Primary Care Plan Update 2017

OneCity Health

September 29, 2017

Introduction

The New York State (NYS) Delivery System Reform Incentive Payment (DSRIP) Program´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent by 2020. To transform the system, the DSRIP Program focuses on the provision of high quality, integrated primary, specialty, and behavioral health care in the community setting, with hospitals used primarily for emergent and tertiary levels of service. The integration of services and the path to value-based care puts primary care at the center of the health care delivery system. Primary care is the cornerstone of the DSRIP Program and is critical to NY State's success in the overall improvement and coordination of health care.

Instructions

The DSRIP Primary Care Plan Update is an opportunity for each PPS to highlight, and inform the New York State Department of Health (the Department) and the DSRIP Project Approval and Oversight Panel (PAOP) of, progress towards and challenges to the improvement of Primary Care under the DSRIP program.

For each fundamental, the PPS is asked to provide a series of brief updates in the space provided (approximately 250 words) to questions under each fundamental in its final Primary Care Plan submitted in 2016. The PPS should reference its previously submitted Primary Care Plan when completing this Update. Completion of the Primary Care Plan Update includes the progress the PPS has made within a fundamental, an outline of any challenges related to implementing the Primary Care Plan strategies, an explanation of any changes that need to be made to the Primary Care Plan, and other related questions where applicable. The Department requests that the PPS be as concise as possible in its responses; where elements are not relevant to their Primary Care Plan, 'N/A' should be written. Under fundamentals where no strategic changes have been made, please describe how the PPS' initial strategies continue to support that fundamental. Throughout the Update, some fields have been auto-populated for the PPS' convenience based on figures available to the DSRIP team. The Department requests that the PPS review these fields for accuracy and make revisions where necessary. The completed template is **due September 29, 2017** to the DSRIP Team at dsrip@health.ny.gov with subject line: 'Primary Care Plan Update'.

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Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

a. From April 1, 2016 to March 31, 2017, describe any overall strategic changes the PPS has made and the impact of these changes on the PPS' final Primary Care Plan submitted in 2016.

Primary care is integral to OneCity Health's strategies and plans and, as such, must play a central role in the high-performing health care system of the future. As described in the PPS' final Primary Care Plan, submitted in November 2016, OneCity Health conducted extensive assessments to understand the state of primary care capacity and performance as well as to identify the gaps to be filled.

OneCity Health is committed to the strategies described in the Primary Care Plan in order to close the significant primary care gap identified. These strategies include expanding and making more efficient use of primary care capacity, helping primary care practices build capabilities and connectivity (including achieving NCQA PCMH 2014 Level 3 recognition), implementing evidence-based care models centered on primary care, and connecting primary care practices with the entire care continuum and the communities they serve.

During the timeframe covered in this Primary Care Plan Update, the PPS has made progress along many dimensions. OneCity Health's progress is described throughout this document and includes: adding primary care partners to expand capacity; focusing on primary care capacity and access within the PPS' largest partner (NYC Health+Hospitals); providing technical assistance and learning opportunities for practice transformation; and contracting that rewards primary practices for outcomes and helps prepare for a value-based payment environment (in accordance with New York State VBP objectives). OneCity Health continues to focus on increasing primary care capacity to address the need for primary care among the people the PPS serves.

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

- PPS' over-arching approach for expanding Primary Care capacity and ensuring the provision of required services (including, as appropriate, addressing gaps in Primary Care capacity)
- How is the PPS working with community-based Primary Care Practitioners (PCPs), as well as institution-based PCPs?

a. Describe the PPS' progress in addressing primary care capacity and needs from April 1, 2016 to March 31, 2017. Include efforts to extend hours and increase access to primary care services:

In order to expand the PPS network's primary care capacity, OneCity Health added eight partners, three of which provide primary care. In addition, OneCity Health re-engaged two partners that provide primary care to encourage their participation in the PPS.

The PPS' largest partner (NYC H+H) has undertaken significant programs to increase primary care capacity and better utilize existing capacity. This included plans to hire practitioners, expand physical footprint, and deploy 24x7 call centers to improve access and utilization of available appointment slots (implementation extends beyond the timeframe of this document). OneCity Health engaged PCMH experts to provide training and transformation support to enable professionals to practice at 'top of license' which is expected to free up physician and nurse practitioner capacity (further detail in the Fundamental 2 section).

