OneCity Health PPS

Primary Care Plan (Revised)

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Contents

Executive Summary 2
Introduction 3
Primary Care Plan Narrative 4
1. Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs 4
2. How will primary care expansion and practice and workforce transformation be supported with training and technical assistance? 8
3. What is the PPS's strategy for how primary care will play a central role in an integrated delivery system? 11
4. What is the PPS's strategy to enable primary care to participate effectively in value-based payments (VBP)? 13
5. How does the PPS's funds flow support the primary care strategies? 15
6. How is the PPS progressing toward integrating primary care and behavioral health (building beyond what is reported for Project 3.a.i)? 16
Conclusion 17

Executive Summary

OneCity Health, the largest Performing Provider System (PPS) in New York State, has made solid progress in meeting critical Delivery System Reform Incentive Payment (DSRIP) program milestones since its inception in 2014. Moreover, OneCity Health is moving toward its vision of establishing a sustainable integrated delivery system to care for its attributed members and all of the people served through the PPS's network of partners.

Primary care is integral to OneCity Health's strategies and plans and must play a central role in the high-performing health care system of the future. OneCity Health, working in collaboration with its partners and other PPSs, has conducted extensive assessments to understand the current state of primary care capacity and performance as well as to identify the gaps to be filled.

OneCity Health is implementing a multi-faceted Primary Care Plan that includes:

- Expanding and making more efficient use of capacity
- Helping primary care practices build capabilities and connectivity
- Deploying evidence-based care models centered on primary care
- Connecting primary care practices with the people and communities they serve

In addition, OneCity Health is working with primary care practices to prepare for an environment in which 80-90 percent of payments will be value-based (in accordance with New York State objectives outlined in the VBP Roadmap).

OneCity Health fully expects this Primary Care Plan to change over time based on the shifting environment and what is learned during implementation. Despite potential changes in specific initiatives, however, primary care will remain central to OneCity Health's strategy and commitment to improving the health of the people of New York City.

Introduction

OneCity Health, established by NYC Health + Hospitals, is the largest PPS in New York State with 635,000 attributed Medicaid members and a partner network of approximately 250 organizations that serve over one million people each year.

OneCity Health envisions the establishment of a welcoming, accessible, and integrated health delivery system that encourages, supports, strengthens, and protects a state of wellness and healthy living for all. Through this transformative effort, it is OneCity Health's aim to demonstrably improve the health of New Yorkers.

OneCity Health's strategy for achieving its vision is centered on providing access to high quality primary care that is accessible and well integrated with other components of the health care system and with the communities served by OneCity Health's partners.

In developing a high performing integrated delivery system, OneCity Health (and its fiduciary and largest partner, NYC Health + Hospitals) is employing a rapid-cycle improvement approach. Accordingly, this Primary Care Plan is a snapshot of OneCity Health's current strategies, planned interventions and progress to date. This Primary Care Plan will evolve based on a deeper understanding of the population's needs, PPS partner capabilities, and actual experience with what works well and does not work well as OneCity Health implements and scales its programs.

The primary care narrative that follows is organized around the six elements outlined by the New York State Department of Health (DOH).

Primary Care Plan Narrative

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

OneCity Health has conducted a thorough assessment of primary care capacity, performance and needs and developed a comprehensive plan for addressing those needs.

In order to assess current primary care capacity, OneCity Health has undertaken significant research and outreach. Specifically, OneCity Health has conducted and/or commissioned:

- Community Needs Assessments - to identify the demographics and health needs of the population in the PPS's service area and provide an inventory and evaluation of the healthcare and community resources available
- Partners Readiness Assessment Tool (PRAT) survey - to gather information on services offered and current capabilities to inform program development and implementation
- Master Partner Data Survey - to gather information from PPS partners that includes structure, services offered, and projects selected for participation to inform partner contracting, performance metrics, and other initiatives
- Target Workforce State Report (in collaboration with three other PPSs)
- Information Technology (IT) Assessment - to understand capabilities including connectivity for exchange of health information, electronic medical records, and tracking/reporting
- Financial Stability Assessment - to understand financial condition of partners to inform contracting and as an input to plans to promote value-based contracting
- In addition, OneCity Health has recently launched a Patient-Centered Medical Home (PCMH) baseline assessment, and a value-based payment readiness survey (for all of its contracted partners)

The remainder of this section provides a summary of OneCity Health's assessment of primary care needs, capacity, performance, strategy and interventions. Many of the elements mentioned in this section are described in greater detail in the other sections of the Primary Care Plan narrative.

