NYU Lutheran
NYU LANGONE HEALTH SYSTEM

NYU Lutheran Performing Provider System

Primary Care Plan

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DSRIP PMO

NYU Lutheran PPS Primary Care Plan

Introduction

This document is intended to demonstrate that the NYU Lutheran Performing Provider System (PPS), led by NYU Lutheran, has developed a Primary Care Plan, thereby fulfilling the requirements set forth by the Department of Health (DOH) during the DSRIP Mid-Point Assessment Period.

Current Vision and Guidance from the Department of Health

Per the DOH Primary Care Presentation (June 2016):

- Primary Care Plans allow PPSs the opportunity to convey their current status of primary care transformation activities and provide insight to the Department of Health (DOH) on their overall strategy for developing primary care access, capacity, and quality.
- Primary Care Plans will be an annual submission to the DOH. PPSs will submit the first iteration of Primary Care Plans, consistent with project narrative formatting, by August 31, 2016 for review within the Midpoint Assessment.
- The PPS Primary Care Plan will address six "fundamentals" and will be submitted by the PPSs via e-mail to DSRIP_MidPoint@pcgus.com by August 31, 2016.

Per guidance and feedback received from the DOH on October 5, 2016, the PPS must submit the revised plan to the Department no later than November 3, 2016.

Fundamentals Associated with PPS Primary Care Plan

Per DOH guidance, the PPS Primary Care Plan will address each of the following six "fundamentals" and will be submitted by the PPSs as a narrative component during the Mid-Point Assessment:

1. Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs
   - PPS's 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 PCPs, as well as institution-based PCPs?

2. How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?
   - What are your PPS's plans for working with Primary Care at the practice level, and how are you supporting them to success fully achieve PCMH/APC?
     - Resources could include collaboration, accreditation, incentives, training/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?

3. What is the PPS's 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's governance committees and structure and clinical quality committees?

4. What is the PPS's strategy to enable primary care to participate effectively in value-based payments?
   - How will key issues for shifting to VBP be managed?(e.g., technical assistance on contracting and data analysis, ensuring primary care providers receive necessary data from hospitals/emergency departments (EDs), creating transition plans, addressing workforce needs and behavioral health integration)

5. How does your PPS's funds flow support your Primary Care strategies?
   - What resources are being expended by your PPS to support PCPs in DSRIP?

6. How is the PPS progressing toward integrating Primary Care and Behavioral Health (building beyond what is reported for Project 3.a.i)?
   - This would include both collaborative care and the development of needed community-based providers.

Fundamental #1: Assessment of current Primary Care capacity, performance and needs, and a plan for remediating need

The NYU Lutheran PPS is built around community-based primary care with both Federally Qualified Health Centers (FQHCs) and smaller physician practices contributing to Primary Care Provider (PCP) capacity. The NYU Lutheran PPS patient base is highly concentrated with 93% of the PPS's attributed lives apportioned to 18 partner organizations. Internal survey results of these PCP practices revealed the following:

(i) All practices offer same day or next day appointments
(ii) All practices offer extended hours
(iii) Nearly all practices have achieved the PCMH 2014 Level 3 status

Despite their current respective capacities, each of our FQHC PPS Partners have short term plans for growth to meet additional primary care needs and demands. Our smaller office practices also plan on adding providers and intend on increasing their capacities for primary care services. Three of the large FQHCs within the NYU Lutheran PPS offer all of the following services: pediatrics, internal medicine and family medicine, in addition to onsite access to some specialty care.

The PPS understands the importance of supporting our Primary Care strategies and moving towards the ultimate goal of the DSRIP Program to reduce avoidable hospital use by 25% by 2020. The PPS intends to focus on telehealth and telepsychiatry to improve access to high volume specialties that support primary care. To improve compliance with retinal screening for diabetic patients, the PPS is working with the NYU Department of Ophthalmology to deploy retinal cameras for remote exams by NYU faculty physicians at selected PPS primary care sites. Similarly, the PPS is planning to implement

telepsychiatry as an adjunct to the face to face visits with mental health clinicians which will link diabetic patients to ophthalmology specialty care as well as increasing access to care for behavioral health services. The NYU Lutheran PPS is working with both institution-based PCPs as well as community-based PCPs to meet the goals of the DSRIP Program and to prepare for the expansion in the primary care setting. The PPS intends on continuing to work with our network PCPs as the DSRIP Program continues.

The following are examples of how some of our PPS Partners intend to expand primary care physical and technological capacity for meeting patient care needs.

(a) NYU Lutheran Family Health Centers: Expected to expand in the coming months and years to create additional primary care capacity. This expansion may include moving clinics out of NYU Lutheran Hospital and expanding or adding more sites. The Family Health Center is committed to opening a FQHC site in Red Hook as a part of an agreement with SUNY on clinical services at the former Long Island Hospital Campus.

