NewYork-Presbyterian
Queens

NewYork-Presbyterian/Queens PPS

Primary Care Plan

PLAN OVERVIEW

Document Title:	NYP/Q PPS Primary Care Plan
Version	2.0
Purpose:	This document outlines the primary care plan for the NYP/Q PPS network to include processes for partner alignment, incentives, and expansion opportunities. This strategy compliments the Population Health Management Roadmap of the PPS.
Approving Committee:	Clinical Integration Committee ï Executive Committee
Approval Date:	10/18/16

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

- PPSôs 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?

The New York Presbyterian/Queens (NYP/Q) PPS considers primary care as a building block for transformation within a complex healthcare environment in order to increase network connectivity, maximize quality improvements, and increase patient access. The PPSô clinical integration strategy utilizes the concept of primary care to link multiple projects with similar deliverables, quality improvement needs, and engaged partners in order to increase efficiencies and outcomes. The PMO strives to build a clinical network that is focused to providing the right care, in the right setting, at the right time by the most appropriate healthcare provider.

As the PPS moved from clinical planning & strategy development to full clinical integration of project plans, the PMO completed network assessments to align partners with projects to ensure full commitment of project deliverables. This commitment allows the PPS to align incentives with timelines and quality expectations which will enhance patient experience, increase access to the underserved Medicaid population, improve quality, and potentially reduce cost of care in the service area. As a collaborative model, the NYP/Q PPS must be creative with tools and incentives in order to keep network partner commitments and ensure success of the program. A well-developed plan of primary care transformation is an essential tool the PPS will use to maintain project commitments of our network providers.

According to the community needs assessment (CNA), the service area of the NYP/Q PPS consists of 60 clinics and 17 FQHCôs serving a population consisting of 43% Medicaid beneficiaries. The projects selected by the PPS were based on the CNA and align primary care; these consist of 2.a.ii (PCHM), 3.a.i (PC:BH Co-location), 3.b.i (Cardiovascular), 3.d.ii (Pediatric Asthma), and 4.c.ii (Increase Access to HIV Care). The PPS will utilize multiple partner types inclusive of free-standing primary care providers, facility-based primary care providers, FQHCôs, Health Homes, Article 28 clinics, behavioral health providers, and community based organizations to implement the project requirements of all projects. All partner types are engaged in the governing structure, inclusive of clinical committees, and have direct lines of communication to the PMO via PAC meetings, committee meetings, onsite engagements, etc.

As the immediate needs to primary care access will be addressed with a number of the PCMH requirements, it is anticipated that the improvements to ED utilization will create additional access needs. The CNA cited 247,000 PPVôs which translates to an estimated 61,750 (25% reduction) additional outpatient visits for our provider network.

An additional source, ñNew York State Health Workforce Planning Data Guide - 2013ò published by the Center for Health Workforce Studies, reflects a deficiency of primary care providers in Queens County when compared to the New York State average. Queens County has 98.4 Primary Care Providers per 100,000 as compared to the NYS rate of 120. This statistic is consisting among PCPôs, Physician Assistants, and Nurse Practitioners, which creates immediate needs of providers to increase primary care access.

Table 1: Primary Care Physicians per 100,000[1]

	Nassau	Queens	New York City	New York State
PCPs (includes Pediatrics, OB/GYN)	145.5	98.4	134.0	120.0
Physician Assistants	87.0	43.6	36.0	61.0
Nurse Practitioners	99.2	36.2	47.0	76.0

Queens County has a large geography of federally designated HPSA areas including Corona, Jackson Heights, Woodside, Elmhurst, and Sunnyside. The NYP/Q PPS partner network was developed to ensure that partner organizations are distributed strategically across the service area and includes a HPSA designated FQHC, BrightPoint Health, and an Article 28 clinic, Jackson Heights. Based on a June 2016 analysis by PCG for the NYS DSRIP program, the NYP/Q PPS has identified that in addition to an overall shortage of primary care providers in Queens County, there are a limited number of practitioners offering after-hours care (34.2%) and the average total care hours per week for a PCP is 29.

