# Primary Care Plan Update 2017

# NYU Lutheran Medical Center

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'.

## Index

## 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.*

1) **VBP:** The NYU Langone Health System established a Medicaid Focused Independent Practice Association (IPA) in December 2016 that allows for Value Based Payment contracting on behalf of NYU Langone Brooklyn PPS Partners. The focus of the IPA is to create a contracting mechanism aligning care across the health system and community providers. The IPA has signed Participating Provider Agreements (PPA) with Nine Tier 1 PPS Partners representing 86% of the PPS's attribution.

2) **PCMH:** The PPS is currently working with Primary Care Development Corporation (PCDC) to transform 5 Primary Care sites to 2014 Level 3 recognition, representing 14 PCPs. As a first step, the PPS purchased the Interactive Survey System (ISS) Tool for required sites before March 31, 2017. Now, the primary care sites are undergoing PCMH transformation efforts, with PCDC providing technical assistance and support for the five eligible sites, affording opportunities for sites to collaborate and learn from each other. PCDC will provide 1:1 practice coaching and facilitation modeling to adequately support the five eligible sites and they will submit for NCQA PCMH 2014 Level 3 Recognition within the current deadline of December 31, 2017.

3) **Workforce:** In order to accomplish DSRIP goals, and prepare the PPS workforce for transformation, the PPS collaborated with PPS stakeholders, including community-based organizations (CBOs) and Community-Based Primary Care Providers to create a robust Workforce Training Strategy. As a result of this collaboration, the PPS created a Role-Based Workforce Training Roadmap, consisting of over 50 training courses. The intent of these courses is to provide patient centered, integrated, and community based health management services, aligned with the needs of the population and community we collectively serve. The trainings will launch in September.

4) **Healthify:** The PPS has implemented Healthify with several partners and is exploring an expansion with more. Healthify is a community resource platform that provides an easy way for case managers, community health workers and other staff to find community-based resources and filter through various types of services to find what their client needs.

5) **Telepscyhiatry:** FHC has begun the process of implementing telepsychiatry to enhance the capacity of psychiatrists to see patients across our system. Initially, targeting the area with the greatest need, FHC will utilize telepsychiatry to provide child psychiatry services to the school health sites which are affiliated with the FHC. Behavioral health social workers are integrated into 18 school-based health clinics across Brooklyn and evaluate children at these schools for behavioral health issues.

**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:*

The Family Health Centers at NYU Langone (FHC) are projected to open a new 4,500 square foot facility located in Red Hook in the late fall of 2018 with 6 exam rooms and 2 dental rooms. The site is expected to serve over 2,500 residents annually and will offer an integrated model of service delivery to community residents including primary care, behavioral health and dental services.

Starting in September, 2017, Ezra will enact its strategy to increase primary care capacity by 16 hours or 25% at its 1312 38th Street site, keeping the center open until 9pm. Ezra received Certificate of Need (CON) approval for adding 10,000 square feet at an additional site, which will be used for primary care. This expansion will add 10-15 primary care rooms. Ezra also purchased three buildings where they will add 10 primary care rooms. These rooms are intended to open within two years.

In August 2016, ODA received Certificate of Need (CON) approval from the NYS Department of Health to certify an extension clinic for one of their locations. The approved Capital Restructuring Financing Project (CRFP) is part of ODA's overall plan to expand access to needed health care services for area residents and meet the growing health care needs of the community. ODA plans to start construction by October 2017 and are awaiting approval of the plans from the NYC Department of Buildings (DOB). The new site intends to expand primary care access to 3,112 new patients in Year 1 and will generate approximately 15,000 new patient visits.

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

The PPS' primary challenge is the need for physical space as our primary care programs continue to expand. Adding new space requires Certificate of Need (CON) approval, construction contracts, approval from the NYC Department of Buildings (DOB), and many other aspects. As a result, with limited resources and bandwidth, tackling physical space expansions can be a challenging process.