(b) ODA Primary Health Care Network: In August 2016, ODA received 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. This expansion of primary care services better equips ODA to meet the growing need for high-quality health care services present in the community, achieve the goals of DSRIP to reduce hospital admissions and the objectives of Triple Aim to provide better care, improve health outcomes and lower costs. The new site will expand primary care access to 3,112 new patients in Year 1 and will generate approximately 15,000 new patient visits.

(c) Ezra Medical Center: Has an additional 10,000 square feet, which they are going to develop and use for primary care: pediatrics, adult medicine, and obstetrics. In addition, they are trying to extend their current hours by 20% for primary care services. They also purchased three buildings where they will have an additional 10 primary care rooms. Those rooms are intended to be opened within two to three years.

(d) NYU FGP and UPN Practices: During DSRIP Year 1 and the beginning of DSRIP Year 2, NYU has built a Medicaid clinically integrated network (CIN). The PPS is working with the FGP and particularly with some UPN practices to possibly increase primary care capacities and better serve the patient population.

(e) Healthix Practice Standards: The NYU Lutheran PPS is working with Healthix. Per the Healthix website: "Healthix is an expert at integrating diverse clinical information systems, commonly used EHRs and care management systems to streamline the user experience so that participant organizations can improve patient care, while realizing greater efficiency. Healthix supports a broad variety of standards for exchanging patient data. They can assess your needs and help develop and execute an appropriate technology integration strategy. Healthix also supports care coordination platforms and other health-related applications that are used in New York Health Homes and other models of care."

Fundamental #2: Primary Care expansion and practice and workforce transformation to support training and technical assistance

The NYU Lutheran PPS is fully committed to expanding and transforming primary care in the communities we serve to improve health outcomes, lower costs and reduce disparities. Workforce training at the site level is critical to supporting this strategy. Training is intended to include, but is not limited to the following: DSRIP 101, Cultural Competency & Health Literacy, Compliance, functionality and use of HIE and Healthix, and trainings that will be designed for clinicians and practitioners engaged in our DSRIP clinical projects.

The PPS plans on working with PCPs at the practice level and intends on supporting their efforts towards fully achieving PCMH certifications. To date, approximately 150 PPS providers have achieved or maintained a PCMH status designation. Some of our partner organizations who have already achieved PCMH 2014 Level 3 include, but are not limited to: NYU Lutheran Family Health Centers, ODA Primary Health Care Network, Crown Medical PC, Boro Park Pediatrics and Olitsa Roth, MD PC. Ezra Medical Center is currently PCMH 2014 Level 2 and has already applied for the Level 3 status designation. The PPS will remain committed to working with network partners in this area.

The PPS plans to retain a consultant to perform an analysis of PCP practices that do not yet meet PCMH standards. In collaboration with the PPS and PCP partners, the consultant will design site-specific project plans which include onsite and/or virtual implementation assistance and learning collaboratives. The PPS is particularly interested in exploring the use of central resources including population health data analytics, care coordination, and a call center using community-based patient health navigation services (Project 2.c.i) to facilitate PCMH achievement among PCP partners. Using functionality developed in EPIC and in use at NYU Langone Medical Center (NYULMC), we plan to implement telepsychiatry consultations for our partners, who could use a workstation equipped with a webcam to take advantage of telepsychiatry resources. Psychiatric consultation and ongoing follow-up is intended to be done in EPIC and available to our PPS Partners via Healthix. Similarly, remote retinal monitoring conducted at clinic sites via the use of retinal cameras will allow for the transmittal of high resolution retinal images to NYULMC ophthalmologists. This is intended to be implemented in 2017 and will expand access to ophthalmology consultation to include screening for diabetic eye disease. By expanding access to specialty care using advanced technology and information sharing, the PPS may be able to accelerate the process of incorporating partners in a truly integrated network.

On August 28, 2016, EPIC (NYULMC's EHR system) was successfully implemented at NYU Lutheran Medical Center, the NYU Lutheran Family Health Centers' nine primary care sites, ten NYU Lutheran physician practice sites, as well as the school-based clinics and shelters. To support efforts of this implementation, EPIC Go Live trainings and at-the-elbow assistance were provided to the appropriate staff members working in the following care settings: Emergency Department (ED), outpatient clinics, operating rooms, and inpatient units. Ongoing EPIC training efforts are expected to continue in the coming months as the DSRIP Program continues.

An enterprise EHR shared between NYU Lutheran Medical Center and NYULMC is the enabling core of the enterprise clinical platform (ECP), ensuring coordination and alignment between the PPS's two acute care hospitals and outpatient clinics. It will enable PPS Partners to leverage NYULMC's suite of population health and care management capabilities. This platform will build integrated and transformative clinical management workflows, connect both patients and providers, and leverage

shared connectivity, care coordination tools, and analytics across the PPS in order to meet performance goals and to successfully implement the DSRIP clinical projects.