[1] Center for Health Workforce Studies. 2013. ñNew York State Health Workforce Planning Data Guideò Available at: http://chws.albany.edu/archive/uploads/2013/09/nys_health_workforce_planning_data_guide_2013.pdf

PCP Analysis Metric	NYP/Q PPS Value
Total # of Primary Care Providers (PCPs) in PPS	244
Total # of PPS's network PCPs in the PNDS	237 (97.0%)
Total # of PCPs participating in multiple PPS	175(71.7%)
# of PPSs that a PCP Participates in:	
1	69 (28.3%)
2	65 (26.6%)
3	25 (10.2%)
4	21 (8.6%)
5 or more	64(26.2%)
% of PCPs Offering After-Hours Care	34.2%
Average Total Care Hours (per PCP per week)	29 hrs.
% of PCPs Accepting New Medicaid Members	93.7%
Total PCPs w/PCMH 2011 Level 2	2 (0.8%)
Total PCPs w/ PCMH 2011 Level 3	27 (11.1%)
Total PCPs w/PCMH 2014 Level 2	2 (0.8%)
Total PCPs w/ PCMH 2014 Level 3	4 (1.6%)

In order to meet the needs of this impact the PPS will utilize the following strategies to address gaps in care:

- ***Expanding Primary Care Access at Behavioral Health Sites*** – The collaboration of primary care at behavioral health sites will immediately increase access to patients providing an additional site of care (right setting) and will build on existing relationships among providers at 9 clinics affecting over 15 primary care providers and 50 behavioral health providers.
- ***Integrating Behavioral Health into Primary Care Sites*** – As with the expansion of primary care at behavioral health sites, the increased access of behavioral health visits will allow for patients to seek appropriate care by appropriate providers; therefore, increasing access in primary care provider schedules where the behavioral health patients were historically seen.
- ***Implementing Open Access to Primary Care Sites*** – A PCMH Level 3 requirement is to offer open access scheduling to patients seeking care. Our PPS has committed to 36 Primary Care

Providers achieving this certification by DY3. The implementation will increase access to appointments (same day or future dates), improve no-show rates, and diversify provider schedules in order to maximize clinical time of providers.

- ***Physician Champions*** – Physician champions have been identified at each participating PCMH site and training was provided for these champions. The training focused on NCQAôs 2014 PCMH standards, practice transformation, role of change management, role of HIT, and lessons learned. Additionally, the PPS is connecting primary care providers with NYC Reach to implement EHRs where needed and ensure practitioners can meet Meaningful Use standards.
- ***Engagement & Inclusion of Non-Physician Clinical Providers*** – Partners will be encouraged to utilize non-physician providers within their scope of practice in order to maximize practice efficiency and allow clinicians to work at the top of scope. This strategy will increase access as well as align patient acuity with provider type for ongoing treatments.
- ***Telehealth Program Development*** – Clinical leads will identify potential needs for telehealth programs based on the needs of the patient or providers to ensure access to providers across the continuum of care regardless of geographic location. The telehealth analysis is currently underway to (1) Identify population & partner needs, (2) Outline partners involved to ensure an effective return on investment, (3) Review local and federal regulations, (4) Identify capital or operational funding potentials for installation, and (5) Plan for sustainability for years outside of the DSRIP program. The PPS is focused to maximizing efforts by engaging specific providers and other PPSôs to review existing programs and discuss lessons learned.
- ***Connection of Partners to IT Tools (RHIO & Population Health Management Tool)*** – A priority of the PPS is to align providers with RHIO connectivity as well as provide them with IT tools that will help increase connectivity and communication among providers. The RHIO Pilot, which provides funds flow incentives to providers, ensures connectivity, and provides the primary care provider with information about the patient care that will ensure a time effective encounter and clinical planning. Allscripts Care Director (ACD) is the Population Health Management Tool approved for the PPS to create an alert system partnered with a care coordination best practice in order for primary care providers to be well informed of their patient facility-based activity (ED & inpatient). The tools along with care coordination strategies will build on the primary care concepts to result in additional access to those we serve.
- ***Conducting Gap Assessment Periodically*** – The PPS is committed to ongoing analysis of our network and community needs and will utilize our governing process inclusive of the PAC committee to complete periodic assessments focused to primary care gaps (patients and providers). According to the studies by the Center for Health Workforce in 2013, Queens borough

had significant low number of PCPs, Physician Assistants and Nurse practitioners compared to rest of the other boroughs and counties.