The PPS has encouraged partners to extend hours and implemented programs to increase access through better linkages to primary care. PCMH champions enhanced access for practices' patient population. NYC H+H makes an effort to provide primary care access both after-hours and on weekends at its 17 main ambulatory care sites, when possible. NYC H+H also implemented televisits to increase access. Transition management teams, embedded in hospital units, develop care plans and send those plans to primary care providers (PCPs) to support linkages and promote access to and use of primary care.

OneCity Health receives updates on PCMH progress directly from PCMH technical assistance vendors and the practices themselves. OneCity Health addressed financial barriers to PCMH by subsidizing PCMH application fees for eligible community primary care sites. The PPS also receives monthly NCQA data feeds to track which practices are recognized. Beyond the reporting period, NYC H+H plans to hire additional PCPs.

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

The PPS faced a number of challenges with addressing primary care capacity needs. Hiring and retaining PCPs has been a major challenge. Causes of this difficulty include an overall workforce shortage among primary care practitioners (MD/DOs, NPs, PAs), the salary gap between primary care and specialties, and the high-cost of living in New York City (which exacerbates the other causes).

Space constraints among PPS partners and the high cost of real estate in New York City make footprint expansion expensive across the PPS.

Budgetary constraints and hiring limitations affected the PPS' largest partner (NYC H+H) during the April 1, 2016 – March 31, 2017 timeframe. NYC H+H has developed approaches to expand primary care capacity (some of which have been implemented after the timeframe of this document).

c. Based on the PPS' progress and challenges addressing Fundamental 1 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 1 outlined in the final Primary Care Plan submitted in 2016?

OneCity Health has not made major strategic changes to Fundamental 1 as described in the final Primary Care Plan submitted in 2016. OneCity Health's initial strategies continue to support Fundamental 1. These strategies include supporting primary care access and expansion; strengthening primary care capabilities and infrastructure (tailored to the needs of different practices); deploying care models that improve primary care and connect it with other settings; and engaging community organizations to connect people to primary care and address social needs.

In light of the challenges OneCity Health has faced in addressing Fundamental 1, the PPS has refined its approach to engaging community based PCPs (as described in section d. below) and added partners to increase primary care capacity and access (as described in section a. above). Furthermore, PPS partners (including NYC H+H) planned to identify and benefit from other funding sources to support adding/renovating space to increase primary care's footprint, thereby increasing access.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:
OneCity Health pursued a number of initiatives to engage community-based PCPs. The PPS conducted face-to-face orientations for new primary care partners who were added to the network. In addition, OneCity Health provided technical assistance (through contracted vendors with PCMH expertise) to help community-based PCPs achieve NCQA 2014 PCMH Level 3 recognition. As a complement to technical assistance, OneCity Health planned and implemented PCMH Learning Collaboratives as a way to engage and support community-based PCPs (as described further in the Fundamental 2 section). Furthermore, OneCity Health included PCPs in the implementation of a number of care models. For example, training and toolkits for primary care are integral components of models to address asthma in the Expansion of the Home Environmental Asthma Management Program (Project 3.d.ii). This includes the "Asthma Project Toolkit for Primary Care" and the PACE (Physician Asthma Care Education) curriculum, in addition to toolkits for other clinical projects such as HIV Access and Retention (Project 4.c.ii), Integration of Palliative Care into the PCMH Model (Project 3.g.i), and Cardiovascular Disease Management (Project 3.b.i).

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	465

e. Additional Information

Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:	1,199
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	642
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	0

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

- What are your PPS plans for working with Primary Care at the practice level, and how are you supporting practices to successfully achieve PCMH or APC recognition? (Resources could include collaboration, accreditation, incentives, training and staffing support, practice transformation support, central resources, vendors to support key activities, additional staffing resources, etc.)
- How is your PPS working to ensure that existing statewide resources for technical assistance are being leveraged appropriately?

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

OneCity Health made progress in working with primary care practices to meet the NCQA PCMH 2014 Level 3 milestones (the PPS focused on PCMH). OneCity Health engaged three practice transformation vendors who provided support to primary care practices, and made plans for another round of technical assistance for primary care practices.

OneCity Health conducted learning collaboratives for primary care practices (held on October 28, 2016, and January 25, 2017) which were attended by approximately 70 people. The sessions covered the first three PCMH Standards: Team Based Care, Enhanced Access, and Population Health Management.