The ECP is enhanced by the ability to connect with EHR systems through NYULMC's HIE as well as through Healthix, our regional health information exchange (RHIO). Together, they provide a cohesive structure for clinical data, performance data, alerts for hospitalizations and ED visits via phone calls, text messages, our patient portal, etc., as well as measures of efficiency. The PPS works closely with Healthix and has engaged in a strategy of targeting PPS Partners with EHRs to Healthix. This approach will strengthen data sharing throughout the PPS. To date, approximately 85% of our DSRIP members are attributed to partners who are connected to Healthix and we anticipate that this percentage will grow as we work towards connecting the next tier of partners and practices to Healthix. This will include addressing the current IT statuses and possible needs for smaller practices within the PPS.

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.

The NYU Lutheran PPS is implementing Salesforce to support practice and workforce transformation. Training materials will be made available to PPS partners through Salesforce, as well as other mediums. Salesforce will be implemented in two phases. Phase 1 will focus on developing the partner portal to enable bi-directional communication between the PPS lead 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.

Salesforce also provides e-learning integration in support of workforce transformation for both clinicians and non-clinicians in a centralized training resource, ensuring that they are appropriately trained and sufficiently knowledgeable to achieve the short- and long-term goals of DSRIP. A combination of e-learning and onsite trainings will be essential in educating the PPS workforce. To effectively implement DSRIP projects, PCPs, administrators and support staff must have access to specific training modules to dually achieve DSRIP goals as well as to provide the best possible primary care services to the patient population. These training and learning efforts will be tracked throughout the duration of the DSRIP Program and continuous trainings are expected to occur post-DSRIP. The intent is to accomplish the Triple Aim of the DSRIP Program and to be sustainable beyond the 5th year of DSRIP. The PPS will adhere to DOH guidelines and will use any applicable and available statewide resources as the DSRIP Program continues.

Fundamental #3: PPS strategy for how Primary Care will play a central role in an integrated delivery system

Activating the PCP is a key to truly reforming the delivery of care and is central to NYU Lutheran PPS's strategy of building an integrated delivery system. In the current healthcare setting, care is often fragmented, inappropriate and inconvenient. Building a strong, accessible, and culturally competent primary care network in patient communities will be crucial to creating the foundation for highly coordinated care. The PPS will rely on PCPs to achieve the goals of DSRIP – reducing unnecessary inpatient and Emergency Department utilization, ensuring timely and convenient access in the appropriate care setting and expediting the collective move towards Value Based Payment arrangements. NYU Lutheran and community partner organizations currently have many available community primary care services and will continue to leverage the long and successful history of delivering high-quality, and culturally appropriate care in Brooklyn. The NYU Lutheran PPS is positioned to leverage the growing primary-care base to effectively manage the population.

NYU Lutheran PPS has created a Medicaid-focused Independent Practice Association (IPA) on behalf of our partners. We have begun enrolling key partners, many of which provide Primary Care in the community, and setting up the infrastructure to support this entity. The IPA will promote improved coordination of care through enhanced IT connectivity, improved transparency and timeliness of information, dedicated resources for patient navigation services and clinical protocols. Providers will be incentivized to improve coordination and reduce unnecessary utilization through risk-based contracts.

High-performing, integrated health systems include the entire spectrum of services built on a foundation of patient-centered primary care. This includes behavioral health services, substance abuse treatment, health home enrollment, social service referrals through community-based organizations or referrals to specialists in the appropriate care settings. Our PCPs will facilitate linkages to patient navigators and/or care coordinators, leading to effective interventions and management of high-risk patient population defined by complex medical and social issues.

In addition, optimizing our IT strategy will allow for the timely transfer of key information to specialists, ambulatory or inpatient settings. Our partner connectivity strategy includes:

(i) Implementing EPIC in the Lutheran Family Health Centers and NYU Lutheran providers offices
(ii) Connecting our PPS partners through NYU's Health Information Exchange (HIE)
(iii) Dedicating IT resources for facilitation and training

To effectively manage the entire patient population, PCPs must have access to a range of high-quality specialists. NYU Hospital Center is investing in the construction of state-of-the-art ambulatory care facilities and embedding sub-specialists in the Federally Qualified Health Centers (FQHCs). Our PCPs will be able to facilitate linkages to these services, with medical information easily accessible through common IT platforms and networks. In addition, the NYU Lutheran PPS is developing protocols to treat patients in the right care settings to include PPS partner organizations and to ensure that high-acuity patients receive tertiary and quaternary care. Our PCPs will be able to manage the population within the framework of an integrated delivery system.

