PRIMARY CARE PLAN
DSRIP YEAR 2

The NewYork-Presbyterian Performing Provider System (NYP PPS) recognizes that comprehensive, accessible, and well-resourced primary care is a key driver of improving the health of a population, reducing unnecessary utilization, and contributing to the goals of DSRIP. As such, the NYP PPS has prepared the first annual Primary Care Plan, as required by the Project Advisory and Oversight Panel (PAOP). This report will provide background on the NYP PPS and address the six required fundamentals, given the PPS's membership and geographic context.

I. Background:

Throughout the first year of DSRIP, the NewYork-Presbyterian Performing Provider System (NYP PPS) has been focused on developing the infrastructure, processes, and policies necessary to: (1) comprehensively implement its DSRIP Projects; (2) improve the health of its attributed population and the associated DSRIP pay-for-performance metrics; and, (3) prepare for future value-based initiatives.

The NYP PPS has pursued a collective impact approach, where NewYork-Presbyterian Hospital (NYPH) is the anchor institution for a broad network of collaborators focused on achieving the aforementioned goals. As the anchor institution, NYPH provides the project management, information systems, analytics and reporting support, and financial controls. This collective impact approach will be further highlighted throughout the organizational elements detailed below.

The NYP PPS – consisting of ~80 collaborators – was initiated in 2014 with the DSRIP application process. At that time, NYPH DSRIP leads decided to focus the network on meeting the needs of the Medicaid population regularly seeking care in the NYPH Ambulatory Care Network (14 PCMHs, 50 specialty sites), emergency departments, and inpatient units (behavioral health, medicine and surgery) as well as a small number of closely connected independent community physicians, and FQHCs. This focus would give the PPS an existing knowledge base of the patient population it would serve increasing the probability of the selected projects' success. This approach also enabled the PPS to quickly develop the infrastructure necessary to support the projects, as well as keep a core group of collaborators more integrated and engaged with the PPS.

Prior to beginning of the DSRIP performance period (April 2015), the NYP PPS conducted a Community Needs Assessment (CNA) to identify the priority challenges experienced by the attributed patient population. In response to these, the NYP PPS selected, developed charters, and established initial budgets for its ten projects. This early budgeting process enabled the projects to start implementation as soon as funding was officially confirmed by NYS (June 2015).

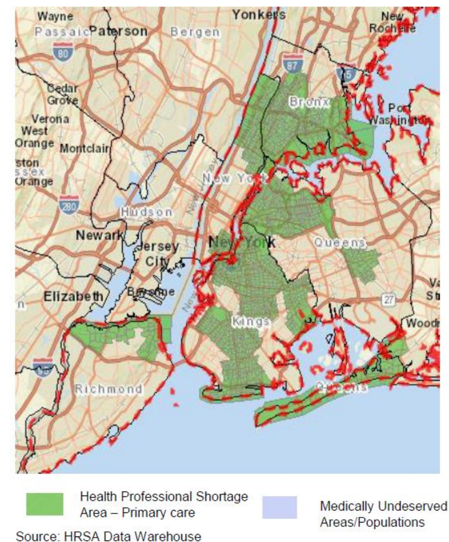
The NYP PPS has committed to a broader definition of "Primary Care," one that extends beyond the practice of a physician (MDs). Given the distinct needs (clinical, behavioral, and psychosocial) of the populations that were identified through the CNA, the PPS has invested heavily in the expansion of Primary Care to include Nurse Practitioners (Psychiatric and Primary

Care), Social Workers, Community Health Workers (CHWs), Peers, and other field-based staff to meet the beneficiary at the right time, the right place, with the right service. The PPS believes this extended Primary Care model will be an optimal substitute for the emergency department or, in some cases, a Primary Care visit. In addition, we believe this will be a creative, scalable deployment of the healthcare workforce in meeting many of our beneficiaries' needs.