OneCity Health has provided financial support and incentives to encourage primary care practices to achieve PCMH milestones. This includes paying for PCMH recognition fees for community-based primary care practices and implementing a contract metric for its PPS partners which provides funds for primary care practices to report on plans for achieving NCQA PCMH 2014 Level 3 recognition status.

The PPS worked with primary care practices to build information technology capabilities and connections across the health care delivery system and with social services organizations. Specifically, OneCity Health engaged a technical vendor to conduct onsite assessments to determine practices' information technology capabilities and connect them to a RHIO.

OneCity Health developed a PPS resource directory to support PCPs in making referrals to organizations to address the non-clinical needs of patients. For the longer term, OneCity Health developed a plan to roll out an online platform to facilitate social services referrals and referral tracking across the PPS.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in working with primary care practices to meet NCQA PCMH 2014 Level 3 or APC milestones:

OneCity Health has encountered several challenges while working with primary care practices to meet NCQA PCMH 2014 Level 3 milestones. Primary care practices face competing priorities and have limited resources. Practices often are expected to meet many metrics from different payers, PPSs, health systems and other stakeholders. These practices can be overwhelmed with the volume of requests and requirements, and are already financially challenged, short-staffed and working long hours.

Furthermore, the NCQA PCMH application process is time-consuming and can be difficult for small primary care practices with limited staffs and resources.

In addition, technology has been a barrier. Community primary care practices (particularly small practices) have difficulty connecting with RHIOs and limited time to respond to surveys or engage with vendors that can help them establish electronic connectivity and provide documentation of this connectivity. Data reporting and analytics capacity is a challenge. OneCity Health hopes to incorporate this into future contracting and future technical assistance to improve partner data and analytic capabilities.

c. Based on the PPS' progress and challenges addressing Fundamental 2 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 2 outlined in the final Primary Care Plan submitted in 2016?

Based on OneCity Health's progress and challenges addressing Fundamental 2, the PPS made a number of changes. The PPS revised the community primary care engagement strategy to develop a deeper understanding of practices' capabilities. This understanding was used to tailor how the PPS works with the practices to make the PCMH development process less burdensome (which is an impediment as described in section b. above). The PPS also changed how the technical assistance vendors' teams work with practices to be more integrated with the staff at the practices.

OneCity Health developed a closer alignment between PCMH-based practice transformation and the clinical programs rolled out as part of other DSRIP initiatives (e.g., primary care/behavioral health integration) to reduce the competing priorities and metric overload that primary care practices experience.

In addition, OneCity Health has encouraged primary care practices with limited technical resources to collaborate with other practices.

OneCity Health's Learning Collaboratives specifically discuss the integration between PCMH concepts and the relevant DSRIP clinical projects such as asthma and CVD. OneCity Health also encourages PCMH technical assistance vendor teams and partners' internal PCMH teams to attend training so everyone is aware of both DSRIP and PCMH concepts. In the future, OneCity Health plans to embed PCMH language into DSRIP implementation to reinforce the idea that PCMH is embedded within transformation as opposed to a separate 'project'.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?
OneCity Health has found a number strategies to be effective to support PCMH transformation. As described above many primary care practices do not have the resources to dedicate to transformation and are overwhelmed with competing improvement initiatives. The PPS has found that for large partners and systems, deploying centralized or dedicated teams to complete the PCMH applications was effective in reducing the administrative burden for primary care practices. When practices need direct support, OneCity Health has found that individual sessions with a technical assistance vendor are more effective than group sessions in understanding the specifics of each practice's situation and conveying needed information. The PPS has also found that providing 'toolkits' that document approaches for practice transformation, managing patient population health, and shifting to team-based care was helpful to achieving improvement. Along with toolkits, treating practice transformation as mainstream work, not a "side project," promoted effective implementation.

e. Additional Questions:

Is the PPS contracting with any vendor(s) for PCMH recognition assistance? ☒Yes ☐No

Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:	102
Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from outside the PPS contracted vendors as of March 31, 2017:	1,097

Is the PPS contracting with any vendor(s) for electronic health record (EHR) transformation assistance?
☒Yes ☐No

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

- How will the PPS strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services?
- How is Primary Care represented in your PPS' governance committees and structure, and your clinical quality committees?