The PPS clinical project governance and project implementation structure leverages individual project work groups, each responsible for focusing on their project goals, interventions and

milestones. Each workgroup is taking a data-driven, evidence-based approach to developing interventions, while leveraging the knowledge and expertise of experienced PCPs and other community-based organizations (CBOs). Key primary care partners are represented within our PPS's governance committees and clinical quality committees. This representation is critical to developing strategies that meet the needs of our PCPs and the patients in their care. Primary care practitioners are represented within the NYU Lutheran 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 23 members in the governance structure who represent primary care practitioners; this represents 37% of the PPS's governance board and committees. Of those who are represented, 13% are hospital based and 87% are community based.

Primary care will continue to be a central focus within the NYU Lutheran PPS. Expanding and transforming primary care with our multifaceted approach of enhancing IT connectivity, improving patient navigation services and implementing risk-based contracting will improve health outcomes, lower costs and reduce health disparities. The NYU Lutheran PPS is dedicated to delivering a sustainable patient-centered model of primary care that maximizes patient access, meaningful use of healthcare IT, care coordination and improves the patient experience.

Fundamental #4: PPS strategy to enable Primary Care to participate effectively in Value-Based Payments (VBP)

The NYU Lutheran PPS is driving towards a long-term, sustainable strategy to provide highly integrated care, reduce unnecessary inpatient and emergency department utilization, and expedite the collective move towards Value Based Payment (VBP) arrangements. To achieve these goals, we have focused our efforts on establishing the mechanism that will allow for risk contracting on behalf of our PPS, through the creation of a new Medicaid-focused, Independent Practice Association (IPA)-based clinically integrated network (CIN). The immediate focus will include enhancing information technology connectivity, developing clinical protocols focused on improving quality while reducing unnecessary spend and dedicating resources to provide highly coordinated care to our patients.

Over the past few months, NYU Lutheran PPS has created a new legal entity and has begun to enroll PPS partners, with the initial focus on the enrollment of Federally Qualified Health Centers (FQHCs) and other providers whose primary focus is the care of Medicaid beneficiaries. The PPS intends on focusing in the following areas: DSRIP projects and clinical protocols, enhanced health information sharing, care coordination, and aligning incentives through joint contracting and shared savings. The CIN will provide a platform for success in DSRIP and risk sharing contracts with Medicaid Managed Care plans.

With the creation of the IPA, we are preparing to transition existing Fee for Service (FFS) contracts to Level 1 or Level 2 arrangements, and to work with existing Managed Care payers with VBP contracts in place to move towards a higher risk level. To prepare for these VBP arrangements, significant activities are underway, including: assessing partners to understand the readiness to move towards risk, building the infrastructure to support VBP arrangements, engaging payers in discussions on moving to VBP, using powerful analytical capabilities to understand the population and total cost of care, and developing patient-centered interventions to ensure patients are receiving the highest quality care in the appropriate primary care setting.

The NYU Lutheran PPS will utilize dedicated care coordinators to manage the timeliness of care and quality measures in risk agreements. The management of care transitions, identification of gaps in care, patient alerts and patient-centered focus for the Medicaid population will be essential within the PPS network in preparation for the expansion of primary care services. The PPS will also provide support for provider engagement with the PPS primary care providers for value based payment contracting, analytics, gaps in care and performance management of both quality and cost.

The PPS also intends on collaborating with Medicaid Managed Care plans to receive daily inpatient, transfer and Emergency room census reports. The PPS will continue to work with MCOs that we are currently contracted with to receive the following information:

(i) Monthly claims data files to reposition data into the hospital network database
(ii) Care management reports for high risk members
(iii) Medical performance review by PCP
(iv) Members in care management programs
(v) Health come participation/health home eligibility
(vi) Enrollment files with re-enrollment dates
(vii) Inpatient short stay by diagnosis and PCP
(viii) Emergency room visits by PCP and diagnosis
(ix) Non-user by PCP
(x) Readmission

The NYU Lutheran PPS will continue working with MCOs as the DSRIP Program continues and understands the shift to VBP arrangements will require buy-in from PPS stakeholders and engagement and education of network providers to advance the goals of DSRIP and to assure that the patient population's primary care demands are appropriately met.

Fundamental #5: PPS funds flow support Primary Care strategies

The NYU Lutheran PPS understands and acknowledges the importance of supporting our Primary Care strategies throughout the DSRIP Program, as well as focusing on sustainability beyond March 31, 2020. The PPS is fully committed to meeting the goals of the DSRIP Program and will continuously strive towards meeting those goals.

The PPS approach and continued focus on proper fund flow support is intended to yield healthier patient populations, a reduction in unnecessary repeat patient visits, and will allow for primary care physicians to improve access for more patients.

