



Bronx Health Access PPS

Primary Care Plan

August 2016

Overview

During the February 2015 DSRIP Project Approval and Oversight Panel (PAOP) meeting, the Panel voted to require each PPS to submit a Primary Care Plan (PC Plan).

The PC Plan will address:

- Current status of primary care capacity
- Plans for reaching primary care-specific project milestones
- Progress toward primary care goals addressing areas of access, capacity, and quality

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Primary Care Plans will be an annual submission to DOH. Each PPS will submit the first iteration of Primary Care Plans, consistent with project narrative formatting, by **August 31, 2016** for review within the Midpoint Assessment,

The PPS Primary Care Plan will address each of the following six “fundamentals” and will be submitted by the PPSs as a narrative component of the Demonstration Year Quarter 1 (DY2 Q1) reporting by each PPS with the delivery of project narratives for Midpoint Assessment within DY2 Q1 reporting.

1. Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs
2. How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?
3. What is the PPS’s strategy for how primary care will play a central role in an integrated delivery system?
4. What is the PPS’s strategy to enable primary care to participate effectively in value-based payments?
5. How does your PPS’s funds flow support your Primary Care strategies?
6. How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?

The Bronx Health Access PMO completed the Primary Care Plan in August 2016. The plan was developed with support from One River Grants and based on the following inputs:

- Partner interviews across project workgroups and with PMO leadership
- Data collection and analysis of primary care demand and capacity across the PPS
- Review and revision of drafts with partners representing Governance, including the Steering Committee, PCMH workgroup, and Clinical & Quality Committee

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

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The Bronx Health Access PPS delivers comprehensive, integrated, and culturally competent primary care services to patients with complex medical, behavioral health, and social needs. Through delivery system transformation and the implementation of 10 DSRIP projects, the primary PPS goal is to create a network of care that improves access, quality, and efficiency for the safety net population in the South Bronx. Four objectives directly support the provision of primary care services to PPS patients: 1) To create a highly efficient Integrated Delivery System in collaboration with providers, across the care continuum, using information technology (IT) interoperability and care coordination to improve the beneficiary's experience and outcomes; 2) To develop integrated value-based contracts and payment that brings all providers closer to the premium dollar; 3) To retrain and redeploy the health care workforce to provide services and supports that improve outcomes; and 4) To create and implement multidisciplinary approaches to care that address issues identified in the CNA. These objectives will be addressed in the six Primary Care Plan narratives included as part of the Mid-Point Assessment.

A review of current primary care capacity shows that the PPS network includes 461 general primary care providers (practitioners) including: general internal medicine, family medicine, and pediatric physicians; nurses; nurse practitioners; and physician assistants. The total PPS attributed population is 133,117 Medicaid members. In addition to the attributed population, another 126,883 patients are considered low-/non-utilizers (with less than two primary care visits per year). Although some Bronx Health Access providers participate in more than one PPS, based on this data, the PPS has a sufficient number of primary care providers to manage the attributed and low-/non-utilizer patient population (with a panel size ranging from 563-700 Medicaid patients per primary care provider).

Despite this positive DSRIP-based primary care capacity assessment, 20% of Bronx residents reported not having a regular primary care provider in the DSRIP comprehensive Community Needs Assessment (CNA). Moreover, several PPS communities are HRSA designated Health Professional Shortage Areas (HPSAs) for primary care services—with 3,500 or more residents per primary care physician—defining an area as high need for primary care services.^{1,2} Several PPS communities are also HRSA designated Medically Underserved Areas (MUAs) as defined by the: ratio of primary care physicians per 1,000 population in local communities, infant mortality rate (higher in the Bronx 5.6 per 1,000 live births, than in NYS, 5.0 per 1,000 live

¹ HRSA Data Warehouse. <http://datawarehouse.hrsa.gov/tools/analyzers/geo/ShortageArea.aspx>.

² HRSA Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations. <http://www.hrsa.gov/shortage/>.

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

births), proportion of residents living in poverty (higher in the Bronx 28.1%, than in NYS, 12.2%)^{3,4}, and the population age distribution.³ The population is burdened by myriad health challenges and socioeconomic circumstances that foster poorer health outcomes than in other NYS regions. Based on health risk factors and health outcomes, the borough ranks last among NYS's 62 counties. It is the least healthy county in the State, and has significantly higher rates of chronic disease for diabetes, cardiovascular and respiratory diseases, cancer, and higher rates of obesity.

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In addition to the public health challenges identified, the DSRIP CNA revealed many personal barriers which impede patient access to timely primary care services including: long wait times for primary care appointments, financial hardship incurred from missed work to accommodate multiple appointments (at different locations), lack of care coordination across care settings for patients with complex care needs, long travel times to appointments via local transportation, and limited provider evening and weekend appointment availability. Vast sociocultural barriers to care are prevalent among the predominantly minority, foreign-born, and low-income population—language barriers (24 different languages are spoken in homes across the Bronx), low health literacy among residents (30% of residents on Medicaid and living below the Federal Poverty Level scored "Below Basic" on a health literacy survey), and inability to follow provider's instructions. These barriers often lead to low patient engagement and difficulties forging continuous relationships with primary care providers.