*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?*

Ezra Medical Center has hired a Certified Diabetes Educator (CDE) to pilot care management for diabetic patients and a Case Manager to focus on proactively tracking visits and closing care gaps. These two positions continue to focus on improving clinical quality measures. Ezra has also purchased NextGen healthcare technology, allowing them to create specialized EHR reports and implement workflows to close gaps, especially related to depression screening.

ODA Primary Health Care Network has established a care management department and has staff dedicated to reaching out to patients to schedule PCP visits. Through the care management department, care managers follow up with patients, including diabetic and asthmatic patients, to ensure that they visit their PCP, receive immunizations, obtain required screenings, and receive required controller medications. ODA is actively recruiting a Care Manager Supervisor and has hired a Report Writer to further increase care management efforts. Furthermore, ODA is in the process of implementing workflows to follow up with patients on ADHD, antidepressant and antipsychotic medications.

| *d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:* |
|---|
| In order to accomplish DSRIP goals, and prepare the PPS workforce for transformation, the PPS collaborated with PPS stakeholders, including community-based organizations (CBOs) and Community-Based Primary Care Providers to create a robust Workforce Training Strategy. As a result of this collaboration, the PPS created a Role-Based Workforce Training Roadmap, consisting of over 50 training courses. The intent of these courses is to provide patient centered, integrated, and community based health management services, aligned with the needs of the population and community we collectively serve. The trainings will launch in September.<br>Furthermore, primary care providers are represented within the PPS governance structure via participation in the Executive Committee, Nominating Committee and all the PPS's Sub-Committees: Finance, Clinical, IT and Compliance. Overall, there are 17 members in the governance structure who represent primary care practitioners; this represents 24.6 % of the PPS's governance board and committees. Of those who are represented, 29 % are hospital based and 71 % are community based.<br>All PPS PCPs (specifically PCPs) have been outreached at least once regarding RHIO connectivity. Early on we learned that a large proportion of our PPS did not have the EMR infrastructure in place to warrant a connection to a RHIO. We focused connections on those who were capable of connecting to a RHIO and had a sizable portion of DSRIP members attributed to them. Next, we devised a plan to provide a "pass-through" for those who were connected to an existing HIE but not our PPS partner RHIO (Healthix). Finally, for those partners who did not have an EMR system or other infrastructure necessary for connecting to a RHIO, we are providing portal access to Healthix as a workaround. With this three-pronged approach, we believe we can overcome technical limitations around RHIO connectivity. |

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| *Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:* | 214 |

e. Additional Information

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| *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:* | 231 |
| *Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:* | 182 |
| *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:*

The PPS is currently working with Primary Care Development Corporation (PCDC) to transform 5 Primary Care sites to 2014 Level 3 recognition, representing 14 PCPs. As a first step, the PPS purchased the Interactive Survey System (ISS) Tool for required sites before March 31, 2017. Now, the primary care sites are undergoing PCMH transformation efforts, with PCDC providing technical assistance and support for the five eligible sites, affording opportunities for sites to collaborate and learn from each other. PCDC will provide 1:1 practice coaching and facilitation modeling to adequately support the five eligible sites and they will submit for NCQA PCMH 2014 Level 3 Recognition within the current deadline of December 31, 2017.

*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:*

When conducting its network analysis, the PPS found that some of the organizations originally thought to be eligible for PCMH recognition were not because those sites did not provide primary care to 75% of their patient populations; the minimum threshold required by NCQA for PCMH eligibility. The PPS outreached primary care practices within our PPS that met the minimum threshold required by NCQA for PCMH eligibility. At this time, we attempted to engage and provide Technical Assistance (TA) for eligible practices but several declined because they were already undergoing PCMH transformation as part of another PPS. As such, the PPS is providing TA to all practices that were willing to participate in PCMH transformation efforts.

With PCMH Status, significant funding and efforts are required to support partners' meeting PCMH NCQA 2014 Level 3 status. Partner buy-in and compliance are additional challenges when moving forward to achieve new levels of PCMH recognition.

*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?*

The PPS identified in the 2016 Primary Care Plan that it needed to retain a consultant to perform an analysis of PCMH certified practices in the PPS. Once that was complete, the PPS planned to work with eligible PCPs at the practice level to support efforts to achieve PCMH 2014 Level 3 certification. The PPS has completed the network analysis and is working with five eligible sites to submit for NCQA PCMH 2014 Level 3 Recognition within the current deadline of December 31, 2017.