In assessing the state of primary care, OneCity Health considers capacity/access as well as performance/needs. For each of these dimensions, the table on the next page summarizes:

- Baseline assessment (what is the current state?)
- Strategy (what is the overall approach to address identified gaps?)
- Intervention (what programs is OneCity Health undertaking to pursue the strategy and achieve measurable success?)

Summary of Capacity/Access and Performance/Needs (additional details follow)

	Capacity/Access	Performance/Needs
Baseline assessment	• OneCity Health's geographic coverage area includes a significant number of Medically Underserved Areas/Populations (MUA/P) and Health Professional Shortage Areas (HPSA) • OneCity Health's network includes 54 partners with 191 sites that provide primary care services • OneCity Health's network includes a headcount of 1,292 PCPs (primary care providers) which equate to ~780 PCP full-time equivalents (FTEs)[1] • External research and analysis has projected the need for 203 additional PCP FTEs by 2020	• PCPs in OneCity Health's network display a wide range of needs based on practice affiliations, size and capabilities • OneCity Health's network includes examples of investment in capabilities and integration including Patient-Centered Medical Home (PCMH) certification and behavioral health integration • There are opportunities to develop stronger connections between PCPs and community organizations • There is significant concern among small practices about value-based payments and lack of resources to invest in practice transformation
Strategy	• Improve utilization of existing PCP capacity • Strengthen capabilities of PCP practices • Expand PCP capacity and support transition to VBP	• Tailor support and training to varying needs of practices • Rollout evidence-based care models • Connect primary care with other settings and with community organizations
Interventions ***(highlights, see other sections of Primary Care Plan narrative for details)***	• Deploy processes, tools and information to achieve higher utilization of existing capacity and increase quality of care • Training and PCMH transformation support to enable professionals to practice at 'top of license', freeing up physician and nurse practitioner capacity • Plan to pilot telemedicine to improve access	• Engage expert consultants to support PCMH certification and primary care/behavioral health services integration • Provide financial and technical support to increase PCP connectivity • Provide workforce development/capacity building in disciplines such as quality improvement (QI) • Engage community organizations to increase cultural competency

[1] These are current estimates, likely to be refined over time. Sources are: NYS DOH PPS PCP Network Analysis Regional Comparison and BDO Target Workforce State Report

OneCity Health has an attributed membership of 635,000 individuals with Medicaid coverage spread across four boroughs of New York City, a geographic area that includes 7.9 million people with great diversity along many dimensions (age, race, ethnicity, religion, country of origin, language preference, gender identity, sexual orientation, health, income, and wealth). Although New York City on the whole has a comprehensive health care infrastructure and many outstanding community service organizations, there are significant gaps and disparities throughout OneCity Health's service area.

OneCity Health's partner network encompasses roughly 250 organizations. Of these, 54 provide primary care at 191 sites. This includes 1,292 primary care physicians, who equate to roughly 780 full-time equivalents (FTEs). Of the 191 partner sites that provide primary care, 133 have fewer than five physicians or nurse practitioners onsite. Of the 133 sites with fewer than five physicians, 32 are part of NYC Health + Hospitals, 63 are part of other multi-site systems, and 38 are single sites.

Not all of this capacity is available to OneCity Health attributed members, because these primary care physicians also treat patients who are not covered by Medicaid or who are attributed to other PPSs.

As the Community Needs Assessments identified, there is a significant gap in primary care capacity, which is particularly severe in many of the communities within OneCity Health's geographic region. There are 48 neighborhoods in the OneCity Health service area (home to over two million people) that meet federal designation criteria as Medically Underserved Areas/Populations (MUA/P). In addition, there are many areas designated as Health Professional Shortage Areas (HPSA) of different types, including 21 for primary care, 10 for dental, and 12 for mental health. Resolving the shortage of primary care physicians and the inequity in primary care access are beyond the direct control of a PPS, although they are salient characteristics of OneCity Health's environment.