In order to mitigate the access to primary care barriers identified, more community-based, ambulatory primary care sites with non-traditional hours (extended evening and weekend operation) are needed. CNA results demonstrated that Medicaid beneficiaries are not always able to easily access the services they need in their local communities. While the PPS includes many primary care providers, there are geographic areas where community services and resources are lacking (e.g., Mott Haven). Increasing the number of community-based primary care sites in and around the neighborhoods where residents live would provide more equitable access to services across a wider geography. In addition, this expansion will mitigate the overutilization of hospitalizations and ED services for patients needing preventive care.

The PPS is developing strategic solutions to enable all participating primary care providers (community- and institution-based) to make substantive enhancements in service delivery to

³ HRSA Medically Underserved Areas/Populations. <http://www.hrsa.gov/shortage/mua/index.html>.

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

5 address the barriers that patients routinely experience. After a rigorous vetting process, Insight Management was chosen as the vendor to support PPS partners in achieving PCMH Level 3 Certification and EHR Meaningful Use standards by the end of Demonstration Year 3. Insight has more than 25 years of experience working with practices towards transformation and their staff are recognized as PCMH Certified Content Experts. Over the past year, Insight has organized more than 150 provider practices into four waves for strategic implementation. Baseline assessment results from the first wave of providers surveyed revealed high support would be needed by: 53% to improve access (PCMH Standard 1), 38% to improve team-based care (PCMH Standard 2), 52% to improve population health management (PCMH Standard 3), 52% to improve care management and support (PCMH Standard 4), 53% to improve care coordination and care transitions (PCMH Standard 5), and 42% to improve performance measurement and QI (PCMH Standard 6). Insight works with each practice to define priorities, write protocols, implement standards, and train staff. All protocols developed are focused on PCMH standards that improve and maximize efficiency of existing primary care resources. This focus allows for enhanced access to care through scheduling improvements, integrated care coordination, and most importantly, using IT to allow patients to access providers.

The PPS will achieve an interactive health information exchange (HIE) and integrated network by building upon existing technology in the Bronx as a primary means to achieve an improved care delivery system. To achieve the goal of an integrated clinical network, Bronx Health Access has engaged the Bronx RHIO as the primary HIE for all participating partner organizations. To achieve this deliverable, the PPS tasked the IT Committee with completing a baseline IT infrastructure and data sharing capabilities survey. The IT Committee has specifically targeted community-based primary care, as well as, other providers in this survey, and has worked with the RHIO to engage providers not yet participating in HIE. The necessary data exchange agreements, between partners and the RHIO, were developed and disseminated early in the project. More recently the IT committee has focused HIE deployment on the most critical partners, assisting in aggregating data for reporting actively engaged patients and providing technical support for reporting capabilities. The RHIO has already provided valuable integrated network capabilities. The IT deployment will utilize a three-phased iterative approach to achieve HIE that will evolve as projects are implemented over time. The deployment will provide the infrastructure, analytics, and tools to maintain future primary care advances implemented through PCMH enhancements.

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

Capital Restructuring Financing Program (CRFP) funds will be utilized to increase the number of primary care locations in the PPS. Nine new sites have been identified: an integrated primary care and behavioral health clinic, a walk-in primary care center, a diabetes retinopathy center, a walk-in behavioral health center, a health and wellness auditorium, and eight new exam rooms across four sites. The increased availability of primary care services (including expanding locations of care, reducing appointment waiting lists, increasing operating hours, and providing increased alternatives to ED care) will improve the quantity and distribution of primary care resources at community-based sites in the South Bronx. The proposed expansions will reduce avoidable ED visits and hospitalizations.

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In spite of the challenging populations of the South Bronx and the high ambulatory sensitive index in various PPS communities, the PPS is currently able to meet the demands for attributed, as well as, low-/non-utilizing patients. As outlined above, several strategies will be implemented to expand access to and the distribution of primary care services. As progress is made towards DSRIP goals and more visits move from the ED to primary care sites, the PPS will need to reassess current strategies to greatly expand primary care capacity. The PPS is committed to health system transformation, and the delivery of high quality primary care services, in alignment with the Triple Aim: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

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

The PPS will utilize a strong training and technical assistance strategy to expand primary care capacity and ensure transformations to primary care practice and the workforce. The PPS Workforce Committee, under the leadership of Selena Griffin-Mahon, Bronx-Lebanon Hospital Center, Assistant Vice President, Human Resources, will lead the PPS-wide implementation of training and technical assistance strategies (aligned to the PPS overarching goal *to create a network of care that improves access, quality, and efficiency for patients*; and *Objective 3, to retrain and redeploy the health care workforce to provide services and supports that improve outcomes*).

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The Workforce Committee has successfully implemented staff training plans and strategies, with support from lead vendor, the 1199 SEIU Training Education Fund, through the Bronx Healthcare Learning Collaborative. The Collaborative is an innovative multisector partnership between several PPSs; unions (1199 SEIU Training and Employment Funds and 1199 SEIU Healthcare Workers East-the Union); colleges (Lehman College, Hostos Community College, and Bronx Community College); the New York City workforce system; hospitals; nursing homes; home care agencies; and clinics. Several training initiatives for primary care providers have already been implemented including a popular, free course, *Spanish classes for Healthcare Workers*. Both primary care providers (e.g., community- and institution-based physicians, nurses, nurse practitioners, and physician assistants) and allied staff (e.g., patient care technicians and social workers) have attended this course. The two-hour course presents a curriculum that develops conversational Spanish-language skills enabling providers and staff to better communicate with patients and their families. With support from the PPS Cultural Competency and Health Literacy Workgroup (led by Diane Strom, Administrator, Pediatrics Department, Bronx-Lebanon Hospital; and Shali Sharma, Program Director, Bronx Works), these and other trainings will continue under a PPS-wide Health Literacy and Cultural Competency standard. The standard will govern the appropriate interaction and care of patients from different race/ethnicity, cultural, language, age, disability, immigration, and sexual orientation groups.