FUNDAMENTAL 1: Assessment of Current Primary Care Capacity, Performance and Needs, and a Plan for Remediating Needs

Current Primary Care Capacity / Performance / Needs

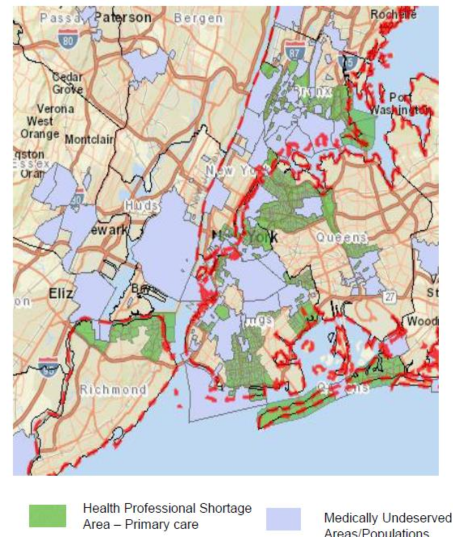
The NYP PPS focuses on the primary geographies of Northern Manhattan (Washington Heights, Inwood, and Harlem), South Bronx, Manhattan, and Western Queens. These are the primary areas where the PPS's collaborators (hospital and outpatient) draw their Medicaid beneficiaries. As identified by the New York State and the HRSA data warehouse, these areas are both designated as (1) Health Professional Shortage areas for primary care and as (2) Medically Underserved areas.



The NYP PPS includes the following primary care providers:

1. Institutional
    i. NewYork-Presbyterian Hospital / Columbia University Medical Center / Ambulatory Care Network (7 sites, all 2011 NCQA Level-3 Designated)
    ii. NewYork-Presbyterian Hospital / Weill Cornell Medical Center / Ambulatory Care Network (7 sites, all 2011 NCQA Level-3 Designated)
    iii. Charles B. Wang Community Health Center Chinatown Health Center
    iv. Harlem United Health Center
    v. Community Healthcare Network / Essex Street Health Center
    vi. Community Healthcare Network / Community League Health Center
2. Independent Community Physicians
    i. Theodore Docu, MD

ii. Gabriel Guardarramas, MD
iii. Andres Pereira, MD
iv. Jose Jerez, MD



There are several other independent community physicians that are part of the Advocate Community Providers PPS.

All of these practices are currently accepting new members and offer some level of after-hours access (whether via phone, patient portal, or collaborations with local health systems). According to NYS data, the NYP PPS (designated as a small PPS) contains 371 primary care physicians, with 88.6% accepting new Medicaid members. Of these 371 providers, 22.5% offer after hours care and 25.3% of these primary care physicians are at sites that are designated 2011 PCMH Level 3s.[1]

Plan for Remediating Need / Approach to Expansion of Primary Care Capacity & Competency

In response to the CNA and survey of the PPS provider network, the NYP PPS identified ten projects to address outstanding patient and provider needs. Many of the projects are based on primary care, including 2.a.i (Integrated Delivery System), 2.bi (Ambulatory ICU), 2.b.iii (ED Care Triage), 2.b.iv (Transitions of Care), 3.a.i (Behavioral Health Primary Care Integration), 3.e.i (HIV Center of Excellence), 3.g.i (Palliative Care) and 4.b.i (Tobacco Cessation). The PPS will leverage the primary care providers listed above, as well as a number of other community-based providers and community-based organizations (CBOs) to achieve the project requirements and implement the necessary transformation to meet the performance measurement goals.

Given that many of the projects focus on reducing unnecessary emergency department and inpatient service utilization, the PPS anticipates that work will be required of the participating primary care providers' practices in order to address needs that might have previously been met in an ED, or possibly, inpatient setting. If preventable emergency department utilization were reduced by 25% over five years, this would mean that 4,546 patient encounters would now need to be supported by the primary care system annually.