The NYU Lutheran PPS has supported the Primary Care strategies via a judicious and strategic flow of funds to partner organizations. The PPS's distribution of funds has focused on dispersing monies to primary care facilities, FQHCs (Federally Qualified Heath Centers), PCPs (primary care physicians), and CBOs (Community Based Organizations).

Master Service Agreements have been entered between the PPS Lead and various PPS partner organizations to work collaboratively to pursue the accomplishment of the following goals:

(i) Supporting the PPS's Primary Care strategies
(ii) Work towards sustainability beyond the fifth DSRIP year to include an expansion in the primary care setting
(iii) Project milestones and DSRIP deliverables
(iv) Overall goal of reducing avoidable hospital use by 25% by 2020
(v) Achieving the Triple Aim of DSRIP and Delivery System Reform:
    - o Reducing Costs of Care
    - o Improving Population Health
    - o Enhancing Experience and Outcomes for Patients
(vii) Engaging primary care physicians within acute care facilities
(viii) Accomplishing deliverables and performance targets for system transformation projects, clinical improvement projects and population-wide projects (Domains 2-4)

Currently, the NYU Lutheran PPS has a significant primary care network in place. The large majority of our attributed patient population is cared for by PCPs in the PPS network. Table 1 below illustrates that 93% of the NYU Lutheran PPS attributed lives are allocated within 18 PPS partner organizations or CBOs.

The NYU Lutheran PPS fund flow distribution will continue to focus on meeting program requirements, creating an integrated delivery system, and continuous efforts in the following areas:

- o Engage primary care physicians in our network
- o Expansion of the current primary care setting
- o Support Primary Care strategies
- o Achievement of the DSRIP Triple Aim and;
- o Reduce avoidable hospital use by 25% by 2020

Table 1: NYU Lutheran PPS Attribution Breakdown (March 2016)

Attributed Provider	# Total Members	% Members
Lutheran Family Health Centers	46,430	39.26%
ODA Primary Health Care Network	20,573	17.40%
University Physicians Network IPA	20,053	16.96%
Lutheran Medical Center	7,279	6.15%
Ezra Medical Center (includes J. Teitelbaum's Me	6,029	5.10%
NYU School of Medicine - Final	3,125	2.64%
CAMBA	1,370	1.16%
Be Well Primary Health Care Center	1,296	1.10%
LMC Physician Services PC	1,266	1.07%
Premium Health Center	535	0.45%
HeartShare St. Vincents Services	519	0.44%
Diaspora Community Services	301	0.25%
Premier Healthcare	165	0.14%
Cobble Hill Health Center	162	0.14%
HeartShare Wellness	147	0.12%
Cerebral Palsy Associations of New York State	131	0.11%
Care for the Homeless	103	0.09%
Turning Point	94	0.08%
Other	8,687	7.35%
Grand Total	**118,265**	100%

93% (109,578) of NYU Lutheran PPS attributed lives (118,265) allocated within these partners and among many others within remaining 7% (8,687) attributed lives.

The PPS model for earning DSRIP payments include analyses of DSRIP Payment Models and efforts in the following areas to potentially achieve the applicable sources of funding for our PPS:

(i) Meeting milestones and deliverables across Domains 1 - 4 (Waiver revenue)
(ii) Accomplishing patient engagement targets that are attainable
(iii) Focusing on areas pertaining to pay-for-reporting (P4R) and pay-for-performance (P4P)
(iv) Involvement in Equity Infrastructure Program (EIP) and working with MCOs
(v) High Performance (HP) and Additional High Performance Program (AHPP) targets
(vi) Focusing on selected metrics for Equity Performance Program (EPP)

The NYU Lutheran PPS is currently working towards an appropriate budget allocation that is geared towards supporting the DSRIP Program and aimed towards a model of sustainability beyond DY5. In the first half of DY2, the NYU Lutheran PPS has flowed funds to DSRIP Partners with a total amount dispersed to date of $3.15M. Per our updated DY2, Q2 PPS Flow of Funds table in MAPP, percentages of disbursements to date of the $3.15M were allocated to the following provider types in the following manner:

- Clinics and Outpatient Facilities 66.69%
- Hospitals 21.04%
- Primary Care Practitioners 6.52%
- Community Based Organizations 4.76%

Per the percentages above, 73.21% of payments to provider types support primary care providers (PCPs), clinics and outpatient facilities, as well as physician/clinical staff. As the DSRIP Program continues to progress, the NYU Lutheran PPS will identify potential opportunities for funds flow by collaborating with partners to achieve the goals associated with clinical projects. Payments for engagement will be assessed by evaluating individual Implementation Plans submitted to the PPS by partner organizations and the monitoring of progress. The NYU Lutheran PPS will continue to flow funds in a manner than supports the Program, as well as the model of sustainability beyond DY5.