Consistent with DSRIP goals to ensure practice and workforce transformation, other trainings and technical assistance programs available through the 1199 SEIU Training Education Fund, targeted to primary care providers and front-line staff, will be utilized including:

- The Institute for Continuing Education which provides onsite, live video cast, live webcast, and in-person prep courses for technical and professional health care workers

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

seeking accredited continuing education, and preparation for licensing and certification exams.

- Skills Training courses to teach health care workers how to utilize information technology in health care settings.
- Training for RNs to enable current and newly employed RNs to upgrade their nursing skills and ensure they are working at the top of their licensure as part of a care team.

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To expand the primary care workforce, innovative training initiatives will be offered to create a path to certification, for paraprofessionals and staff with their GED (e.g., social workers, substance abuse counselors, medical assistants, patient care technicians, care coordinators, peer educators, and others). The 1199 SEIU Training Education Fund offers:

- The Colloquium Series, a one-year bridge to college developed to help Spanish-speaking health care workers pass the City University of New York (CUNY) entrance exam.
- Patient Care Technician (PCT) Training Program to recruit Spanish-speaking workers to enroll in PCT certificate training programs (i.e., certified nursing assistant, phlebotomy, EKG) with job placement in Bronx-based health care facilities.
- Integrating Basic Education and Skills Training Program (I-BEST), a training model that helps bilingual workers learn job skills and improve their English reading, writing, and mathematics proficiencies.
- Care Coordination and Patient-Centered Care, a program that uses two curricula to support new models in health care delivery, such as increased focus on preventive care, care coordination, and the provision of patient-centered care.
- Access to College, a coalition of the three Bronx CUNY schools, health care employers, the Union, and the Training and Employment Funds focuses on improving college access and reducing time to degree completion for adults seeking college degrees in an allied health profession.

The PPS PCMH Committee is actively working with primary care providers, at the practice level, to successfully achieve 2014 Level 3 PCMH recognition and EHR Meaningful Use standards by the end of Demonstration Year 3. Insight Management is the chosen vendor to engage participating community- and institution-based providers. As the chosen vendor, Insight is providing practice transformation support and technical assistance to providers across the six PCMH standard categories: *Standard 1: Access*, *Standard 2: Team-based Care*, *Standard 3:*

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

Population Health Management, *Standard 4: Care Management and Support*, *Standard 5: Care Coordination and Care Transitions*, and *Standard 6: Performance Measurement and QI* (with training oversight by the PPS Clinical Quality Committee). Insight has organized the PPS network of 461 providers into four waves for strategic implementation. The Stakeholder Engagement Workgroup is actively supporting these efforts to facilitate provider communication with the vendor, and to provide additional technical support.

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The PPS IT Committee, with primary support from the Bronx RHIO, is working to achieve PPS-wide health information exchange (HIE) and health information management (HIM) capabilities. An example of the positive impacts achieved through HIE enhancements is evidenced by the gains made at Urban Health Plan, a key PPS partner. Urban Health Plan is a federally qualified community health center now in its 40th year of providing comprehensive and affordable primary and specialty health care services to the Hunts Point, Mott Haven, and Morrisania communities of the Bronx. With 108 medical providers, Urban Health Plan served 75,000 unique patients across 25 sites in 2015. With PPS funding and training, Urban Health Plan is now participating in the Bronx RHIO, with secure access and sharing capabilities for all patient encounter and vital medical information, and in particular, HIE with Bronx-Lebanon Health Center. Through the timely access and sharing of patient health information, primary care providers (e.g., physicians, nurses, and physician assistants) at both sites can implement more informed clinical decision making using standardized patient data, prevent medication and diagnostic errors, remedy duplicate test orders, improve diagnoses and treatment planning, and support coordinated care. The PPS IT capability enhancements are currently focused on the most critical partners to meet DSRIP project goals first. Utilizing a three-phased iterative approach to achieve HIE and HIM, the deployment will evolve as projects are implemented over time to include an accepted process for HIM. This will ensure continuity of managed care primary care provider assignment through technical assistance and training for end users.

The PPS is using the monthly newsletter and email broadcasts to notify participating partners and providers about existing NYS resources for technical assistance. Opportunities for training and education are posted for wide distribution to interested partners and providers. Additionally, the Stakeholder Engagement Workgroup has completed the redevelopment of the PPS web site, for launch at the end of the summer (2016). The newly developed web site will serve as an interactive, one-stop shop featuring upcoming trainings and announcements regarding technical assistance resources.

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

The PPS will ensure that primary care is a key driver in the formation and sustainability of an integrated delivery system by embedding primary care into the foundation of all health care delivery services, across all DSRIP projects. This structure will be supported by four critical success factors: 1) strengthening the primary care continuum through linkages to secondary and tertiary services; 2) implementation of the PPS Clearinghouse; 3) primary care provider representation on all PPS committees and workgroups; and 4) PCMH integration as a standing Clinical Quality (CQ) Committee priority. These critical success factors are directly aligned to the PPS primary goal and its supporting objectives (*Objective 1: To create a highly efficient integrated delivery system in collaboration with providers across the care continuum using IT interoperability and care coordination to improve the beneficiary's experience and outcomes; and Objective 4: To create and implement multidisciplinary approaches to care that address issues identified in the CNA*).