To address these anticipated challenges, the PPS is pursuing the following strategies:

1. *Connection to Health Information Exchange (HIE) Tools*
   The PPS is rolling out the Healthix RHIO to all of its participating providers and community-based organizations. Pending CRFP funds, the PPS network will be completely integrated to sharing information across providers in NYC. This will enable connectivity and communication across providers, potentially reducing unnecessary testing and conflicting healthcare efforts.

[1] The NYP PPS does not believe this statistic to be accurate as the vast majority of physician PPS members are affiliated with NewYork-Presbyterian Hospital and practice within their Ambulatory Care Network primary care sites, all of which were designated 2011 NCQA Level-3 PCMHs.

The PPS is also providing Allscripts Care Director (ACD) – the PPS's cross-agency care management platform - access to a number of CBOs that provide care management and coordination services to the highest risk patients. This platform is also used by the NYP Health Home. This tool will be connected to the RHIO as well as the NewYork-Presbyterian Hospital electronic health records, allowing primary care providers to communicate and coordinate effectively with those care team members who are working in patients' homes and communities.

2. *Expanding Access to Primary Care at Behavioral Health Sites*
   The NYP PPS is collaborating with the New York State Psychiatric Institute (NYSPI)'s two community-based behavioral health practices to place full time primary care nurse practitioners to address the unmet needs of the beneficiaries currently seeking the majority of their care through the NYSPI practices.

   The PPS is also working, and participated in the NYS MAX series to do so, to better integrate the care between the primary care and behavioral health settings at NewYork-Presbyterian Hospital. These settings already operate on the same EHR, but have opportunities to address the day-to-day collaboration between providers. These same sites are also investigating the integration of substance use treatment within the sites to address unmet substance abuse issues.

3. *Expansion of Hours at NewYork-Presbyterian Hospital Ambulatory Care Network Sites*
   The NewYork-Presbyterian Hospital Ambulatory Care Network (ACN) is currently investigating the opportunity to expand the weekend and evening access to Adult and Pediatrics primary care practices. These sites which serve nearly 150,000 Medicaid and Medicare beneficiaries are already existing PCMHs and have made significant investments in community programs to address patient's needs within and outside of the practice, including community health workers and emergency department patient navigators who are functioning as an extension of existing primary care practices.

4. *Collaboration with Non-Primary Care Providers*
   The PPS is making significant investments in non-physicians services to expand primary care practices' reach into the home and community. These include the integration of Health Home care managers into practices and the integration of Community Health Workers and Peers.

5. Implementing Open Access to Primary Care
   As part of the NCQA Level 3 PCMH achievement process, all participating PPS primary care providers will implement "patient-centered open access" processes to enable enhanced access to their respective care teams.

6. The PPS is also collaborating with a FQHC to staff their Mobile Medical Unit to provide "primary care-light" services , including PrEP and PeP, to at-risk beneficiaries at areas

around the City that are convenient to the population. The PPS anticipates this program to be operational in October 2016.

FUNDAMENTAL 2: Primary Care Expansion, Practice and Workforce Transformation as Supported by Training and Technical assistance

Working with Primary Care at Practice Level; Support to Achieve PCMH/APC

The NYP PPS is pursuing a tiered approach in supporting primary care practices to be successful in the DSRIP program and to be setup for future value-based payment efforts.

All practices are invited to participate in PPS Governance Committees, PPS Webinars (Housing, PCMH, and Palliative Care), biannual PPS Collaborator Symposia, and other events. These efforts are not provider type-specific and bring all providers together to collectively address the needs of the community.

For the 14 NewYork-Presbyterian Hospital ACN primary care practices, the NYP Office of Community Health and Development is actively pursuing the NCQA 2014 Level 3 PCMH designation for 2016. This Office takes a hands on approach with the designation effort – meeting weekly across the practices to address/share best practices and meeting at the practice level to ensure compliance with best practices and PCMH standards. This effort is occurring without support from the DSRIP resources.