OneCity Health (in partnership with three other PPSs) engaged BDO Consulting (BDO), "to define the target workforce state through the analysis of workforce impacts as a result of system transformation and implementation of clinically integrated programs"[2]. BDO used a health care demand microsimulation model that projected staffing requirements based on both demographic changes and the programs being implemented by OneCity Health and its partners. Based on this analysis, BDO estimated that over the next four years, the combination of demographic changes and the impact of OneCity Health's DSRIP initiatives will drive the need for an additional 203 primary care physician FTEs[3]. The modeling performed by BDO provides a framework for projecting capacity needs and will be a basis for refining estimates of primary care demand over time. Under the DSRIP Program, it is unlikely that any PPS can resolve the problem of profound staffing shortages; however, OneCity Health will use all options to improve capacity and access to strong primary care teams through DSRIP contracting (incentives), support of PCMH certification, and primary care team training.

In addition to the need to fill capacity gaps, OneCity Health has identified the need to engage people who do not currently use primary care and may not be inclined to do so on their own. This is particularly

[2] Target Workforce State Report for OneCity Health, BDO, page 3.
[3] Target Workforce State Report for OneCity Health, BDO, page 1.

important in the context of an integrated delivery system that is responsible for the health and health care of a population (including people who are not currently engaged with the health care system).

OneCity Health recognizes that many of its partners are making investments and progress in strengthening primary care. NYC Health + Hospitals has embarked on a primary care transformation that includes attaining NCQA PCMH recognition, deploying ambulatory care transformation coaches, and improving population health. Moreover, OneCity Health has contracted with PCMH consultants to assist 92 primary care sites in achieving NCQA 2014 Level 3 certification, and is exploring expanding the number of sites supported to meet the needs of newly added partners and sites. In addition, 20 community primary care sites that are part of OneCity Health's partner systems either have, or are in the process of, attaining NCQA 2014 Level 3 certification.

OneCity Health is implementing a multi-faceted primary care plan to address identified needs. The table below summarizes major elements of the plan:

Element	Description and Example Interventions
Supporting primary care access and expansion	• Providing care team training and support (including the PCMH transformation process), which will enable physicians and other professionals to practice at 'top of license' and free up capacity for patient care • Forming new partner relationships to increase primary care capacity and working with existing partners to expand capacity and improve referral process • Establishing relationships between partners to better utilize existing primary care capacity • Developing information and tools to make referrals easier (paper and web-based directories have been rolled out) • Establishing borough-based contact centers to schedule primary care and other appointments • Defining a workforce strategy to expand, engage, and train workforce to meet future needs
Strengthening primary care capabilities and infrastructure (tailored to needs of different practices)	• Providing financial and technical support to primary care practices to connect to a Qualified Entity (QE) and transmit/receive data • Engaging consultants to provide technical assistance to help: o Practices achieve NCQA 2014 PCMH Level 3 certification o Primary care practices and behavioral health service providers deliver collaborative care o OneCity Health and partners understand IT capabilities
Deploying care models that improve primary care and connect it with other settings	• Implementing evidence-based care models that strengthen health care delivery within the primary care setting and connect it to other clinical settings and to the community

Engaging community organizations to connect people to primary care and address social needs	• Working with community organizations to reach out to people in need of primary care who are not connected • Deploying cultural competency and health literacy training to increase reach and impact of primary care • Using community experts and organizations to provide services that address social determinants of health

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

OneCity Health is supporting primary care expansion and practice and workforce transformation with significant training and technical assistance (including support for practice transformation, establishing learning collaboratives for ongoing improvement, and helping with connectivity for exchange of health data).

It is important to recognize that training and technical assistance needs vary significantly for different practice structures and sizes. Although each primary care practice and facility is unique, one approach to classifying practices is based on the level of information technology (IT) infrastructure and experience with managed care contracting. Specifically:

1. Institution-based (i.e., a primary care practice within a hospital or other large facility)
    - Has significant information technology (including electronic medical records), infrastructure and dedicated support staff
    - Has experience contracting with payers, often including value-based payments
2. Large groups/clinics/Independent Physician Associations (i.e., a primary care group that is part of a larger entity that may also provide specialist or other clinical services)
    - Has information technology and other infrastructure as well as dedicated support staff
    - Has experience contracting with payers, degree of leverage depends on size and relative importance to payers' networks
3. Small practices (i.e., five or fewer physicians in an independent practice or clinic)
    - Limited technology, infrastructure, and support staff
    - Has network participation contracts with payers, but limited expertise in contracting and very little leverage with payers