The PPS has issued a Request for Proposals (RFP) for selected partners to conduct an Evidenced Based Intervention (EBI) program for Diabetes – Diabetes Stanford Model Program as part of New York City Department of Health and Mental Hygiene's "Clinical-Community Program Linkages" program. The goal of Clinical-Community Program Linkages (CCPL) at the Primary Care Information Project (PCIP) is to develop sustainable and scalable pathways from the clinical environment to Evidence Based Interventions (EBI). Selected CBOs with personnel capacity will be trained to administer workshops related to the evidence based intervention (EBI) and use a tool created by the Quality & Technical Assistance Center of New York (QTAC).

The PPS collaborated with PPS stakeholders, including community-based organizations (CBOs) and Community-Based Primary Care Providers to create a robust Workforce Training Strategy. As a result, the PPS created a Role-Based Workforce Training Roadmap, consisting of over 50 training courses, including courses focused on Chronic Disease Management and Behavioral Health Management. Roles include but are not limited to Primary Care Physicians, front desk staff, administrative staff, physicians, nursing staff, social workers, diabetic educators, and medical assistants. The intent of these courses is to provide patient centered, integrated, and community based health management services, aligned with the needs of the population and community we collectively serve. The trainings will launch in

| *d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?* |
|---|
| The PPS has found the 1:1 practice coaching and facilitation model to be the most effective way to support PCMH transformation. This model requires each site to designate a multi-disciplinary, cross-hierarchical team to lead and manage the PCMH implementation process and work closely with the coach to achieve PCMH submission. |

e. Additional Questions:

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

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| *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:* | 14 |
| *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:* | N/A |

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?

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| *Number of Engaged Primary Care Practitioners* | 410 |

*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:*

As of July 2017, EPIC has been successfully implemented at NYU Langone Brooklyn, the FHC's nine primary care sites, and ten physician practice sites. To support efforts of this implementation, EPIC Go Live trainings and at-the-elbow assistance were provided to approximately 3,900 staff members working in Emergency Department (ED), outpatient clinics, operating rooms, and inpatient units.

The NYU Langone Brooklyn PPS has established an Enterprise Clinical Platform (ECP) as the core information technology infrastructure of the PPS. The ECP is fundamental to the PPS's integrated delivery system, designed to eliminate care gaps, facilitate care transitions, and address the full range of health and social needs to improve the health of the Medicaid population (including the DSRIP population) served. The ECP is also a foundational component of the Patient Navigation Center (PNC), which is intended to provide referral, care coordination, and transition services across the network. Connecting PPS partners with existing EHRs to the NYU HIE and/or Healthix is essential in capturing and sharing data between systems. This also provides portal view and other tools for viewing data/information within the PPS care network, as well as matches patient records and assigns unique medical record numbers for PPS patients.

The PPS also uses analytical tools such as Optum One and Azara for risk stratification and population health analytics, supplementary tools including Salesforce (for partner engagement and data management), the DSRIP Dashboards, Salient Interactive Miner (SIM), and Healthify (for lookup and referral to community-based PPS partners) are also being utilized as part of this effort.

*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 NYU Langone Brooklyn PPS has encountered several challenges including:
1) With IT connectivity, significant funding and expertise is required to meet EHR, data sharing and HIE connectivity requirements.
2) MCO contracting is complex and has considerable legal structural impediments. The Collaborative Contracting Model requires that each partner remain autonomous.
3) Patient Engagement involves the difficulty of engaging hard to reach patients, many of whom may have little familiarity with the health care system.
4) Provider Engagement consists of challenges to engage some providers to follow IDS care coordination protocols, use standardized interventions/tools and participate in performance management programs.
5) There is a significant risk with the State not transmitting timely, accurate, valid and meaningful current patient-specific data on our attributed population required for population health management.