First, the PPS will strengthen the primary care continuum by ensuring necessary linkages to secondary and tertiary services through the implementation of three DSRIP projects: 1) 2.a.iii Health Home At-Risk Intervention Program: Proactive Management of Higher Risk Patients Not Currently Eligible for Health Homes through Access to High Quality Primary Care and Support Services; 2) 2.b.i Ambulatory ICUs; and 3) 2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions. Projects 2.a.iii and 2.b.i align with the mandate to improve vertical care integration—directly linking patients to needed clinical, specialty, mental and behavioral health, and social services to meet all of their complex care needs using a coordinated approach, eliminating service fragmentation. Through Project 2.b.iv, the Care Transitions team will ensure that patients are linked back to their primary care provider (as documented in the EHR, with real-time updates from the Bronx RHIO, to ensure continuity of care), and the provision of needed secondary and/or tertiary services.

Secondly, the PPS Clearinghouse initiative provides one centralized point of contact for all PPS providers to determine if a patient already has a care coordinator, and if they are in a health home, as well as, staff deployment to re-engage appropriate patients to their primary care provider. Based on lessons learned through the Bronx Health Home, the PPS is harnessing the power of the Clearinghouse (IT analytics from the Bronx RHIO) in order to:

- Provide secure message alerts to providers, community health workers, care coordinators, and social workers in real-time when a patient is admitted to the hospital
- Deploy staff to engage patients at the point of care (i.e., inpatient unit, ED)

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

- Provide a LACE (Length of stay, Acuity of Admission, Comorbidities, and Emergency Department visits) score that risk stratifies patients into low-, high-, and super-utilizer groups
- Show insurance coverage status, Medicaid eligibility, Health Home assignment, acuity scores, and flags for high-risk social conditions (e.g., homelessness)
- Provide a demographic and clinical care patient snapshot showing missing services (e.g., recent HbA1c or eye exams for patients with diabetes) which are linked to PPS clinical quality metrics

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Through the Clearinghouse, accountability reports will be generated to ensure that necessary follow-up occurs with the patient's documented, preferred primary care provider within 30 days. The unparalleled capabilities afforded by the Clearinghouse will enable multidisciplinary care teams to develop actionable plans to accomplish DSRIP goals. Further, the PPS seeks to better manage gaps in services by merging the Clearinghouse capabilities with data received from managed care organizations (MCOs). In this way, prospective identification of patients (by individual client identification number, CIN) will help to determine gaps in services and if these services have actually occurred. Missing data will be resubmitted back to the MCO for reconciliation via a pseudo-claim. The PPS will also be in a better position to achieve improvements through value-based payment reforms as the Clearinghouse capabilities are scalable and will expand with PPS expansion. With PPS growth, the Clearinghouse will continue to provide significant and actionable information that will make other determinations quite evident, such as: staffing ratio projections, and the outreach mechanisms needed to maintain actively engaged patient targets.

Thirdly, primary care providers are among the key representatives on all PPS committees and cross-functional work groups. The Steering Committee oversees the execution of all PPS operations and PPS-wide strategic decision making. The Steering Committee consists of three primary care providers, in addition to key stakeholders representing community-based organizations; FQHCs; substance abuse, home care, housing, and mental health organizations (Comunilife, Urban Health Plan, VNS of NY, 1199 SEIU, Hudson Heights IPA, Mount Sinai Hospital System, and Dominican Sisters Family Health Services). Each Governance committee (Finance, CQ, IT, Workforce, and Compliance), and the Cross-functional Workgroups (PCMH, Care Coordination, Stakeholder Engagement, and Cultural Competency and Health Literacy)

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

also have primary care providers as standing members. This ensures that the voice of the primary care provider is always heard, solicited, and incorporated into PPS activities.

Fourthly, the CQ Committee, led by John Coffey, MD, Bronx-Lebanon Hospital Center, Emergency Department Director, was developed to oversee the implementation of all DSRIP projects. While the PCMH and Stakeholder Engagement Cross-functional Workgroups continue to facilitate practice transformation through the chosen vendor to engage participating providers, the CQ Committee supports primary care transformation by reviewing PPS-wide performance measures and identifying action steps to achieve them. The Committee convenes bi-monthly Workgroup meetings, with committee leads, workgroup leads, and project managers in attendance. During these meetings, attendees review project accomplishments, challenges, and discuss the evidence-based models being implemented to achieve performance outcomes. This forum also serves as an opportunity to escalate concerns and share lessons learned. An area of regular focus and discussion is the achievement of 2014 Level 3 PCMH recognition by the end of DSRIP Demonstration Year 3. Improved care coordination and patient access are performance measures that impact project quality, and therefore, should be addressed through the achievement of PCMH Level 3 accreditation. The CQ Committee regularly reviews available data around this and other metrics in order to identify improvement strategies that can be implemented by all partners.

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

The future of value-based payment (VBP) reform will be sustained by primary care providers utilizing population-based health strategies to improve health outcomes for high-risk, high-need, and high-utilizing PPS patients (*Objective 2: To develop integrated value-based contracts and payment that bring all providers closer to the premium dollar, and Objective 4: To create and implement multidisciplinary approaches to care that address issues identified in the CNA*).