PCMH capabilities provide an important example of the differing needs of primary care practices. As reported by the United Hospital Fund:

"A PCMH focuses on organizing care teams, on meaningful use of electronic medical records, on using registries to identify complex patients who are at risk for poor outcomes and potentially avoidable high-cost care, and using dedicated staff to help manage their care. These are capacities that require organizational scale and expertise, easier to achieve in organized systems and larger practices than in smaller, independent practices."[4]

[4] "Recent Trends and Future Directions for the Medical Home Model in New York," United Hospital Fund, Gregory Burke, August 2015, page 11.

OneCity Health's training and technical assistance plan consists of six elements, which are summarized below:

Element	Description and Example Interventions

PCMH training and technical assistance	• Expanding access to high-quality primary care requires a commitment to meeting NCQA 2014 Level 3 PCMH standards by Demonstration Year 3
	• OneCity Health's partners that provide institution-based primary care are making strong progress not only in achieving PCMH certification, but also going beyond those requirements. For example,
	  ○ NYC Health + Hospitals includes 38 primary care sites that have obtained NCQA 2011 PCMH Level 3 recognition and expects 28 primary care sites to obtain NCQA 2014 PCMH Level 3 recognition
	  ○ A team of 10-15 ambulatory care transformation coaches provides technical assistance to individual sites and works with site leadership to assess performance and develop improvement plans
	• For 92 primary care sites, OneCity Health has contracted expert PCMH technical assistance consultants to assist with practice transformation and NCQA certification. OneCity Health is exploring expanding the number of sites for which it provides PCMH technical assistance
	• OneCity Health and supporting consultants will establish learning collaboratives among partners that provide primary care to promote ongoing learning and share best practices
	• OneCity Health is developing a strategy for supporting community-based primary care practices (including small practices) that includes evaluating what services would be of greatest value to those practices

IT and connectivity assistance	• The ability to exchange information is an important enabler of coordinating patients' care and functioning within an integrated delivery system • OneCity Health has engaged a technical vendor to conduct onsite assessments to determine the technical capacity of partners to share clinical data and connect to a Qualified Entity (QE) • OneCity Health is supporting partners in setting up electronic connections to a QE and to establish feeds for admissions, discharges, transfers (ATD) and clinical information • OneCity Health is providing technical assistance to help practices acquire electronic medical record systems (EMRs) that meet Medicaid and Medicare Meaningful Use requirements

Cultural Competency and Health Literacy (CCHL) training	• Improving cultural competency and health literacy (CCHL) among the workforce is a key element of transformation, improving primary care access and quality, and addressing health disparities • OneCity Health has developed a training strategy for its community partners focused on addressing drivers of health disparities that includes conducting CCHL organizational assessments with partners to set baselines and establish improvement targets
Workforce strategy to support primary care expansion and practice and workforce transformation	• To ensure focus on workforce needs, OneCity Health established the Workforce Committee, a subcommittee of its Stakeholder and Patient Engagement Committee • OneCity Health formed a consortium with three other PPSs to engage an expert vendor (BDO) to develop a profile of the current workforce and project the incremental workforce needs over the next four years as a result of demographic changes and DSRIP initiatives (including the impact on the primary care workforce) • NYC Health + Hospitals continues multi-year access improvement efforts through building and redesign efforts aimed at expanding primary care capacity and increasing utilization

Training, information and tools to improve access to primary care and social services	• Connecting people to primary care and social services will be key to a successful integrated delivery system
	• OneCity Health is developing information and tools to streamline the process of locating sites that offer primary care and social services
	  ○ OneCity Health is rolling out a paper and online directory/map of services offered by its ~250 partners (including primary care). Initial users will be ED and other departments of NYC Health + Hospitals
	  ○ OneCity Health plans to expand the distribution of this information and tools to OneCity Health partners. It will be valuable for primary care practices to help patients find needed social services, and for social service organizations to connecting their clients with primary care
	• Over time, OneCity Health plans to enhance these tools and consider functions such as appointment scheduling, reminders, mapping, and other features that improve access and engagement
	• NYC Health + Hospitals has developed tools and data to identify and map population needs and available health care resources
	• NYC Health + Hospitals is establishing contact centers that will allow people to schedule primary care and other appointments