Number of Engaged Primary Care Practitioners	1351

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards implementing an integrated delivery system with Primary Care playing a central role. Be sure you address efforts to strengthen the continuum of Primary Care and ensure meaningful linkages to necessary secondary and tertiary services:

The PPS made significant progress towards a primary care centric integrated delivery system (IDS).

OneCity Health implemented teams to manage transitions between emergency departments and primary care, as well as between inpatient and primary care. Transition teams embedded in hospitals developed patient care plans and sent them to patients' PCPs.

The PPS implemented programs to link PCPs and their patients to needed services. For example, PCPs were trained in asthma management and provided with an asthma toolkit. PCPs made referrals to community health workers who conducted home visits and identified interventions to address asthma triggers. In addition, OneCity Health launched training for community-based PCPs regarding appropriateness of specialist referrals.

A critical element in strengthening primary care's role in an IDS is integration of behavioral health. The PPS supported integration of behavioral health treatment into primary care settings, and vice versa. This also included providing more depression management and substance abuse treatment in the primary care setting.

The PPS contracting approach supports primary care's central role. Phase 1 contracts encouraged PCMH recognition and Phase 2 contracts linked payments (in part) to outcomes measures, with an emphasis on outcomes impacted by primary care.

OneCity Health's largest partner (NYC H+H) planned and rolled out initiatives to strengthen primary care as the focus of the system. This includes stronger care management linking patients to primary care, secondary and tertiary services. Furthermore, NYC H+H enhanced its call centers to facilitate scheduling and promote linkages to primary and specialty care.

b. From April 1, 2016 to March 31, 2017, describe the PPS' challenges in implementing an integrated delivery system with Primary Care playing a central role:

The PPS has faced challenges in implementing an IDS with primary care playing a central role. The challenges fall into two broad categories: technology/information sharing and primary care capacity.

A number of primary care practices are not connected to a RHIO and are limited in their use of information exchange after practices are connected. The lack of interoperability across EMR, appointment scheduling and other systems throughout the PPS network is a barrier to information flows across an IDS. In addition, reluctance of some primary care practices to share data, skepticism about RHIOs, and inconsistency in obtaining patient consent for adults and children are impediments to the information flows required in a high-functioning, primary care centric IDS.

In addition to the technology/information challenges, the limited number of primary care practitioners is an ongoing challenge for implementing an effective, primary care centric integrated delivery system (as described in the Fundamental 1 section above).

c. Based on the PPS' progress and challenges addressing Fundamental 3 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 3 outlined in the final Primary Care Plan submitted in 2016?

OneCity Health has not made major strategic changes to Fundamental 3 as described in the final Primary Care Plan submitted in 2016. OneCity Health's initial strategies continue to support Fundamental 3. These strategies include integrating primary care and behavioral health services; promoting cardiovascular disease and asthma management in the primary care setting; supporting palliative care led by primary care; linking patients in the Emergency Department to primary care; managing transitions from inpatient setting to primary care; helping connect people who are not regularly engaged with the health care system to primary care; and providing Health Home At-Risk (Project 2.a.iii) patients with care management and linkages to primary care.

In light of the technology challenges OneCity Health has faced in addressing Fundamental 3, the PPS has refined its approach to supporting primary care practices with connectivity. This has included more tailored technical assistance (with an additional round of TA planned). Moreover, the PPS developed an approach for future contracting that will provide financial incentives for primary care practices that demonstrate RHIO connectivity and usage.

To address the primary care capacity/supply challenges, OneCity Health has taken steps that include adding partners who provide primary care, helping providers practice at 'top of license' to free up clinicians' time, and working with its largest partner (NYC H+H) to increase capacity and use existing capacity more effectively.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices with implementing EHRs and reaching Meaningful Use Stage 2:

OneCity Health built upon research done with PPS partners starting in 2015, specifically an assessment of Electronic Health Record (EHR) use across the PPS. This research included the Partner Readiness Assessment Tool and interviews with stakeholders, including primary care providers. Based on this research, the PPS developed a plan to procure a Meaningful Use Stage 2 EHR that would be offered in the future to PPS partners free of charge. OneCity Health also developed an approach for offering training and technical support to primary care practices on using an EHR, enabling secure messaging, and connecting with Qualified Entities (QE).