Fundamental #6: PPS progression towards integrating Primary Care and behavioral health

The NYU Lutheran PPS has been progressing in its effort to integrate Primary Care and Behavioral Health. It is not possible to fully separate the work being done in this area from what is reported for Project 3.a.i, as this project provides the underpinning of Primary Care and Behavioral Health integration across the PPS network, however, we describe below the ongoing efforts in this arena.

The PPS has developed a network of collaborative care which has served as the basis for the integration of primary care as well as behavioral health. This has involved building IT information tracking and exchange, initially within the NYU Lutheran system, with plans to expand this beyond to the PPS CBO partners. As we move forward, this IT infrastructure will allow the PPS to identify individuals with behavioral health needs through prescription databases and clinical visit information (e.g. emergency department, hospitalization and PCP visits). Working closely with the Patient Navigation Center, care managers will serve as a bridge among the primary care team, patients, hospitals, emergency rooms, community behavioral health and substance use providers, and other CBOs providing outreach to patients with behavioral health issues to ensure linkage with clinical care teams and other resources as needed.

We have collaborated with our early adopter primary care partners to start Phase 1 of the project with these sites recruiting and hiring behavioral health staff, beginning the process of co-located services. This has involved regular meeting with these early adopters to problem solve and provide technical assistance. Included in this has been the development of evidence based screening and treatment protocols implemented through the NYU Lutheran PPS which has been made available to the primary care providers within our network. These include SBIRT (Screening, Brief Intervention, Referral to Treatment), use of the CRAFFT tool (11-17 years old) or AUDIT-C (18 years old and above), shown in Table 2, and depression screening with the PHQ-2/9. Evidenced-based treatment algorithms for depression have been provided to primary care providers to allow for increased comfort in the management of mild to moderate depression in primary care settings (Table 3). Furthermore, a standard procedure for contacting the primary care provider after hours and holidays has been developed within NYU Lutheran Family Health Center to ensure the ability of Behavioral Health providers to have rapid access to primary care for their patients.

The PPS has developed protocols for "warm handoff" of patients who screen positive for mental health/substance use disorder to behavioral health providers and developed 'open access scheduling' for behavioral health providers to accommodate these warm handoffs as well as any crises which may arise.

Education and training have been employed as a method to enhance the integration of primary care and behavioral health. The primary care behavioral health integration team has been participating in the Department of Health Medicaid Accelerated eXchange (MAX) Series to learn best practices for behavioral health integration and implementation strategies at the NYU Lutheran Family Health Center pilot site, with lessons learned transferred to our CBO partners. They have provided training on 'What BH/PC Integration is and Why is it Important ' and trained PCP's at a pilot site on Medication Management for Psychotropic Medications geared towards primary care physicians.

NYU Lutheran PPS has a wide range of primary care settings, at this time across 11 NYU Lutheran Family Health Center sites some level of behavioral health services exist at 7 sites; early adopter Ezra Medical Center has implemented a culturally competent co-located model; and early adopter ODA streamlined its service integration. Moving forward this will continue to expand, in addition we are actively developing a telepsychiatry program which will enhance the availability of our behavioral health providers to their primary care partners.

Table 2: Screening and treatment protocol for alcohol use disorder *Located on Page 12*
Table 3: Depression screening and treatment algorithm *Located on Page 13*

Conclusion

The NYU Lutheran PPS will continue current efforts with practice transformation activities, the expansion of primary care services, and building an integrated delivery system. The PPS's focus will remain patient-centered to assure that patients receive care in the most appropriate care settings. The PPS will also continue to develop primary care access, capacity, and quality.

Primary care physicians and clinicians will have essential roles in working at the top of their licenses and providing exceptional primary care services to the patient population. The PPS intends on continued collaboration with PPS partners to meet DSRIP Program goals and also focus on population health management and sustainability beyond DSRIP Year 5.