Leveraging statewide resources for technical assistance	• OneCity Health is helping its partners leverage the capabilities of a QE by assisting them with connectivity. A number of practices are also utilizing state resources to support QE connectivity and Meaningful Use EMRs • OneCity Health is working with approximately 25 primary care sites that are exploring the CMS Transforming Clinical Practice Initiative (TCPI) • NYC Health + Hospitals is leveraging a State grant (Capital Restructuring Financing Program, CRFP) to build contact centers to manage patient requests for services 24/7 in multiple languages. The contact centers will initially focus on appointment scheduling (primary and specialty care) and are expected to incorporate additional services over time (e.g., nurse hotline)

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

OneCity Health has a multi-faceted strategy for how primary care will play a central role in an integrated delivery system. Primary care plays an integral role in many of the clinical initiatives that OneCity Health has developed and is implementing. Each clinical initiative strengthens the continuum of primary care and ensures meaningful linkages to secondary and tertiary services.

Moreover, OneCity Health is deploying evidence-based care models that will enable practitioners to not only treat people in the primary care setting but also help patients manage their conditions at home and in their neighborhoods. This will require connections to community organizations and community health workers (CHWs) who can bring people into primary care and bring primary care to people who are not currently engaged with the health care system.

The table below summarizes OneCity Health's strategy for how primary care will play a central role in an integrated delivery system.

Element	Description and Example Interventions
Primary care and behavioral health services integration	• Delivering behavioral health services in the primary care setting, delivering primary care in the behavioral health services setting, and supporting integrated screening and management of behavioral health conditions in the primary care setting • NYC Health + Hospitals is conducting universal depression screening for adults in primary care (225,000 adults screened in 2015) • Promoting connections among professionals as part of a care team and also between professional and institutional settings (e.g., inpatient psychiatric setting, substance abuse treatment setting)
Cardiovascular disease management in primary care setting	• Cardiovascular disease management in the primary care setting including implementing guidelines for management of hypertension, generating a registry of hypertensive patients, establishing support for home blood pressure monitoring, screening and counseling for tobacco use, prescription of aspirin for cardiovascular prevention, and implementing guidelines for cholesterol management • NYC Health + Hospitals has implemented "Treat to Target" program which promotes nurse-led patient visits to help patients with hypertension achieve healthier blood pressure levels • Longer-term, promoting connections between primary care and community-based organizations for improved cardiovascular health

Element	Description and Example Interventions
Asthma self-management (led by primary care)	• Asthma self-management led by primary care practices with the support of CHWs and asthma educators • Promoting connections among primary care professionals, community health workers, and asthma health educators (as part of the care team) • Longer-term, promoting connections between primary care and specialist physicians and between professional and institutional settings (e.g., emergency department [ED])
Palliative care (led by primary care)	• Palliative care management led by primary care practices including health care proxies, symptom management and advanced illness management • Longer-term, promoting connections between primary care and specialist physicians and between professional and institutional settings (e.g., inpatient, emergency department, long-term care facilities, hospice)
ED care triage and linkage to primary care	• Connecting patients presenting in the ED to appropriate follow up including scheduling appointments with primary care physicians, linking to care management resources, and transition management for patients with complex needs • Promoting connections between primary care and the ED
Care transitions management	• Providing 30 days of supportive community-based care to address the needs of patients discharged from a hospital • Promoting connections between primary care and institutional settings. This includes: scheduling and completion of primary care follow-up after discharge; transfer of information between hospital and care management to the primary care practice; and connections between community-based support services and primary care in the post-discharge period
Health Home At-Risk	• Expanding eligibility criteria for Health Home-like care management services, thereby increasing care management resources for primary care practices • Identifying high-risk patients and providing care management within the community, including support for accessing primary care • Promoting stronger linkage and communication processes between Health Home partners and primary care physicians
Outreach to connect people to primary care	• Promoting linkages between primary care and people who are not regularly connected to the health care system (this requires overcoming barriers including immigration status, cultural and language challenges, homelessness, and distrust) • Partnering with community organizations that have established relationships within their communities to overcome barriers to engagement • Developing relationships through Community Advisory Workgroups and the Community Advisory Boards of NYC Health + Hospitals • Engaging CHWs and peer educators to support outreach and engagement
Representation of primary care in OneCity Health governance	• Providers of primary care are represented on OneCity Health's governing bodies, including the Executive Committee, Care Models Committee, Stakeholder and Patient Engagement Committee, and Bronx and Manhattan Hub Steering Committees. • Primary care representation on the Care Models Committee promotes direct input on clinical programs and quality initiatives