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In this new VBP patient-centered environment, primary care providers are critical to the success of DSRIP interventions as they provide the direction and oversight for care teams deployed to work at the top of their licensure and provide services that enable patients to meet desired health outcomes. The key to this success lies in the successful engagement of PPS providers. Successful engagement has two components: 1) revenue opportunity, and 2) opportunity for practice transformation and integrated care coordination. Revenue opportunity primarily comes from incentivizing participation in the PPS through DSRIP provider incentive payments, as well as, shared savings arrangements negotiated with managed care organizations as part of the requirement to achieve PPS-wide shared savings arrangements over time. As the lead PPS entity, Bronx-Lebanon Hospital Center (BLHC) builds upon the existing relationship with Healthfirst, a full risk arrangement in which Urban Health Plan is a participant. For employed BLHC primary care physicians, a reimbursement methodology for provider engagement in care coordination, VBP outcomes, and improved managed care performance has been developed and implemented. Successfully achieving desired VBP outcomes requires integrated care teams consisting of multidisciplinary staff—patient navigators, community health workers, licensed clinical social workers, behavioral health staff, and credentialed alcohol and substance abuse counselors—managing patients with multiple comorbidities (e.g., medical, behavioral, and mental health) and reducing their barriers to care (e.g., un-/under-insured). Allied health workers and patient navigators will support patients' receipt of preventive care and treatment, such as cancer screenings. Provider schedules will have openings to support patients with complex care needs and walk-in patients. Group therapy rooms will be equipped with telemedicine capacity to increase access to specialty behavioral and mental health services. These transformative practice and staffing innovations will improve PPS patient outcomes, and assist providers in receiving their DSRIP incentive payments. To achieve these desired practice improvements training and implementation assistance is a key component to ensure adequate primary care engagement.

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

The Finance Committee, led by Victor DeMarco, BLHC, Senior Vice President and Chief Financial Officer, has developed and approved policies and procedures for the flow of funds to allocate provider incentive payments. The funds flow methodology was developed with support from KPMG and input by the PPS Executive Team, Board, Finance Committee (with representatives from more than 15 community-based organizations), as well as, DSRIP project leaders and team members (including physicians in internal medicine, primary care and preventive medicine, pediatrics, and specialty care). The methodology developed reflects the broad involvement of the provider network, specifically primary care providers (comprising 45% of all PPS providers), in the funds flow planning process. In particular, primary care providers are integral to the formulaic determination of DSRIP project revenue allocated to PPS organizations based on specific primary care contribution and performance factors—measures largely supported by improvements in patient clinical care outcomes and HEDIS measures. Thus, all negotiated arrangements for sustainable VBP reforms begin with primary care providers to guide the flow and distribution of funds. The goal is to mirror the incentive programs developed for the PPS in all community-based provider practices over time.

Primary care provider performance will be directly supported by the innovations of the PPS Clearinghouse—the technological infrastructure, with IT analytics from the Bronx RHIO, enabling health information exchange (HIE) and health information management (HIM) capabilities (as described in Fundamental # 3). Routine accountability reporting generated ensures that the necessary follow-up occurs with the patient's documented, preferred primary care provider within 30 days; maintains provider continuity; increases the number of patients linked to and retained in primary care following an ED visit or hospitalization; increases the receipt of preventive care and screening; and decreases avoidable ED visits and hospitalizations. The long-term VBP vision will be supported by health information technology advances with electronic HIE, HIM, and real-time data analytics.

In this new VBP system, the requisite training for primary care providers is needed to manage key issues. The Workforce Committee, with the PCMH and Stakeholder Engagement Cross-functional Workgroups will provide significant support to maintain primary care provider participation in the new VBP system. The Workforce Committee will respond to training competency needs identified through PPS partner surveys. Anticipated training needs for primary care providers surround three essential themes:

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

- 1. Providing high quality team-based clinical care:** Implementing evidence-based models of care; technical assistance for HIE between providers, hospitals, and EDs; improved care coordination, care transitions, and care management for high-risk patients; protocols for reporting; and strategies for improving quality metrics.
- 2. Ensuring provider financial sustainability:** Improving cost efficiencies of operations; understanding potential gains from performance achievements, provider incentive payments, and base reimbursement; understanding the alignment of payment policies with quality goals and metrics; implementing reforms to monitor productivity; managing patient health care utilization, risk stratification, and costs; effectively working with managed care organizations; coding of services; determining clinical capacity and managing patient panel sizes; and protocols for accountability reporting to maintain transparent operational practices.
- 3. Meeting changing workforce/staffing needs:** Efficient, integrated multidisciplinary care teams; health information technology, data management, and data analysis; increased capacity; expanded hours; telemedicine and e-consults; patient engagement strategies; and demonstrated cultural competency to serve diverse patient groups.

The PCMH and Stakeholder Engagement Cross-functional Workgroups will continue to facilitate practice transformation through the achievement of 2014 Level 3 PCMH recognition by the end of Demonstration Year 3. Insight Management, the chosen vendor, will continue to engage participating providers. Data from the first two of four stratified provider waves shows that most providers will require medium to high support to improve three PCMH standards directly affecting care delivery:

- **PCMH Standard 3 – Population Health Management:** Patient information is in searchable fields; clinical data supported by EMR reporting; utilizes a consistent comprehensive health assessment template; population management reminders are executed in an organized manner at least yearly for chronic and preventative care services; and CDS rules are activated including BH or substance use disorder.
- **PCMH Standard 5 – Care Coordination and Care Transitions:** Test and imaging tracking and notification of results to providers and patients; referral tracking and referral

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

agreements; and processes for care transition notification, information sharing, and patient follow up.