For the 4 independent community physicians, the NYP PPS has contracted with the Primary Care Development Corporation (PCDC) to provide support for their NCQA application status. We anticipate these applications to be submitted in 2017. The NYP Office of Community Health and Development, which has a history of collaborating with the physicians through previous HEAL grants, will also be working on-site with the community physicians to support their change processes. In addition the PPS has developed a menu of consultative services (see appendix I) that would be available to the independent community physicians; these services would be available both on-site and via webinar.

For the 4 federally qualified health centers (FQHCs), the PPS is currently providing regular check-ins and support to FQHC PPS members in order to ensure Level 3 certification achievement in line with the appropriate timelines for their respective Medicaid managed care contracting strategies and DSRIP requirements.

The PPS is also making general population health and project-specific education materials available via a centralized Learning Management System (LMS). This system is not yet operational, but we anticipate it will be available in late September 2016.

Appropriate Use of Statewide Resources for Technical Assistance

The PPS PMO is constantly reviewing the wealth of resources available through New York State and the local trade associations (GNYHA, HANYS, CHCANYS, etc.). We have also developed a close relationship with the New York City Primary Care Information Project (PCIP) who keeps us abreast of new resources. Any resources related to APC/PCMH or general primary care improvement are distributed to the PPS members through the Governance Committees, website, and newsletter.

FUNDAMENTAL 3: PPS Strategy How Primary Care will play a Central Role in IDS

Strengthening the Continuum of Primary Care and Ensuring Linkages to Secondary/Tertiary Services

The PPS is actively pursuing the development of an Integrated Delivery System, including meeting the requirements of Project 2.a.i. Not only will the development of an IDS position the PPS for success in the DSRIP initiative, but it will also prepare the PPS, and its individual members, to be successful in future value-based payment arrangements. To enable the PPS's primary care providers' access to the full continuum of care, the PPS is pursuing the following strategies:

1. *Integrating all collaborators into Healthix RHIO*
   Pending CRFP funding, the PPS has committed to integrating all PPS members on to the Healthix RHIO health information exchange. The PPS has already begun baseline assessment of collaborators – stratifying members between highly-connected and connected groups to ensure the prioritization of RHIO access to those providers that drive performance. Access to the Healthix RHIO will facilitate enhanced communication and information exchange across the PPS, reducing the likelihood of unnecessary utilization.

2. *Integrating CHW, Peers, and other Field-Based Staff onto Allscripts Care Director*
   The PPS is supporting the rollout of ~30 field-based staff, including CHWs, Peers, and substance use specialists, to work in patient's homes and communities, as extensions of their primary care providers. These staff will document in Allscripts Care Director, a shared care management platform that will give primary care providers access to the efforts of their patients' extended care team.

3. *Integrating Substance Use and Behavioral Health Resources into Practices*
   As part of the Behavioral Health – Primary Care Integration (3.a.i) project, the PPS is also investing in bringing much-needed resources to primary care practices for their patients who have unmet/undiagnosed substance use needs. As promoted by New York State, this will leverage SBIRT to screen, diagnose and identify treatment options for beneficiaries while in their primary care setting.

4. *Improving Communication Across ED, Acute, and Outpatient Settings*
   The PPS is actively working on improving communication across key transitions between emergency departments, acute inpatient, and outpatient settings. This includes (1) alerts to providers when their patients are hospitalized, (2) transmission of summaries of care from inpatient discharges, and (3) active follow-up via Patient Navigators in the emergency department. The rollout of Healthix will enable these efforts.

Primary Care Representation in PPS Governance and Quality Committees

The PPS has worked diligently to include Primary Care providers in the governance and oversight of the PPS and projects. This inclusion effort takes on multiple forms:

1. *PPS Leadership includes Primary Care Representation*

The PPS Executive Committee includes several high-level Primary Care representatives, including (1) Dr. Emilio Carrillo, a practicing primary care provider at NYPH, leads the Clinical Operations Committee, (2) Dr. Steven Kaplan, the Chief Medical Officer for the NYP/ACN, leads the IT/Data Governance Committee, (3) and Betty Cheng, Chief Operating Officer of Charles B. Wang Community Health Center, is the Co-Chair of the Executive Committee.

