Bronx RHIO. To improve connectivity and consent rates, BPHC worked through contracts and its PCMH TAs to educate providers on the importance of standardizing the patient consent process and the BPHC CSO engaged focus on this issue by sharing consent rates with the BPHC IT Subcommittee and the Executive Committee. BPHC also worked with its QCIS Committee to identify a set of data elements that each of its connected partners would commit to push to the RHIO so that the PPS could begin to have more standardized data across participating providers.

Timely access to provider performance data has also been an issue. While State performance data is much delayed, BPHC analytics began to formulate performance report cards designed to reflect organizational, site specific and provider specific performance on DSRIP measures. The essential template of these report cards were developed through March, with a distribution date to providers planned for April and May once fuller MY2 data was received from the state and after presentation to the PAC which was planned for May 11. DSRIP measures. The essential template of these report cards were developed through March, with a distribution date to providers planned for April and May once fuller MY2 data was received from the state and after presentation to the PAC which was planned for May 11.

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?

None specifically during DY2.

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:

BPHC has been engaging its MCO partners directly through our reports to our paired MCOs in connection with EIP, and through regular meetings and relationship building with our paired MCO partners. We have been meeting regularly with a number of our partners and have started to discuss potential areas of collaboration. We also have been talking to the MCOs about data exchange with us, or directly with our partners in those instances where the MCO has concluded that it cannot share data with the PPS. Our goal is to ensure the seamless transition by our partners to MCO engagement and VPB contracting, building on the foundational exchanges that we are currently having with the MCOs.

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):
Our work to support provider performance in asthma management and diabetes management continues with contracts issued to Health People and a.i.r. NYC. These two community based organizations complement primary care services by providing peer supported self-management education classes to low literacy individuals in the community and home visits by community health workers to help families improve asthma self-management skills as well as connect families to home abatement services to help reduce asthma triggers in compromised home environment. In addition, BPHC also launched a Community Health Literacy Program and contracted with seven community based organizations to help educate individuals, who are homeless, precariously housed or left out of a system of care, how to navigate the health care system by helping them obtain insurance and connect with primary care providers and Health Home services. Finally, in the Spring of 2017, BPHC analytics began to formulate performance report cards designed to reflect organizational, site specific and provider specific performance on DSRIP measures. The essential template of these report cards were developed through March, with a distribution date to providers planned for April and May once fuller MY2 data was received from the state and after presentation to the PAC planned for May 11.

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: BPHC partnered with Manatt to evaluate options for PCPs to form an IPA or ACO.

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:

Our funds flow strategy laid out in the original version of the Primary Care Plan has been on schedule for implementing without much change or deviation. Priorities during DY2 still included: 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.

During the inception through March 31, 2017 (DY2Q4), BPHC has spent 36% of total funds distributed on the primary care support for the PPS, and 24% of DY2 funds flow. The primary care support is divided into two areas: a) primary care providers (PCPs) for which 29% was distributed, and b) PMO spending to support primary care for which 7% was spent. Through DY2, 29% PCP support included funds for DSRIP Program Directors (DPDs) and Ambulatory Implementation Funds for the major seven partners of the PPS – SBH Health System (SBH), Montefiore Medical Center (MMC), Acacia Network (Acacia), Morris Heights Health Center (MHHC), the Institute for Family Health (IFH), Union Community Health Center (UCHC), and Bronx United IPA (BUIPA). 15% went to Hospital-based Ambulatory Care (SBH and MMC). Another 12% was distributed to Federally Qualified Health Centers (FQHCs) that include Acacia, MHHC, IFH and UCHC. 2% was distributed to BUIPA's PCPs.

BPHC spent 7% from the PMO budget in DY2 for primary care support that includes PPS RHIO connectivity, information technology development of care models (GSI Health for care coordination management system), partners' PCMH support to achieve NCQA 2014 Level 3, and a community-based behavioral health initiative.

Below summarizes the narrative in a composite table (Spending through DY2Q4)

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$41,587,922	**100%**
Primary Care Provider	$11,693,951	29%
Hospital-Ambulatory Care	$6,008,564	15%
Federally Qualified Health Centers (FQHCs)	$4,850,988	12%
Primary Care Practitioners	$834,399	2%
PMO Spending to support Primary Care	$2,769,380	7%

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?
As mentioned in section a, we have deviated minimally from the original Primary Care Plan submitted to the State. Through the end of DY2Q4, we, along with all other PPSs, have focused much of our effort into the pay-for-reporting work as aligned with the State's priorities. Thus much of the effort went into implementing what we had set ourselves out on the trajectory as described in the original Primary Care Plan.