Table 2 for Fundamental Question #6

Table 2: Screening and treatment protocol for alcohol use disorder

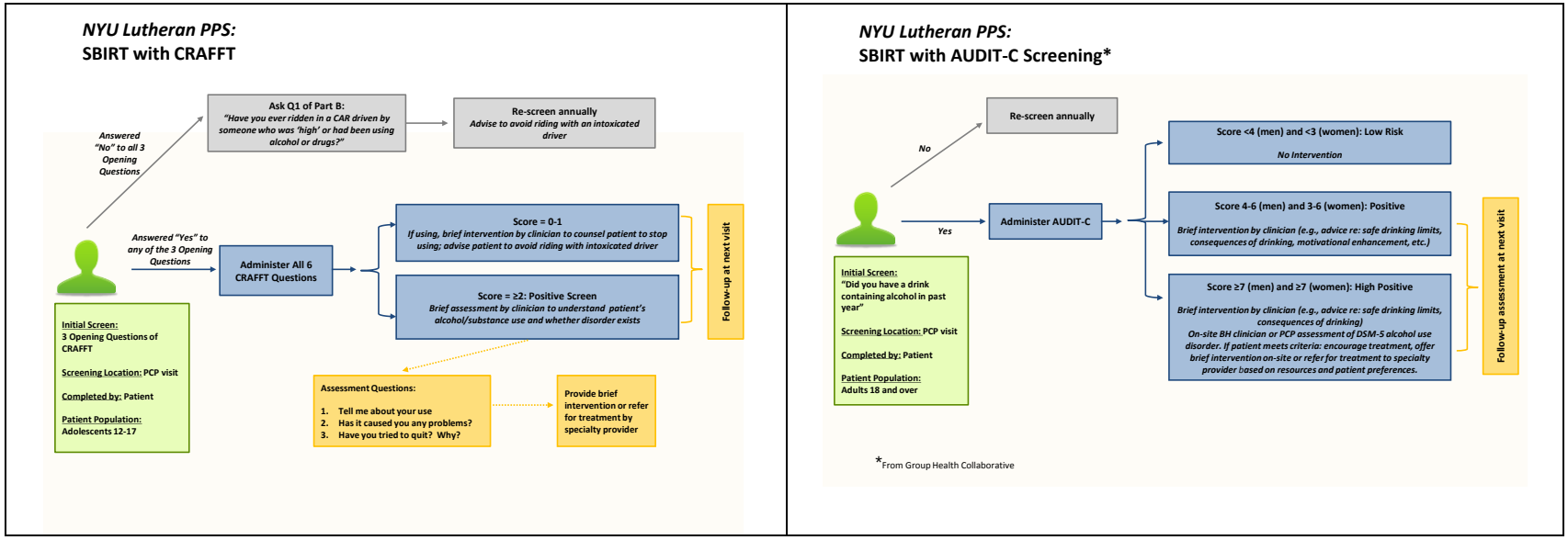
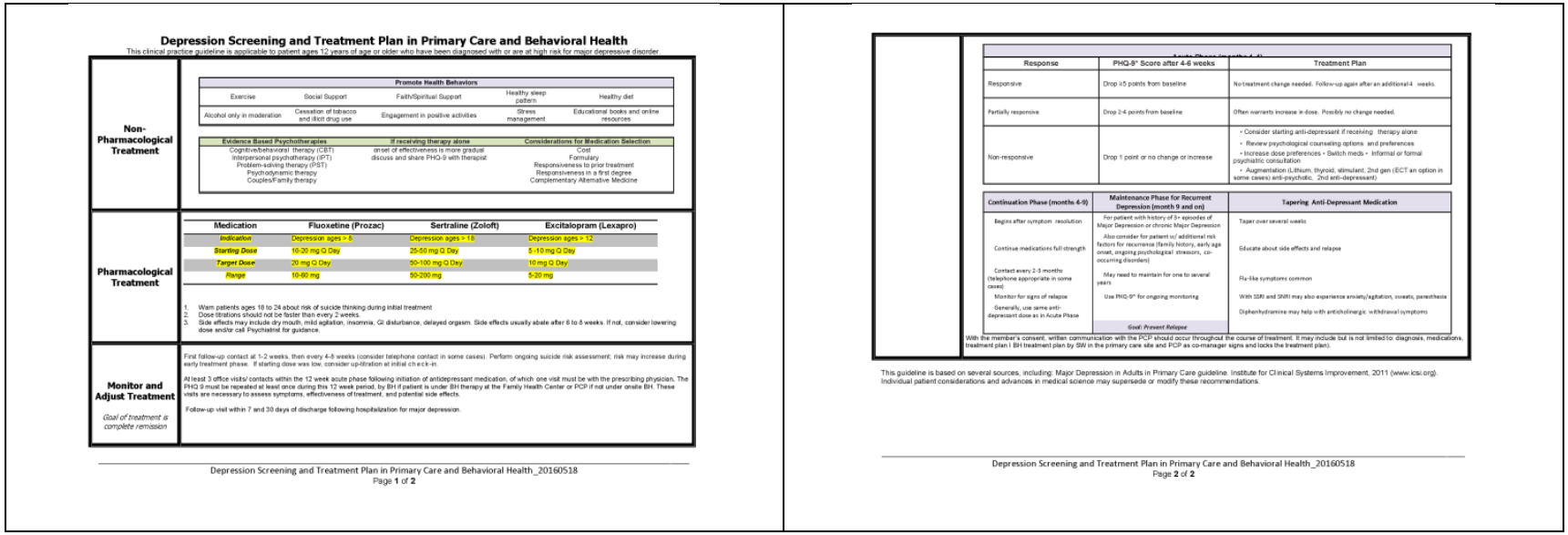


Table 3 for Fundamental Question #6

Table 3: Depression screening and treatment algorithm



Depression Screening and Treatment Plan in Primary Care and Behavioral Health

This clinical practice guideline is applicable to patient ages 12 years of age or older who have been diagnosed with or are at high risk for major depressive disorder.