Three of the eleven committee members are primary care providers or primary care provider representatives.

2. *PPS Governance Committees include Primary Care Participants*
   The PPS Committees include representatives from a number of Primary Care stakeholders, including (1) Harlem United – Clinical Operations (1 of 11 members), (2) Community Healthcare Network – Finance(1 of 11 members), and (3) Dr. Andres Pereira (an independent community physician) – IT/Data Governance (1 of 9 members).

3. *PPS Project Leads include Primary Care Representatives*
   A number of the PPS's projects are led by Primary Care Providers, including (1) Ambulatory ICU (3 pediatricians, 2 internists), (2) ED Care Triage (1 pediatrician), (3) HIV Center of Excellence and Reducing HIV Morbidity (2 infectious disease MDs). The Behavioral Health Integration and Palliative Care projects also include Primary Care Providers as key stakeholders and advisors.

4. PPS Clinical Operations Committee Includes Primary Care Representation
   The Clinical Operations Committee currently includes a representative from a FQHC as well as the project leads previously mentioned, many of whom are Primary Care Providers.

5. The PPS is focused on implementing a number of its projects' components in the NYP Ambulatory Care Network (14 primary care practices, representing 250+ primary care providers). These providers are actively and continuously engaged in DSRIP-related conversations through training, implementation conversations at practice team meetings, and engagement with new services made available through DSRIP funding (e.g. introduction of a Tobacco Cessation service).

The PPS will continue to rotate PPS members, including Primary Care stakeholders, through the Governance Committees throughout the remaining DSRIP performance years.

FUNDAMENTAL 4: PPS Strategy to Engage Primary Care in Value-Based Payments

Managing Key VBP Issues, Including Contracting, Analysis, HIE, and Workforce

The PPS is just beginning its investigation into achieving 80% level-1 value-based payments for its members. At this point, the PPS has made it a priority to disseminate information from New York State in an accessible format and to encourage participation in the State-sponsored VBP Bootcamps.

As with other efforts, the PPS will pursue a collaborative model in developing its VBP strategy, for both Primary Care and Non-Primary Care providers. This strategy will leverage all relevant

NYS, trade association, and PPS resources. To-date, the PPS has completed the Value-Based Payment baseline survey with its members.

The PPS PMO is collaborating closely with NYP/Queens PPS on the VBP strategy.

The PPS anticipates making the following available to its members:

1. *Developing VBP Educational Opportunities*
   In collaboration with its workforce collaborators and Workforce Advisory Workgroup, the PPS will develop education related to Value-Based Payment. This will include a focus on (1) the NYS VBP Roadmap, (2) contracting considerations, and (3) performance measurement considerations. The goal of the education will be to equip each provider with the necessary competency to construct an equitable agreement with their MCO partners.

2. *Assistance Navigating NYS Data Resources*
   The PPS PMO and Analytics Team will make itself available to help providers navigate future analytical resources that will be provided by New York State.

Fundamental 5: PPS Funds Flow Support for Primary Care Strategy

Resource Expense Related to Primary Care

The PPS is currently expending resources across five areas to support primary care:

1. *Direct Investment in Resources (FTEs, IT, etc.) in Primary Care Practices via Projects*
   As a number of the projects are Primary Care-focused, the PPS is investing in new staff (Care Managers, Social Workers, CHWs, etc.) to expand the capacity and efficacy of Patient-Centered Medical Homes (PCMHs).

2. *In-Kind Investment in 14 NYP/ACN PCMHs – Several dedicated FTEs*
   As mentioned previously, the NYP Office of Community Health Development is currently focused on achieving 2014 NCQA Level-3 PCMH recognition for the 14 primary care practices.