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

OneCity Health recognizes that sustainability for an integrated delivery system will depend on the ability of primary care practices to participate effectively in value-based payments. Furthermore, adapting to value-based payments will require significant change and be a challenge for some primary care practices. OneCity Health estimates that roughly 40 percent of its partner sites that deliver primary care have a managed care contract that ties some portion of reimbursement to performance metrics. OneCity Health has research underway to gain additional insight into PPS partners' experience with value-based contracting.

There are three types of requirements for success in an environment that includes a significant proportion of value-based payments:

1. *Operational: being able to contract for value-based payments, track and report on the required metrics, provide required access to care, work in a care team, and use health information technology to exchange information*
2. *Financial: being able to absorb financial risk (particularly when value-based payments include downside risk) and access stop-loss insurance and/or other financing resources*
3. *Impact: being able to deliver and demonstrate value as measured by cost, quality, patient experience and outcomes*

OneCity Health is implementing a comprehensive strategy to enable primary care practices to participate in value-based payments successfully. Each component of this strategy is described below:

Element	Description and Example Interventions
Assessing primary care readiness for VBP	• Conducting a VBP readiness survey with PPS partners to understand their experience with value-based payments and identify gaps (and how they vary by type and size of partner)
Practice transformation and PCMH certification	• Providing technical assistance and training to help practices achieve PCMH certification. This will enable practices to receive higher reimbursements (in the near term) and/or enable practices to qualify for care coordination fees
Practice connectivity	• Supporting practices in connecting to QEs to enable data exchange that is a prerequisite for success in a value-based payment environment (e.g., receiving data from hospitals/EDs)
Coaching and best practice sharing	• Coaching and establishing learning collaboratives for PPS partners to enable primary care practices to transform and evolve on an ongoing basis (e.g., strengthening contracting and data analysis capabilities)
Reporting requirements	• Designing OneCity Health's data and reporting requirements to help partners adapt to VBP reporting requirements

Element	Description and Example Interventions
Improving value and reducing avoidable costs	• OneCity Health's programs are focused on key drivers of avoidable health care costs (which will help primary care practices achieve targets in a VBP environment). For example: o Transitions: OneCity Health's care transitions program is focused on actionable care plans to reduce avoidable readmissions o Chronic care management: OneCity Health's asthma self-management, cardiovascular disease management, and HIV programs will improve health/outcomes and reduce avoidable costs for people with these chronic conditions o At-risk patients: OneCity Health's Health Home At-Risk program is focused on high-risk patients who are not currently eligible for Health Homes. This program provides access to intensive care management, high quality primary care and support services o Palliative care integration with primary care will enhance management of patients with complex medical conditions who have progressive or fluctuating illness, uncontrolled symptoms, or functional decline
Promoting team-based care	• Helping primary care practices function as high performing teams with the necessary information, connectivity, care models, training, and connections into the community

5. How does the PPS's funds flow support the primary care strategies?

OneCity Health supports its primary care strategies with its fund flow through metric-based schedules and investments in capabilities and technical assistance.

OneCity Health's funds flow supports learning about project implementation, partner capabilities and interest, market drivers, and patient flow. Funds are distributed to partners based on metrics, number of attributed patients, and project selection (primary care practices are participating in each OneCity Health project).

The total funds flow available to partners for the current contract phase (through March 31, 2017) is $55 million. Additional funds support primary care practices through PCMH technical assistance and licensing fees, information technology support, and consulting help with primary care/behavioral health co-location. Primary care practices have begun to receive funds, including payment for engagement.