*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?*

1) Epic Healthy Planet: a population health management module of Epic, is currently being implemented with a projected go live of October 2017. Healthy Planet is an Epic software module that has extensive reporting capabilities, dashboards and workflow tools, and compiles patient data to allow care managers the ability to truly manage patient populations. This software will provide the PPS with the tools to coordinate care delivery, monitor quality and cost, reduce financial risk and engage patients through a centralized data warehouse.

2) Salesforce: PPS is implementing Salesforce to support practice and workforce transformation. Salesforce will be implemented in two phases. Phase 1 will focus on developing the partner portal to enable bi- directional communication between the PPS leads and PPS Partners, as well as integrating tools to communicate data, training materials, and relevant information to the PPS. Phase 2 will focus on supporting the EPIC and PNC workflows, referral management and community resource tools.

3) Healthify: We've implemented Healthify with several partners and is exploring an expansion with more. Healthify is a community resource platform that provides an easy way for case managers, community health workers and other staff to find community-based resources and filter through various types of services to find what their client needs.

4) To address care patterns of high ED utilizers: a Community Health Worker (CHW) program is in the process of being implemented as part of the PNC. The CHWs will help patients make and maintain connections to essential medical, behavioral health, and social services in order to improve the patient's ability to care for him or herself. This will be done by assessing needs, creating a transitional plan, and by providing a "hands-on" intensive 30 day follow after the patient leaves the ED. CHWs will provide a warm handoff to the next level of care management services to appropriate medical, behavioral health, and social services. The ED Care Triage project has hired four CHWs to date and the intervention was deployed in August 2017. Two more CHWS have been identified and are currently being vetted by HR for the project. Over the past two months the CHW team has outreached 230 high risk patients in the emergency room. From the 230, 174 patients have accepted the 30 day transitional support which is a 75% engagement rate.

*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:*

1) Electronic Health Record (EHR): In summer 2016, Epic was implemented at NYU Langone Hospital – Brooklyn, 9 Federally Qualified Health Centers (FQHCs) at Family Health Centers at NYU Langone, as well as NYU Langone physician practice sites. This also includes the implementation of Epic-based disease registries, custom built care management/ coordination tools, and operational performance analytics or a population health module for use PPS Partners. This is intended to result in widespread adoption of standard order sets, continuity of care, risk stratification, care coordination and navigation within the same EHR. Customized disease registries and care management tools facilitates management of chronic illness, reduce avoidable emergency department visits and hospital admissions, and connect to community based health and social services.

2) Connecting the Community (HIE and RHIO): Connecting PPS partners with existing EHRs to the NYU HIE and/or Healthix is essential in capturing and sharing data between systems. This also provides portal view and other tools for viewing data/information within the PPS care network, as well as matches patient records and assigns unique medical record numbers for PPS patients. This makes it possible for the PPS to receive alerts of hospitalizations and ED visits, and to access all current and past services. The intended result is an information transfer for continuity of care among PPS partners, data aggregation across the network for analytical and management purposes, highly coordinated care to the PPS's patients, and enhanced system efficiency, reducing redundant or duplicative care. Partners without an EHR will access Healthix through the Healthix web portal.

*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):*

PPS has conducted a current state assessment to help develop a gap analysis. This strategy informs which PPS partners to prioritize when expending resources and timing to support partner's EHR/HIE connectivity implementation. PPS will continue to leverage NYU's HIE platform that already connects 26 different EHRs from various institutions, provides technical assistance to partners without existing EHRs, and help establish connectivity to HIE and the RHIO. To date, approximately 85% of our DSRIP members are attributed to partners who are connected to Healthix. Data collected through the HIE will feed into NYULMC's analytics and data warehousing platforms, which will perform analyses and facilitate population health management efforts. In addition to those resources, the PPS has engaged a healthcare analytics firm to provide real-time patient risk analytics. The analytics will provide population and patient-risk hot spotting, actionable clinically-driven content, proprietary predictive risk models, and the ability to create registries in an effort to focus interventions within the physician practice and PNC. Together, the combination of EPIC, Healthix and our healthcare analytics approach will aid the PPS and primary care physicians to reduce avoidable hospital use and increase clinical efficiency. The PPS's efforts and activities will provide the technological platforms for practitioners and partners to better integrate primary care services within the PPS network, support the integrated delivery system model, help move towards Value Based Payment scenarios, sustain practice transformation and help improve the coordinated level of care for our patient population.