In addition to EHR support, the PPS has encouraged partners to use tools to promote development and sharing of care plans (GSI) and make referrals (HHC Advantage) – important elements of an IDS.

OneCity Health is in the process of reaching out to partners regarding RHIO connectivity. As part of this effort, OneCity Health will provide a free meaningful use certified EMR option, that is connected to a RHIO, for partners who provide clinical services but do not have a meaningful use certified EMR.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to assist primary care practices to connect to Regional Health Information Organizations (RHIO)/Qualified Entities (QE) and the State Health Information Network of New York (SHIN-NY):

The PPS supported a dedicated outreach effort to encourage primary care practices to connect to a RHIO and the SHIN-NY. OneCity Health developed plans to offer direct technical support to primary care practices that is tailored to practices' needs. In some cases, the PPS supported in-person, onsite assistance to connect primary care practices to a QE.

Furthermore, the PPS has and continues to work with NY Care Information Gateway to educate primary care practices on the benefits of being part of a QE and to answer any of the network practices' questions (in addition to offering direct technical support).

OneCity Health developed plans to provide financial incentives through PPS contracting that will reward practices that connect to a RHIO and use that connection for data exchange.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	1,117

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	20, 18%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	18, 90%
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	2, 10%

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

- How will key issues for shifting to Value-Based Payment (VBP) be managed? (e.g. technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals and emergency departments (EDs), creating transition plans, addressing workforce needs and integrating behavioral health)

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards VBP Readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan:

OneCity Health has made progress toward VBP readiness in primary care as determined by the PPS' VBP Needs Assessment and VBP Support Implementation Plan. To understand the current situation, OneCity Health conducted a VBP readiness survey to assess the level of VBP experience and understanding among primary care (and other) partners. The results of the VBP readiness survey informed the development of OneCity Health's VBP training program.

OneCity Health has sponsored practice transformation support which incorporates aspects of performance and measurement that are critical to participating effectively in value-based payments.

In addition, OneCity Health developed an approach for PPS network contracting that includes outcomes measures. This approach creates upside-only shared savings for primary care practices and is consistent with Level 1 VBP on the State VBP Roadmap.

Lastly, OneCity Health's largest partner (NYC H+H) developed (and has since rolled out) a population health dashboard that focuses on quality and cost/efficiency measures. This type of regular reporting and feedback will be critical to success in VBP contracting arrangements.

The PCMH model requires practices to perform QI and continuously monitor performance. OneCity Health shares PPS outcome measures with practices (upside only) and will offer additional technical assistance. This will build upon PCMH to help practices maximize their results on incentive programs.

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

The PPS has faced several challenges in working towards VBP Readiness among the PPS' primary care providers. Many primary care practices do not have experience with VBP, and the level of understanding varies greatly. Based on the PPS VBP readiness survey, 49% of primary care respondents indicated that they have existing VBP arrangements and 26% of primary care respondents indicated that they are very familiar with VBP.

Patient panels and attribution are typically components of VBP contracts for primary care practices (at higher VBP levels), yet some community-based primary care providers struggle to understand which patients they are responsible for. This is made more difficult by the diversity of attribution methodologies and limited communication to providers (and patients) about the meaning and impact of attribution.

Furthermore, many primary care practices have little access to data and limited reporting and analytical capabilities/resources. This situation is exacerbated by the large number of metrics (from government payers, commercial payers and third parties) that makes measurement challenging and dilutes focus of quality improvement efforts.

c. Based on the PPS' progress and challenges addressing Fundamental 4 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 4 outlined in the final Primary Care Plan submitted in 2016?

OneCity Health has not made major strategic changes to Fundamental 4 as described in the final Primary Care Plan. OneCity Health's initial strategies continue to support Fundamental 4 by helping partners meet the requirements for success in a VBP environment. This includes meeting operational requirements of being able to contract, report and manage the team that plans for and delivers care, meeting financial requirements of being able to assess and absorb financial risk (including ability to access stop-loss and/or other financing resources), and meeting requirements to deliver and demonstrate value as measured by cost, quality, patient experience and outcomes.

In light of the challenges OneCity Health faced in addressing Fundamental 4, the PPS refined its VBP readiness initiatives. OneCity Health began to develop a comprehensive VBP training program, informed by findings from the VBP Readiness survey. This training addresses the challenge of limited understanding of VBP among the PPS partners.