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):

In DY2 Bronx partners for Healthy Community (BPHC) partnered with Institute for Family Health (The Institute) to support adoption of the integrated models. Support to the 342 primary care providers (PCPs) across 96 practices consisted of needs assessments to identify gaps or challenges that needed to be addressed. A key area of focus was working with providers to implement new workflows, along with the staffing and technical changes that needed to occur. A great deal of time was spent with providers to make the needed EHR updates for population health management and for accurate reporting. In addition to intense support around improving workflows, assistance was also provided in updating and educating staff/leadership around new policies and procedures. Trainings were also delivered to educate staff on how to properly screen patients and talk to them about their screening outcome. EHR enhancements have been made at multiple partners to capture data for PHM including required fields for: PHQ2 screening with PHQ9 required if positive; screening for tobacco use and the 5As; identification of diabetics and alerts to order required tests such as A1C, podiatry exams, retinal exams; identification of asthmatics and triggers, severity, referrals to our home-based asthma program. Standardized fields can then be mined for reports and sent to the RHIO to enhance the centralized reports they create for the PPS. By the end of DY2, EHR updates were reported as completed and all partners were sending data into the RHIO, additionally each provider is actively tracking patients with depression in a registry. The depression registry, in use by all practices, captures screening scores and screening repetition, so staff can properly manage their patients with depression and provide "stepped care." The depression registry is a tool that practices are using for population health management. There are refinements that still need to be addressed in the RHIO data being shared and BPHC is actively working with providers on this.

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

The greatest challenge experienced in the prior year was related to logistics around staff capacity to engage a large number of sites. Additionally, the sites' ability to engage in training or TA that will facilitate adoption of PCBH. The requests for trainings were very broad and difficult to coordinate with trainers and schedule. The need to address individual challenges experienced by the sites across organizations necessitated more staff time and content expertise. Many sites struggled with nuanced workflow-related issues that were best addressed through tailored support with the sites.

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

Many of our sites are FQHC's and are not eligible for some of the waivers for this project. The greatest challenge experienced was the ability to bill for two services on the same day by co-located practices, as the PCBH requires the warm hand off and a brief visit with the co-located provider (whether BH or PC). Guidance around this issue has been multi-layered and confusing. Only one organization submitted follow up information to obtain the waiver for increased rates for second service provided on the same day, which was a confusing process as well. Apart from being able to bill for services provided on the same day, the main challenge observed as it relates to regulatory aspects of PCBH implementation relates to the value of submitting waivers (if they will be reversed after DSRIP), the eligibility to apply and receive certain waivers, and confusion with the processes related to waivers.

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?

In DY2 the Central Service Organization (CSO) established a newly structured contract with Institute for Family Health (IFH), with whom BPHC previously partnered to provide trainings and technical assistance around implementation. In this new contract the types of training to be made available were refined to hone in on key aspects of implementation that were identified for BPHC's partners. These include: Co-location and collaborative care implementation (for newly on-boarded sites); psychopharmacology; Problem Solving Treatment; Behavioral Activation; and Assessing and Managing Suicide Risk. Additionally, the agreement was structured to include regular assessments on implementation utilizing the Integrated Practice Assessment Tool (IPAT); The IPAT was developed by researches with the SAMHSA-HRSA Center for Integrated Health Solutions. Participants are also engaged through regular (monthly) coaching sessions for each organization and their respective sites. To date, 66 out of 96 PC/BH sites have completed their first assessment. Coaching focuses on critical implementation challenges such as: collaborative care enrollment; demonstrating co-location; screenings (PHQ, SBIRT, GAD-7, DAST); EHR optimization; population health management tools and practices; implementing suicide and safety protocols and procedures; and developing sustainability plans. The IPAT assessment and coaching inform the development of continuous quality improvement (CQI) activities that are being developed in collaboration with Institute for Family Health (IFH), BPHC, and the participating organizations. This approach allows for the CSO to look at indicators of the quality of integration model implementation, while also being responsive to the technical assistance needs of sites.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	61	12	49
Model 2	13	7	6
Model 3 IMPACT	51	36	15

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): DAST, 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