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| *Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:* | 157 |

f. Additional Information

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| *Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:* | 13% |
| *Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:* | 29% |
| *Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:* | 71% |

**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:*

The NYU Langone Health System established a Medicaid Focused Independent Practice Association (IPA) in December 2016 that allows for Value Based Payment contracting on behalf of NYU Langone Brooklyn PPS Partners. The focus of the IPA is to create a contracting mechanism aligning care across the health system and community providers. The IPA has signed Participating Provider Agreements (PPA) with Nine Tier 1 PPS Partners representing 86% of the PPS's attribution including NYU FGP, Crown Medical, Premium, ER Medical, ODA, Olitsa Roth, Ezra, the Family Health Centers at NYU Langone (FHC), and Boro Park Pediatric Associates.

The NYU Langone IPA established a Level 1 VBP arrangement with United Healthcare Community Plan, effective January 1, 2017. The Network has a total membership of around 45,000, it is a shared savings arrangement with clinical integration measures and quality gate. Prior to forming the IPA, the FHC established a Level 1 VBP arrangement with Healthplus (22,200 Medicaid Memberships), and the FHC and Family Group Practice (FGP) established a Level 3 VBP arrangement with Healthfirst (20,600 Memberships). The NYU Langone IPA is also exploring shared savings/risk arrangements with other Medicaid plans.

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

One of major challenges facing the PPS is accessing and sharing the data that is necessary to improve performance under shared-risk/value-based models. At present, gaps in readiness are most pronounced in data sharing and application. The PPS is building technical capabilities that are important to succeed in risk-based value arrangements in the areas of interoperability, and real-time data access. Although Epic was rolled out at NYU Langone Hospital – Brooklyn in August of 2016, it took time and effort to train staff and make them familiar with Epic software. Connecting our VBP partners to a shared platform is another challenge that the PPS is working to overcome.

*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?*

To prepare partners for VBP arrangements, the IPA provides:

1) Enhanced information sharing through centralized infrastructure to provide services such as analytics, pharmacy management, and IT connectivity
2) Improving coordination of care between providers across the continuum of care
3) Expanding the use of integrated information technology systems such as EPIC and Healthy Planet to enable connectivity across the health system and PPS partners
4) Gap in care analysis and building the necessary systems to monitor gaps in care and to manage care transitions
5) Powerful analytical capabilities to understand quality and total cost of care for the population
6) Frequent ED utilizers, and readmission data
7) Identifying high risk cohort patient and engaging for care coordination

*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 IPA provides analytic reports and resources focused on providers and community based organizations that have potential to deliver higher value care via:

1) United Healthcare High Risk Cohort analytical reports
2) Hospital admission and readmission trend reports
3) Performance Data
4) Open Gap in Care Reports
5) Cost/Utilization Data

Additionally, the IPA continues to work with MCOs to receive clinical integration measures including: Access to Care, Inpatient care transitions, Emergency visit care transitions, and High risk cohort patients. To further support VBP alignment across its network, the IPA conducts monthly and quarterly meetings with its partners, and leverages the ED Care triage program at NYU Langone Hospital Brooklyn and works with Patient Navigation Center (PNC) leadership team to identify patients in the United Healthcare Community Plan contract to help ensure internal care management hand offs. The IPA has also developed culturally sensitive call scripts and letters to target unengaged patients. For providers the IPA also provides tools through EPIC such as; Healthy Planet, which is connected to partner's EMR.