Element	Description and Example Interventions
Funding for clinical project implementation that supports primary care strategy	As part of the PPS funds flow, specific metrics have been identified for each clinical project example listed below: • Project 11 - engaging uninsured and Medicaid low- and non-utilizers which is a prerequisite to promoting individuals' connection to primary care • ED care triage - providing patients presenting in the ED with primary care appointments for follow-up care • Care transitions post-discharge - documenting care transition plans for patients with complex medical and/or social needs in a patient's medical record and providing it to the patient's primary care practitioner. Engaging care team in a case conference and ensuring that transition plan elements are addressed • Primary care/behavioral health integration - documenting use of Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model • Palliative care integration into primary care setting - reporting on current counseling approach and process for completing health care proxies
Funding for technical assistance that supports primary care strategy	• PCMH technical assistance and consulting support from three expert organizations. This investment in technical assistance and consulting will reach 92 primary care sites in the OneCity Health network • Information technology support to develop connections to a QE and to establish feeds for admissions, discharges, transfers, and clinical information • Technical assistance and consulting support for primary care/behavioral health services integration. This technical assistance and consulting will focus on 10 pilot practice sites
Funding for training, transformation and equipment that supports primary care strategy	• Cultural competency and health literacy training to help partners engage the diverse population the PPS network serves • Learning collaboratives for primary care providers to share best practices and strengthen capabilities needed to thrive in the value-based payment environment (e.g., data analytics, contracting) • Funding for NCQA PCMH licensing fees (for many practices) • Equipment for care models that are being rolled out, for example medical equipment required for asthma management

6. How is the PPS progressing toward integrating primary care and behavioral health (building beyond what is reported for Project 3.a.i)?

OneCity Health is making significant progress toward integrating primary care and behavioral health services. The description for Project 3.a.i in the Mid-Point Assessment summarized many of the efforts underway. This section provides additional details on initiatives in process and those that go beyond what is reported for Project 3.a.i.

Element	Description and Example Interventions
NYC Health + Hospitals' progress on collaborative care	• NYC Health + Hospitals, OneCity Health's largest partner, has made significant strides integrating primary care and behavioral health services. The experience to date was described in the *New England Journal of Medicine Catalyst*[5] ○ Conducted universal depression screening for adults in primary care since 2014 (including 225,000 adult primary care patients in 2015) ○ Implemented the Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) model across 17 NYC Health + Hospital sites ○ Developed a team of collaborative clinical care coaches ○ Provided targeted primary care within behavioral health services settings
Technical assistance	• OneCity Health is contracting with consultants to provide technical assistance to primary care sites and behavioral health services sites to develop the ability to provide collaborative care
Community outreach and engagement	• OneCity Health is working with community organizations to reach people who are not seeking primary care or behavioral health services, and who may be disconnected from the traditional health care delivery system
Examples of other projects supporting integration of primary care and behavioral health services (not including Project 3.a.i.)	• Care transitions - reducing readmissions through transition planning, care planning and engagement of care teams including primary care practitioners. This includes patients with behavioral health disorders being discharged from hospitals and patients being discharged from inpatient psychiatric facilities • Health Home At-Risk - providing care management resources for high-risk patients, including people identified in primary care settings as having depression, anxiety, substance abuse issues, ADHD or other behavioral health issues (but who do not currently qualify for a Health Home) • Mental health and substance abuse reduction infrastructure - increasing mental health and substance abuse literacy among New York City middle and high school students. This includes linking schools to hospitals and community-based providers to promote partnership and collaboration in addressing student needs

[5] "Collaborative Care for Depression in a Safety-Net Health System," NEJM Catalyst, Case Study May, 24, 2016. Jessica Black, MSW, MPH, Dave A. Chokshi, MD, MSc, Monica Gould, MPH and Jesse Singer, DO, MPH.

Conclusion

OneCity Health has numerous initiatives underway that both strengthen primary care practices and place primary care in a central role within the integrated delivery system of the future. These efforts are sensitive to the significant variation among primary care practices and, therefore, are not a 'one-size-fits-all' approach.

Among the key elements of the Primary Care Plan are expanding capacity, helping primary care practices build capabilities and connectivity, deploying evidence-based care models centered on primary care, and connecting primary care practices with the people and communities they serve. OneCity Health will continue to engage, collaborate and learn from its community partners. The actual experience of OneCity Health partners and the people they serve will inform ongoing program development and refinement.

Ultimately, success will be measured by the value OneCity Health and its partners create, and the ability to sustain an integrated delivery system in a value-based payment environment. OneCity Health expects that many of its initiatives will evolve over the next several years, but primary care will remain a critical element to improving the health of the people OneCity Health and its partners serve.