OneCity Health planned for additional technical assistance for community-based primary care practices. Training and technical assistance are complemented by OneCity Health-sponsored PCMH Learning Collaboratives open to all community-based primary care partners. Additionally, partners that are eligible for a contract with OneCity Health will be eligible to receive an incentive payment and TA for initial and ongoing RHIO connectivity.

Finally, a number of steps were taken to begin to address the data and reporting challenges that impact moving successfully towards VBP. These include a population health dashboard developed and rolled out at NYC H+H, support for connectivity among community-based PCPs, and ongoing development of the PPS' analytical resources.

d. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers to engage Managed Care Organizations (MCOs) for VBP contracting:

The PPS worked with its largest partner (NYC H+H) on the Value Based Payment Quality Improvement program (VBP QIP) which promotes the use of value-based contracts between NYC H+H and all of the MCOs with which it contracts. VBP QIP is a 5-year New York State Department of Health initiative related to, but distinct from DSRIP. VBP QIP has three objectives: fund financially distressed hospitals, promote value-based contracting with managed care organizations, and reward quality improvement. VBP QIP included establishing metrics (e.g., diabetes control, follow-up after mental health discharge) that rely on primary care practitioners and are consistent with elements of value-based contracts.

In addition, OneCity Health worked closely with Healthfirst, EmblemHealth and MetroPlus, three of the largest Managed Care Organizations that serve people with Medicaid coverage within the PPS' geographic region, to improve data flows and establish quality measures.

e. From April 1, 2016 to March 31, 2017, describe what the PPS has done to support Primary Care providers in levels 2 & 3 VBP arrangements to address social determinants of health and engage Tier 1 Community-Based Organizations (CBOs):

Based on the limited prevalence of VBP arrangements in the PPS (as described in section b. above) it is unlikely that many primary care partners in the PPS had a level 2 or 3 VBP arrangement in place during the timeframe of this document. OneCity Health's largest partner (NYC H+H) is in level 2 or 3 VBP arrangements.

OneCity Health has worked with NYC H+H primary care providers to address social determinants of health and engage Tier 1 CBOs. The PPS has supported information and referral sources to help connect patients to CBOs (including a CBO resource directory and services from Health Leads).

The PPS has engaged CBOs through a Strategic Advisory Workgroup to advise the organization on making connections that address social determinants of health. The Strategic Advisory Workgroup identified various challenges and outcomes in working with PCPs including: PCPs are unaccustomed to having CBOs as members of their care teams and are therefore hesitant to make referrals. CBOs are unable to determine the impact of their interventions on a patient's health because CBOs do not have access to patients' health information such as hospitalizations or results of health screenings. It is a challenge to develop metrics for the impact that CBOs have on the social determinants of health.

Moreover, OneCity Health developed plans to implement a social services referral platform across the PPS network. It is expected that primary care practices would be heavy users of this referral platform. After the timeframe specified for this document, OneCity Health has proceeded with selecting and contracting for a referral platform and has developed a plan for rolling this out across the PPS network.

As additional PPS primary care partners move into level 2 and 3 VBP arrangements, the steps described above will support engagement between primary care providers and CBOs.

f. Additional Questions

Is the PPS planning to form a contracting entity (e.g. ACO Certificate of Authority)? ☐Yes ☒No ☐N/A

…If yes, has it been granted? ☐Yes ☒No

Has the PPS provided technical assistance to primary care partners planning to form a contracting entity (e.g. ACO or IPA)? ☐Yes ☒No

…If yes, describe: Click or tap here to enter text.

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

- What resources are being expended by your PPS to support PCPs in DSRIP?

a. Describe how the funds flow model(s) support(s) primary care in the PPS network:

OneCity Health continued to support its primary care strategies with its fund flow models through metric-based schedules and investments to help primary care practices develop information technology and other capabilities. In addition, the PPS funded technical assistance for practice transformation.

Metric-based schedules initially provided funds based on implementing care models that address the needs of PPS members, providing information required to develop an IDS, and engaging with the PPS. During the specified timeframe, the PPS developed a modified contracting approach that (consistent with the overall DSRIP program) evolved to incorporate outcomes measures that primary care practices can influence.