- **PCMH Standard 6 – Performance Measurement and QI:** Measures clinical quality performance on preventative and chronic care annually with stratification for vulnerable groups; measures data for care coordination and utilization; measures patient and family experience; ongoing QI for clinical, care coordination, and experience with actions for improvement; measures effectiveness of CQI with achievement; has a process for sharing QI data; and has a process and access to HIE.

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Practice improvements achieved through these and other PCMH standard elements will: ensure the provision of high quality primary care, improve patient clinical care outcomes on HEDIS measures, strongly impact provider performance factors, and ultimately increase providers' ability to participate in VBP. To ensure that all providers have equitable access to resources, technical assistance, and primary care transformation resources, the Stakeholder Engagement Workgroup will continue to provide education to practices and key stakeholders. Education will focus on increasing provider and stakeholder understanding of health care transformation and how the PPS can provide supportive resources during their transition.

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

The principal PPS goal is to create a network of care that improves access, quality, and efficiency for the safety net population in the South Bronx. The Finance Committee, led by Victor DeMarco, Bronx-Lebanon Hospital Center, Senior Vice President and Chief Financial Officer, in strong collaboration with KPMG, the PPS Executive Team, Board, and DSRIP project leaders, developed a funds flow methodology aligned to the PPS Primary Care strategies.

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In the PPS, primary care is delivered in a comprehensive, integrated, and culturally competent manner with evidence-based population-management approaches as the cornerstone of care strategies utilized. Approaches to patient care are routinely evaluated and optimized through continuous quality improvement methods to ensure that services meet patient's medical, socio-economic, socio-cultural, and psychosocial needs; reduce barriers; and improve clinical care outcomes. This is accomplished by several key elements:

- Integrated and comprehensive primary and preventive services provided at the same clinical site (with multidisciplinary teams of primary, behavioral and mental health, and specialty care providers, supported by pharmacists, social workers, care coordinators, patient educators, and community health workers)
- Culturally competent and racially/ethnically diverse providers and care teams
- Locations that are community-based and accessible to major public transportation routes
- Access to care supported by open access scheduling and non-traditional hours to accommodate patient appointments
- Patient Centered Medical Home (PCMH) recognition at PPS sites
- Health information technology advances, meeting Meaningful Use standards, supporting electronic health information sharing and monitoring, with real-time data analytics
- Targeted services and programs to address the high prevalence of chronic disease, substance abuse, and mental illness in the service area
- Referrals to a strong, local network of social service partner agencies, such as patient advocacy, housing, legal, immigration, food assistance, and domestic violence services
- Training to support providers practicing at the highest level of their licensure
- Value-driven reimbursement to incentivize improved health outcomes, quality, and cost accountability

The Finance Committee has developed and approved policies and procedures for the flow of funds to allocate provider incentive payments. The funds flow methodology was developed with

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

broad input from the provider network. All negotiated arrangements for sustainable value-based payment (VBP) reforms begin with primary care providers and it is anticipated that these reforms will be mirrored in all PPS community-based provider practices over time. The funds flow methodology is flexible and will lend itself to needed revisions as project implementation progresses.

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The funds flow methodology guides the distribution of funds applied to PPS costs first (including reserves needed and project implementation costs), as well as the distribution of bonus payments to providers. It is anticipated that payments will be distributed twice yearly within 60 days of the receipt of PPS payments from the NYS DOH. The methodology determines the amount available for provider distribution by:

1. Calculating available funds to provider categories or types (e.g., primary care provider, non-primary care provider, etc.)
2. This determined amount is the “contribution percentage”
3. Each provider type is grouped into a “pool”
4. Funds are distributed to the individual provider or contracting entity based upon a “distribution factor” agreed upon by each project workgroup
5. Individual provider performance is defined by specific requirements set forth in the individual provider’s contract. (Providers who do not meet the PPS performance factors outlined in their contracts will not be incentivized. Policies and procedures are in place to support providers seeking to enhance their performance.)
6. Adjustments to the final “performance factor” are calculated, based on achievement towards project metrics, to determine the provider’s eligible payment
7. Each participating contracting entity will receive a minimum payment amount to acknowledge their project participation, as part of Project 2.a.i

The funds flow methodology is directly aligned to the primary care strategies implemented to support evidence-based population-management approaches.

1. **Project Implementation.** The Finance Committee is supporting the implementation of 10 DSRIP projects (totaling more than \$6M in DY2 budget requests). Through project implementation, integrated and comprehensive primary and preventive services will be provided by culturally competent, multidisciplinary teams, at community-based and

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

accessible locations. Domain 2 and 3 (with public health-driven Domain 4) projects specifically will deliver targeted primary care services to address the high prevalence of medical, mental health, and substance abuse disorders in the service area, supported by a strong, local referral network of social service partner agencies.