Non-Pharmacological Treatment

Promote Health Behaviors				
Exercise	Social Support	Faith/Spiritual Support	Healthy sleep pattern	Healthy diet
Alcohol only in moderation	Cessation of tobacco and illicit drug use	Engagement in positive activities	Stress management	Educational books and online resources

Evidence Based Psychotherapies	If receiving therapy alone	Considerations for Medication Selection
Cognitive/behavioral therapy (CBT) Interpersonal psychotherapy (IPT) Problem-solving therapy (PST) Psychodynamic therapy Couples/Family therapy	onset of effectiveness is more gradual discuss and share PHQ-9 with therapist	Cost Formulary Responsiveness to prior treatment Responsiveness in a first degree Complementary Alternative Medicine

Pharmacological Treatment

Medication	Fluoxetine (Prozac)	Sertraline (Zoloft)	Excitalopram (Lexapro)
Indication	Depression ages > 8	Depression ages > 18	Depression ages > 12
Starting Dose	10-20 mg Q Day	25-50 mg Q Day	5 -10 mg Q Day
Target Dose	20 mg Q Day	50-100 mg Q Day	10 mg Q Day
Range	10-60 mg	50-200 mg	5-20 mg

1. Warn patients ages 18 to 24 about risk of suicide thinking during initial treatment
2. Dose titrations should not be faster than every 2 weeks.
3. Side effects may include dry mouth, mild agitation, insomnia, GI disturbance, delayed orgasm. Side effects usually abate after 6 to 8 weeks. If not, consider lowering dose and/or call Psychiatrist for guidance.

Monitor and Adjust Treatment

Goal of treatment is complete remission

First follow-up contact at 1-2 weeks, then every 4-8 weeks (consider telephone contact in some cases). Perform ongoing suicide risk assessment; risk may increase during early treatment phase. If starting dose was low, consider up-titration at initial check-in.

At least 3 office visits/ contacts within the 12 week acute phase following initiation of antidepressant medication, of which one visit must be with the prescribing physician. The PHQ 9 must be repeated at least once during this 12 week period, by BH if patient is under BH therapy at the Family Health Center or PCP if not under onsite BH. These visits are necessary to assess symptoms, effectiveness of treatment, and potential side effects.

Follow-up visit within 7 and 30 days of discharge following hospitalization for major depression.

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Response	PHQ-9* Score after 4-6 weeks	Treatment Plan
Responsive	Drop ≥5 points from baseline	No treatment change needed. Follow-up again after an additional 4 weeks.
Partially responsive	Drop 2-4 points from baseline	Often warrants increase in dose. Possibly no change needed.
Non-responsive	Drop 1 point or no change or increase	• Consider starting anti-depressant if receiving therapy alone • Review psychological counseling options and preferences • Increase dose preferences • Switch meds • Informal or formal psychiatric consultation • Augmentation (Lithium, thyroid, stimulant, 2nd gen (ECT an option in some cases) anti-psychotic, 2nd anti-depressant)

Continuation Phase (months 4-9)	Maintenance Phase for Recurrent Depression (month 9 and on)	Tapering Anti-Depressant Medication
Begins after symptom resolution	For patient with history of 3+ episodes of Major Depression or chronic Major Depression	Taper over several weeks
Continue medications full strength	Also consider for patient w/ additional risk factors for recurrence (family history, early age onset, ongoing psychological stressors, co-occurring disorders)	Educate about side effects and relapse
Contact every 2-3 months (telephone appropriate in some cases)	May need to maintain for one to several years	Flu-like symptoms common
Monitor for signs of relapse	Use PHQ-9* for ongoing monitoring	With SSRI and SNRI may also experience anxiety/agitation, sweats, paresthesia
Generally, use same anti-depressant dose as in Acute Phase		Diphenhydramine may help with anticholinergic withdrawal symptoms
	Goal: Prevent Relapse	

With the member's consent, written communication with the PCP should occur throughout the course of treatment. It may include but is not limited to: diagnosis, medications, treatment plan I BH treatment plan by SW in the primary care site and PCP as co-manager signs and locks the treatment plan).

This guideline is based on several sources, including: Major Depression in Adults in Primary Care guideline. Institute for Clinical Systems Improvement, 2011 (www.icsi.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

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