Furthermore, OneCity Health funds flow includes investments that support the PPS' primary care strategies including practice transformation technical assistance, financial support for NCQA PCMH application and licensing fees, and technological support to connect to a RHIO, achieve Meaningful Use requirements, and gain access to an electronic medical record (EMR).

As shown below, over 40% of total funds distributed flow has been directed to support primary care. It is important to note that the Hospital-Ambulatory Care category also includes some of the FQHCs in the PPS (such as those part of NYC H+H). To avoid double-counting, these funds are not included in the Federally Qualified Health Centers category. As a result, the total funds flow for FQHCs is greater than the amount shown in the FQHCs category (in the chart below).

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	$51,443,388	**100%**
Primary Care Provider	$13,954,021	27.1%
Hospital-Ambulatory Care	$13,015,515	25.3%
Federally Qualified Health Centers (FQHCs)	$699,133	1.4%
Primary Care Practitioners	$239,373	0.5%
PMO Spending to support Primary Care	$6,917,645	13.4%

c. Based on the PPS' progress and challenges addressing DSRIP performance from April 1, 2016 to March 31, 2017, what strategic changes have been made to the funds flow model outlined in the final Primary Care Plan submitted in 2016?

OneCity Health has not made major strategic changes to Fundamental 5 as described in the final Primary Care Plan submitted in 2016. However, the PPS has adjusted its funds flow approach to reflect the shift toward performance/outcomes of DSRIP and emphasize primary care.

During the timeframe of this report, OneCity Health developed the Phase II Comprehensive Schedule B framework (effective April 1, 2017 – December 31, 2017). The contracting methodology prioritized funds flow to primary care. In the Phase II contracting methodology, 25% of the total allocation in each partner's Schedule B is based on the PPS achievement of select outcomes metrics, shifting PPS contracting toward value-based payments. Furthermore, the PPS utilized a weighting system that reflected the impact of primary care on many outcomes metrics.

d. Additional Questions

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving PCMH or APC recognition? ☐Yes ☒No

From April 1, 2016 to March 31, 2017, did the PPS distribute payments for achieving defined performance measurement targets? ☒Yes ☐No

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

- Including both collaborative care and the development of needed community-based providers.

a. From April 1, 2016 to March 31, 2017, describe the PPS' progress towards integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i. within the quarterly report):

OneCity Health has made significant progress towards integrating Primary Care and Behavioral Health for both co-location of these services and implementation of the Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) model for depression screening at multiple locations. To promote co-location, OneCity Health engaged a vendor to work with 10 pilot sites over a 12-month period to develop implementation plans for co-location. Three of the pilot sites received capital funding from the Capital Restructuring Financing Program (CRFP) to support integration efforts to provide primary care to high-risk patients in behavioral health settings. The pilot explored potential partnerships between two community behavioral health providers and FQHC primary care partners in the PPS.

The PPS implemented the IMPACT model with 16 NYC H+H facilities and 13 community primary care partners. Furthermore, NYC H+H planned for the expansion of its successful collaborative care program for patients facing maternal depression and substance use disorders.

OneCity Health also partnered with the NYC Department of Health and Mental Hygiene (NYC DOHMH) to promote the Mental Health Service Corps, part of the Thrive NYC initiative. Both NYC H+H and community primary care sites applied to participate in the Mental Health Service Corps, which places social workers in primary care practices to conduct assessments, screenings, and treatment for substance use and mental health issues.

36 practices are currently participating in Mental Health Service Corps based on the applications submitted. 30 of these practices have full-time placements and the other six have part-time placements that spend 2-3 days a week at the practices. Year 2 placements began on September 18, 2017 and the practices received technical assistance focused on screening and warm handoffs.

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

The PPS faced a number of challenges to integrating Primary Care and Behavioral Health.

As with other aspects of the Primary Care Plan, staffing shortages, space constraints and limited technology/information sharing capabilities are a challenge to integrating Primary Care and Behavioral Health.

Additionally, consistently identifying gaps in care, establishing appropriate care coordination and ensuring ongoing engagement with primary care and behavioral health providers pose difficulties.

The challenges with co-location include the limited experience among partners. Importantly, the specifics of how to make co-location financially sustainable are complicated and some financing options (e.g. capital funding) are not available to all partners, meaning partners must develop tailored financial plans and identify other funding sources for upfront investments.