- 2. PCMH Enhancements.** The PCMH Committee DY2 budget of \$368,333 has been fully met. The Finance Committee has recognized this need and is supporting PPS partners (both community- and institution-based) in achieving PCMH Level 3 Certification and EHR Meaningful Use standards by the end of Demonstration Year 3. The chosen vendor, Insight Management, has more than 25 years of experience working with practices towards transformation and their staff are recognized as PCMH Certified Content Experts. Over the past year, Insight has organized more than 150 provider practices into four waves for strategic implementation. PCMH recognition will directly lead to substantive enhancements in service delivery to remediate barriers to care patients commonly experience through scheduling improvements, integrated care coordination, and ready access to providers.

- 3. IT Enhancements.** The DY2 budget request of \$1.4M has been fully met to support the initiatives developed by the IT Committee. To create an interactive health information exchange (HIE) and integrated network, the Bronx RHIO is the PPS's primary vendor. The necessary data exchange agreements, between partners and the RHIO, were developed and disseminated early on, and the RHIO has already provided valuable integrated network capabilities for critical PPS partners. To speed the HIE enhancements underway, the Finance Committee has discussed providing the upfront expenses to providers and/or practices to support the acquisition of new EHR equipment, software, and licenses in conformance with Meaningful Use standards. Any providers and/or practices supported would reimburse these costs once the PCMH recognition is achieved. Additionally, through investments in the Clearinghouse initiative, the PPS has one centralized point of contact for all PPS providers to determine: if a patient already has a care coordinator, if the patient is in a health home, risk stratification according to utilization patterns, missing clinical services, and staff deployment at the point of care to re-engage appropriate patients with their primary care provider. These enhancements will provide the data sharing and monitoring infrastructure, real-time data

analytics, and tools to maintain future primary care advances implemented through PCMH enhancements.

- 4. Training.** Over and above the training and technical assistance provided by Insight Management (through PCMH activities), the PPS is directly funding training initiatives through the Workforce Committee. The full DY2 budget request of \$3.5M has been met to support providers practicing at the highest level of their licensure, to ensure practice and workforce transformation through skills training for current and newly licensed providers, and through innovative training initiatives to expand the health care workforce for paraprofessionals and staff. In particular, training curricula that emphasize care coordination and patient-centered care are sought after programs to enable the supportive members of the primary care team (such as community health workers, patient navigators, and peer coaches) to implement the new PPS transformation models in health care delivery, which focus on preventive care, care coordination, navigation, and wellness.

- 5. Shared savings plans.** The PPS is leveraging its strong health plan experience and increased “star” rating with Healthfirst to implement new VBP reforms. Through Healthfirst, a large Medicaid managed care plan, Bronx-Lebanon Hospital Center (DSRIP lead entity) is part owner, managing 100,000 capitated lives. Current discussions with Affinity Health Plan, who has already entered into a Level 1 VBP contract, are ongoing. Additionally, PPS partners have already successfully enacted shared savings plans, among them, Urban Health Plan, one of the PPS’s largest participating partners, has entered into a shared savings contract with Affinity Health Plan and has already accepted full capitation for some of its members. Another PPS partner, the Mount Sinai Health System, one of the PPS’s major participating providers, has championed VBP reforms from the outset. Mount Sinai has an important role on PPS Governance Committees and cross-functional Workgroups, and as an active member, shapes PPS policies and strategies. Their innovations and experience in implementing provider incentive payments and shared savings contracts will support the PPS’s goal to implement sustainable VBP reforms that incentivize providers to improve patient outcomes.

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

The funds flow methodology demonstrates that primary care services are a priority in the funding of PPS initiatives by implementing strategies that will ultimately engage and maintain patients in primary care. The methodology is one of the core vehicles to accomplish the PPS goal to create a network of care that improves access, quality, and efficiency for the safety net population in the South Bronx.

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

All PPS activities occur within a framework that prioritizes the comprehensive, integrated, and culturally competent delivery of services to meet patient needs. As reported in the DSRIP comprehensive Community Needs Assessment (CNA), patients in the South Bronx communities served suffer disproportionately from co-occurring (comorbid) medical and psychiatric, and/or chemical dependency diagnoses including diabetes, obesity, cancer, cardiovascular disease, asthma, violence, and behavioral health issues (such as anxiety, depression, and substance use).⁴ To meet the needs of the at-risk population, the PPS is implementing Project 3.a.i, *Model 1 (PCMH Site)* and *Model 3 (IMPACT)*, at nine participating primary care clinic sites, operated by Bronx-Lebanon Hospital Center (BLHC) and the Dr. Martin Luther King, Jr. Health Center, as well as, VIP Community Services. Project 3.a.i and the strategies implemented directly support the PPS-wide commitment to health systems transformation, and core objectives (*1: To create a highly efficient Integrated Delivery System in collaboration with providers across the care continuum using IT interoperability and care coordination to improve the beneficiary's experience and outcomes; and 4: To create and implement multidisciplinary approaches to care that address issues identified in the CNA*). Four specific strategies will be utilized to advance the integration of primary care and behavioral health services.

First, a significant capital project supported by the Capital Restructuring Financing Program (CRFP) will enable the creation of a new adult comprehensive primary care integrated behavioral health center at BLHC. Several clinical design elements will be customized in the space to facilitate more patient centered care and close team collaboration per the *Nuka Model of Care—an evidence-based model that embraces the concept of wellness by establishing a long-term relationship between patients and providers*.⁵ This model is best facilitated using a pod layout for accessible, integrated, and sequential team-based care (i.e., multiple patient-staff interactions in one visit) provided by a multidisciplinary team of primary care physicians, psychiatrists, nurses, licensed social workers, care coordinators, community health workers, medical assistants, and other specialty and social service staff. The site will include: triage, exam, and interview rooms for clinical interactions; private talking rooms and patient evaluation workstations where providers can meet with patients and provide health education; shared conference space for team meetings and case conferences; toilets close to patient exam rooms; and staff and patient support spaces. Improvements in health information technology and connectivity in the new location (such as EHR access, shared record keeping, and participation

⁴ New York Academy of Medicine. Primary data findings, September, 2014.