*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):*

In addition to ongoing efforts of the NYU Langone IPA, the PPS developed a VBP support implementation plan to provide specific support activities for providers and community-based organizations based on the needs identified in the Value Based Payments Needs Assessment (VNA). This VBP Support Implementation Plan focuses on:
1) The PPS is in the process of completing a VBP 101 learning course to be offered in the format of electronic learning or "e-learning." The e-learning platform will allow PPS Partner organizations to access the trainings, education and materials in a manner that is most convenient for each individual user. The PPS plans to further engage primary care providers, behavioral health providers, and CBOs focused on social determinants of health through a robust training schedule indicating a minimum of two sessions for each provider category per Demonstration Year from DY3 through DY5

2) The PPS intends on working closely with network partners and allow opportunities for collecting feedback on emerging trends, challenges and issues with the transition to VBP. Time will be allocated to collect feedback from PPS network partners during VBP training and education sessions

3) During this period, the PPS also hired an Assistant Director of DSRIP Partner Relations and Engagement. A main focus of his work has been understanding the capacity of CBOs within the PPS and building a relationship with them. Through this outreach, the PPS has plans to contract with CBOs around engagement, diabetes management, and asthma home visits. During this time period, the PPS explored the possibilities of partnership and plan to use DSRIP partnerships to incubate connections that could work under a VBP arrangement.

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: See Fundamental 4, part a.

**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:*

The NYU Langone Brooklyn PPS 's funds flow model is intended to support primary care via the following:

1) Direct payments to PPS Partners as the financial resources needed to expand their capacities for primary care services
2) Develop and implement a Patient Navigation Center to transition care from the hospital to community-based care provided by network PPS Partners
3) Develop a Medicaid-focused Independent Practice Association (NYU Langone IPA) intended to be a platform for PPS Partners to be included in Value Based Payment contracting
4) Invest in training and education to ensure that the PPS's workforce has the appropriate access to training materials as the healthcare landscape moves to more community and value-based care

The PPS's funds flow approach in the areas listed above are expected to yield healthier patient populations, allow PPS Partners with the opportunity to expand their primary care services, and support Partner transition to Value Based Payment contracting.

| *b. Funds Flow* | *Total Dollars Through DY2Q4* | *Percentage of Total Funds Flowed* |
|---|---|---|
| Total Funds Distributed | $19,773,025.27 | **100%** |
| Primary Care Provider | $13,773,530.27 | 69.66% |
| Hospital-Ambulatory Care | $10,931,492 | 55.28% |
| Federally Qualified Health Centers (FQHCs) | $2,587,316.27 | 13.09% |
| Primary Care Practitioners | $254,722 | 1.29% |
| PMO Spending to support Primary Care | $5,624,177 | 28.44% |

*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?*

NYU Langone Brooklyn PPS's funds flow model continues to focus on meeting program requirements, achieving the goals of DSRIP, creating an integrated delivery system, and ongoing efforts in the following areas:

1- Engage primary care physicians within PPS network
2- Support primary care strategies
3- Reduce avoidable hospital use by 25% by 2020
4- Achieve the Triple Aim

During the timeframe of April 1, 2016 to March 31, 2017, the PPS worked collaboratively with PPS Partners in respect to project implementation and a foresight for clinical performance. During that period, the PPS's funds flow approach to Partners was aimed towards developments within the PPS network in care transitions, education/trainings and VBP contracting. As a whole, the PPS's flow of funds aligns with the Triple Aim in trying to reduce costs of care, improve population health, and enhance the experience and outcomes for patients.

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):*

Family Health Centers (FHC) at NYU Langone: Behavioral health providers are incorporated into the treatment teams of the FHC at 7 out of 10 primary care services. Social Workers (SW) are available for warm handoffs from the primary care team; they provide short-term, focus, psychotherapy aimed at addressing anxiety and mood disorders. In addition, SWs are able to determine if a higher level of care is needed for patients with mental illness; these patient are then referred to the behavioral health clinic for full evaluation and treatment.

Ezra Medical Center: Ezra has hired 6 social workers to work in the same space as primary care providers and has developed protocols for warm handoffs of patients who screen positive for mental health/substance use disorders to behavioral health providers. Ezra applied for the Access Increases in Mental Health and Substance Abuse Services (AIMS) Grant to further expand mental health services and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse. Ezra has received CON approval for acquiring and renovating a new building to further support the integration of Primary Care with Behavioral Health.