3. *Direct Investment in Primary Care Development Corporation (PCDC) - $60K contract*
   The PPS has directly contracted with PCDC, on behalf of its members, to collaborate with the 4 independent community physicians. PCDC and the NYP Office of Community Health Development will work closely with these physicians to ensure that they've developed the necessary competencies and infrastructure to (achieve PCMH recognition and be successful in VBP arrangements.

4. *Indirect Investment in Workforce / Training Opportunities*
   The PPS, in collaboration with its workforce partners, are making a number of training and education resources available (Fall 2016) for all of its members. These resources will be valuable in practice's continuous success in DSRIP and future VBP efforts.

5. *Direct Investment in Primary Care Clinician Time to Serve as Project Leads - ~$270K/year*
   As mentioned earlier, a number of the PPS's projects are led by active primary care clinicians. As such, the PPS is directly funding portions of their time to serve in this administrative role.

The PPS is currently flowing funds to providers/collaborators through service (direct purchase) agreements only. As an example, there are a number of CBOs receiving funds to support the recruitment and use of Community Health Workers to target the underserved and unengaged Medicaid beneficiaries.

Primary Care Providers are not currently receiving direct financial support, unless they're covered as a project lead (line #5 above). There are not currently payments for engagement.

The PPS's funds flow model will continue to evolve, as DSRIP transitions from pay-for-reporting to pay-for-performance. The PPS anticipates that rather than block-grant, sub-contracts, as it is currently utilizing, that it will transition to a more pay-for-performance model that rewards Primary Care Providers for their achievement of process and outcome milestones. This model is yet to be developed.

FUNDAMENTAL 6: PPS Progress toward Integrating Behavioral Health and Primary Care

The PPS is actively pursuing the integration of Primary Care and Behavioral Health across a number of settings:

1. *Integrating Primary Care at New York State Psychiatric Institute (NYSPI) Outpatient Clinics*
   The PPS is currently finalizing a contract with NYSPI to place Primary Care Nurse Practitioner at their two community-based mental health practices. These NPs will provide full spectrum primary care for those patients whose primary point of contact with the healthcare system is through psychiatry.

2. *Developing Integrated Ties with Community-Based Behavioral Health Providers*
   The PPS is focused on developing streamlined referral and information exchange with community-based providers for those patients who do not wish to receive co-located care or who have existing relationships with external Behavioral Health providers. These relationships will be supported by Healthix access.

3. *Embedding Behavioral Health Resources into Practices*
   For the NYP/ACN practices, the PPS is enhancing the communication and information exchange with currently embedded behavioral health resources. These existing resources often provide psychopharm treatment to patients in their primary care setting, but do not work on transitioning them back to their primary care provider once stable. New protocols will be developed to ensure access to existing resources is maintained.

4. *Embedding Substance Use Treatment into Practices*
   The PPS is investigating, and collaborating with the other NYC-based, Performing Provider Systems, the best process to embed substance use screening (including the use of on-site

CASACs) into primary care and behavioral health practices. This includes evaluating the applicability of SBIRT and the various standardized substance use screening tools.

5. *Embedding Substance Use Treatment into Practices*
   The PPS is investing in identifying the appropriate mix (staffing, embedded vs. employed, etc.) of substance use treatment resources to integrate into Primary Care practices. These new resources will bring much needed attention to the under-diagnosed / under-treated substance use behaviors in the community. This will also include close ties to outpatient rehabilitation programs for those beneficiaries who need additional support.

6. *Embedding Depression Care Management into New Practices*
   Several participating practices already leverage the IMPACT Depression Care Management model and have seen significant uptake in screening and treatment. This model will be expanded to other primary care practices.

Summary

The NewYork-Presbyterian Performing Provider System is actively implementing its population health management strategy, including a significant focus on strengthening patient-centered medical homes as the anchor of these activities. The PPS will continue to evolve its engagement of and focus on Primary Care Providers, supporting them as they transition from DSRIP-funded initiatives to future VBP efforts.