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

The PPS faced a number of regulatory challenges to integrating Primary Care and Behavioral Health. Partners had difficulty understanding the available regulatory options and the financial, clinical and operational implications of each option.

Limitations in workforce scope of practice and, in particular, the inability of non-FQHC Article 28 providers to bill for services provided by social workers to the general clinic population also create a barrier for partners to overcome. Combined with the lack of a regulatory mechanism to support a complete integration of existing programs under a single license, these restrictions pose a challenge to partners.

Also related to staffing, the 16-hour minimum requirement of the Integrated Outpatient Services License (IOS) for integrating primary care in the behavioral health setting is a challenge for sites with limited patient volume.

Lastly, regulations regarding facilities (physical plant) are viewed as cumbersome by providers and the time-limited nature of the DSRIP 3.a.i waiver for behavioral health integration creates uncertainty for providers.

d. Based on the PPS' progress and challenges addressing Fundamental 6 from April 1, 2016 to March 31, 2017, what strategic changes have been made to Fundamental 6 outlined in the final Primary Care Plan submitted in 2016?

OneCity Health has made adjustments, though not major strategic changes, to Fundamental 6 as described in the final Primary Care Plan submitted in 2016. The PPS continued to focus on co-location of behavioral health services into primary care settings and vice versa. OneCity Health continued to implement the IMPACT model in many locations across the PPS network, including the PPS' largest partner (NYC H+H).

In light of the challenges OneCity Health has faced in addressing Fundamental 6, the PPS has remained flexible in its implementation approach and made several adjustments. For co-location, the PPS and its vendor provided technical assistance materials such as regulatory guidance, financial models, needs assessment tools and clinical recommendations. The PPS expects that this support assistance will address some of the challenges driven by the complexity of regulations and many partners' inexperience with co-location.

PPS partners collaborated with the Mental Health Services Corps which funds positions and is one vehicle for easing the financial challenges to providing integrated care.

To address staffing challenges, OneCity Health helped NYC H+H to develop plans to implement a program embedding peer counselors in substance use disorder outpatient programs. The PPS planned to deploy peer counselors to work with care management teams in Emergency Departments to link patients to ambulatory care.

Through VBP QIP, the PPS has worked with two managed care organizations to promote the connection of patients discharged from an inpatient behavioral health facility to primary care, with a quality measure and payments tied to timely primary care visits.

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	In planning	4	4
Model 2	In planning	8	6
Model 3 IMPACT	In planning	4	29

f. Please check all trainings that the PPS provides directly, or supports partners in delivering, to Primary Care Providers for Behavioral Health Integration within DSRIP projects from April 1, 2016 to March 31, 2017:

☒Alcohol Use screening
☐ Billing for Integrated Care
☒ Collaborative Care for Depression, i.e. IMPACT model
☒ Depression screening
☐ EHR Integration
☐ Health Homes
☒ Medication Assisted Treatment (MAT) e.g. for Opioid Use Disorder or Alcohol Dependence
☐ Mental Health First Aid
☐ Outcomes Measurement
☐ Patient Consent and Privacy regulations specific to Behavioral Health populations
☒ Person-Centered Care
☐ Peer Services
☐ Population Health
☐ PSYCKES
☒ Quality Improvement Processes
☒ Regulatory Issues
☒ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
☐ Serious Mental Illness
☐ Tobacco Cessation
☐ Trauma Informed Care
☐ Other Mental Health screening (please specify): Click or tap here to enter text.
☐ Other Substance Use screening (please specify): Click or tap here to enter text.
☐ Other

Describe:

Click or tap here to enter text.

GLOSSARY OF TERMS

Community-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is not employed by a hospital or hospital-system

Engaged Provider: Providers reported in PIT/PIT-Replacement as engaged on at least one project

Institution-Based Primary Care Practitioner/Provider/Practice: A practitioner/provider/practice servicing primary care that is employed by a hospital or hospital-system

PPS-defined Network: Provider Network in the MAPP DSRIP PPS Network Tool filtered to Practitioner-Primary Care Provider (PCP) for Provider Category or PPS-defined Provider Category

Primary Care Practice: Individual sites providing primary care services

Primary Care Practitioner (PCP): Individual practitioner providing primary care services

Primary Care Provider: Entity providing primary care services

RHIO/QE Connectivity: Providers sharing data with RHIO/QE or have an active BAA in place with the RHIO/QE