ODA: Behavioral health and primary care are integrated at Heyward, Bedford and Park location. The integration encompasses both warm handoffs and involvement of the Behavioral health staff in the wellbeing of our patients. 90% of ODA patients have received a depression screening over the last year. ODA has developed a warm handoff workflow to connect patients with behavioral health providers. In addition, weekly reports are developed to further follow up with patients who have scored positive on the PHQ.

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

We continue to grow as a PPS in integrating PC and BH, and while there have been great successes, there are also various degrees of implementation challenges that we are addressing and attempting to resolve. These challenges include: lack of previous clinical training for BH providers in integrated care models leads to small pool of applicants already qualified to work in this innovative service setting; primary care providers being unfamiliar with the co-location model or the impact of behavioral health on chronic illnesses requires more training and awareness raising than anticipated; cultural differences in discussing substance use and mental health across Brooklyn PPS partners has made different patient populations minimize or underreport their MH/SUD needs; PCP's have variable levels of discomfort in addressing MH and SUD with different cultural populations; difficulty recruiting for child psychiatry due to shortage nationally; switch of EMR from eCW to EPIC in August 2016 led to delays in data report requests and a learning curve for providers to enter and collect PHI at the NYU Langone Brooklyn campus; delays in state data and reliance on claims data means that our understanding of our current state and progress on measures is lagged (however, we recently recruited an in-house data analyst to help pull EMR data for our PPS and forecast estimated progress towards metrics in the absence of timely claims data).

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

Some of the regulatory challenges in integrating primary care and BH in our PPS during the time period have been around lack of reimbursable services and what qualifies for us or partners: unclear which BH providers can be reimbursed for what services, particularly within an FQHC that is APG exempt; PPS partners and BH providers can bill for few services even when not APG exempt (social workers in Article 28's); BH/SUD screenings appear to be reimbursed only under a minority of circumstances; peers not adequately reimbursed; telepsychiatry; same day visits (two visits with two providers on same day - integrated/whole-health care approach not reimbursed); unclear if a PPS partner in an Article 28 providing psychotherapy services can refer to Article 31 for psychiatric services only while continuing to provide psychotherapy services); difficulty navigating different sets of regulations between OASAS, OMH, DOH; an Article 31 smoking cessation treatment cannot be billed for by an LCSW or licensed psychologist; unclear how BH groups can be reimbursed within an Article 28.

*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?*

Through the MAX series, a multidisciplinary group across departments, and with representatives from our PPS CBO's, the group met for three consultant-led workshops to develop action plans with weekly follow up to assess and improve processes. In the MAX High Utilizer program, patients who had four or more all- cause admissions were assessed for the drivers of utilization which are frequently related to inadequately treated psychiatric illnesses and substance use disorders. Psychiatry staff is embedded within the group assessing and following these patients throughout the hospital, serving as consultants to the team assessing these drivers and discussing appropriate follow up and disposition. In the MAX Behavioral Health Integration into Primary Care program, social workers and psychologists are embedded at the FHC sites to assess behavioral health concerns among the clinic patients as referred by their primary care provider.

FHC has begun the process of implementing telepsychiatry to enhance the capacity of psychiatrists to see patients across our system. Initially, targeting the area with the greatest need, FHC will utilize telepsychiatry to provide child psychiatry services to the school health sites which are affiliated with the FHC. Behavioral health social workers are integrated into 18 school-based health clinics across Brooklyn and evaluate children at these schools for behavioral health issues. A proportion of these children are in need of child psychiatry services which then requires travel to the behavioral health clinic in Sunset Park, oftentimes a hardship for the children and their families. By offering the option to participate in psychiatric evaluation and treatment via telepsychiatry within the school we hope to increase compliance with appointments and expand the ability of our child psychiatry team to offer services throughout Brooklyn.

| *e. Model* | *Number of Sites Planned* | *Number In Progress* | *Number Complete* |
|---|---|---|---|
| Model 1 | 10 | 7 | 0 |

| | | | |
|---|---|---|---|
| Model 2 | N/A | N/A | N/A |
| Model 3 IMPACT | Unclear | 2 | 0 |

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): DAST 10
☐ 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