⁵ Gottlerib K. The Nuka System of Care: Improving health through ownership and relationships. *Int J Circumpolar Health*, 72: 21118

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

in regional data exchange through the Bronx RHIO) will provide the infrastructure, analytics, and tools to maintain future primary care and behavioral health advances. The NUKA model has proven successful in reducing preventable health care utilization (a DSRIP PPS goal), while achieving high quality standards for patient care, and is consistent with the NCQA standard for achieving and maintaining Patient-Centered Medical Home (PCMH) recognition.

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Secondly, as the PPS lead agency, BLHC is leading the charge in the integration of primary care and behavioral health services despite the shortage of behavioral health providers. The Bronx-Lebanon Integrated Services System, Inc. (BLISS), in association with FQHC subrecipients, BLHC and the Dr. Martin Luther King, Jr. Health Center, received \$4.4M in HRSA funding in FY 2016 to expand substance abuse services at three health center sites (two primary care clinics and a primary care clinic that services patients with HIV/AIDS). These sites are currently at an intermediate level of behavioral health integration. HRSA funding will directly support the following goals: 1) hiring new staff to support an integrated clinical care team with a pharmacist, nurse educator, and health home coordinator under a fully collaborative model; 2) increasing the number of patients screened for substance abuse disorders and connected to treatment via the Screening, Brief Intervention, and Referral to Treatment (SBIRT) and opioid screening tools; 3) increasing the number of patients with access to medication assisted treatment (MAT, e.g., buprenorphine) for opioid abuse; 4) coordinating services necessary for patients to achieve and sustain recovery; and 5) providing training and education for health professionals on opioid prescribing. All staff will participate in case conferences to enhance the therapeutic alliance between providers and ensure that all patients are well established in care.

Additionally, a second FY 2016 HRSA award will provide \$1.7M, over five years, for primary care training at BLHC in the Family Medicine and Internal Medicine departments. Funding will support enhanced training for medical students, residents, faculty, and practicing physicians, with benefits to more than 100 faculty and over 280 medical students in these areas. A newly-developed primary care training curriculum will specifically support five objectives: 1) provide interdisciplinary training in PCMH principles to internal medicine and family medicine residents and faculty; 2) provide trainees with the knowledge, skills, and professional development required to champion quality improvement and patient safety practices; 3) increase trainees' understanding of the CMS transformational agenda and BLHC's role in system transformation; 4) strengthen trainees' knowledge and understanding of public health issues and disease

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

epidemiology in the service area; and 5) give residents opportunities to implement knowledge of PCMH principles, care coordination, and team-based care in primary care settings.

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Thirdly, primary care providers are being trained in best practices for the management of patients with behavioral health conditions, specifically Serious Mental Illness (SMI), mood disorders, and bipolar disorder. Under the leadership of 2.b.i. Project co-leads (Jeffrey Levine, MD, Chairman Psychiatry, BLHC; and Debbie Lester, Urban Health Plan); 3.a.i Project co-leads (Vicente Liz Defillo, MD, Attending Physician, Psychiatry, BLHC; Debbie Pantin, VIP Services; and David Gerber, St. Christopher's Inn); primary care teams in the PPS will be trained to build skills and comfort in behavioral health patient management. Techniques and best practices—relating to patient screening and assessment using validated instruments (such as the SBIRT and the Patient Health Questionnaire, PHQ-2 and PHQ-9); medication management and treatment algorithms; communication and consultation models—will be implemented in primary care settings for patient screening. In particular, the SBIRT integrated care model ensures that patients receive universal screening, secondary prevention, early intervention, and treatment for substance use disorders within the primary care setting, and referral to specialty care. High-risk patients will be referred for inpatient detoxification at community facilities for more intensive treatment.

Fourthly, to promote needed data sharing and management across partners, the IT Committee has engaged the Bronx RHIO with the goal of achieving PPS-wide health information exchange (HIE) and health information management (HIM) capabilities. Through the Clinical Needs Assessment, the PPS collected data from project workgroups and other key stakeholders to better understand data integration needs. The resulting Clinical Integration Strategy is focused on five priority areas: 1) HIE, 2) centralized analytics, 3) electronic medical records, 4) actively engaged reporting, and 5) a care coordination platform.

As an identified vendor, the Bronx RHIO will deploy a dedicated team to support the PPS central data management, analysis, and reporting capabilities (i.e., data quality, PPS patient tracking, data security, analysis, etc.). The RHIO will take the lead in the integration of additional data types that support HIE (e.g., case management system, provider database system, Medicaid claims, etc.). Under the fully collaborative model, primary care providers, psychiatrists, social workers, and other support staff will be trained to share relevant health information, have access to patient registries, and to utilize other tools that will facilitate patient tracking and

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

clinical monitoring. In addition to critical notes access, secure health messaging system capabilities will also facilitate improved communication and collaboration across the PPS.