The PPS will conduct further analysis in ongoing basis which will provide valuable network information on access and quality to address patient and partner needs for future engagements or program developments.

Fundamental 2: Primary Care Expansion, Practice and, Workforce Transformation to Support Training and Technical Assistance

- What are your PPSôs plans for working with Primary Care at the practice level, and how are you supporting them to successfully 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?

The NYP/Q PPS contracted with HANYS (Healthcare Association of New York State) to provide implementation services for PCMH certification across the provider network. The consulting group focuses to achieving 2014 Level 3 status for 36 primary care providers inclusive of community-based & institution-based providers. The HANYS team developed a rigorous timeline with PCMH and DSRIP deliverables to meet all expectations and works hand-in-hand with our network providers to achieve deliverables. Along with consultative services, our network providers also have access to the HANYS team to problem-solve PCMH integration needs to ensure a custom approach to clinical integration of this program. HANYS also provides Physician Champion training & engagement opportunities, and staff training based on the needs of the PPS & clinical providers.

Along with the practice transformation support, the NYP/Q PPS built the funds flow model to incentivize primary care transformation inclusive of PCMH transformation and engaged patient activity. The model rewards providers for achieving 2014 Level 3 status as well as provides incentives to partners for meeting engaged patient definitions for all primary care aligned projects.

The PMO team is partnering with other PPSôs and engaging in non-DSRIP state-wide strategies to ensure full understanding of opportunities related to DSRIP clinical integration and communicates findings or opportunities to network partners utilizing a PPS website, network emails, committee meeting agenda items, PAC updates, and Town Hall agenda items. Examples of resources utilized by the PPS include:

NYC REACH, NCQA Website tools, HANYS PPS Leadership forum, GNYHA All PPS meetings, HIV Statewide workgroup, etc.

Fundamental 3: 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 PPSôs governance committees and structure and clinical quality committees?

The NYP/Q PPS chose project 2.a.ii ï Implementation of PCMH versus project 2.a.i ï Implementation of an Integrated Delivery System (IDS) with a collaborative care model to focus the impact of the DSRIP program. Although the PPS is not integrating an IDS, the vast majority of the PCMH deliverables align with the IDS strategy. Such strategies include, (1) Establishing comprehensive services across the continuum of care, (2) Ensuring clinical integration to patient focused care, (3) Mapping proper geographical coverage of providers, (4) Standardized care utilizing industry best practices and/or evidence based medicine approaches, (5) Performance measuring and management of quality and finances, (6) Innovative culture for governance and leadership, (7) Information Technology infrastructure, and (7) Physician engagement & integration.

The PPS is committed to strengthening the continuum of primary care and ensuring linkages to secondary and tertiary services utilizing the following tactics:

- ***RHIO Connectivity*** – The PPS leadership considers Healthix a critical partner in the DSRIP program for healthcare connectivity transformation. A key tactic of ensuring connectivity for the continuum of care is access to vital records for patient coordination and planning. The PPS developed a RHIO pilot to provide incentives to providers for RHIO connectivity and incorporates RHIO expectations into each project integration.
- ***Behavioral Health Access*** – The co-location of behavioral health providers into primary care clinics will allow the clinical teams to address: Primary prevention which focuses to target individuals at high-risk for developing a disorder, secondary prevention that seeks to diagnose mental health conditions in their early stages, and tertiary prevention which focuses to the reduction of negative impacts due to the condition. The behavioral health and primary care projects implement screening, training, and best practice utilization focused to ensuring access to the behavioral health community.
- ***Implementation of Cureatr*** – The PPS is implementing the IT tool Cureatr which will provide event notifications to Care Coordinators, and primary care providers located at primary care

practices, notifying them of their patientsô visit to an emergency department, or inpatient admission. The tool will prompt the coordinators to perform patient outreach and ensure connectivity to primary, secondary, or tertiary services.

- ***Care Coordination Training*** **–** The Workforce Training Strategy defined by the PPS outlines specific care coordination training which will ensure primary care engagement and access to levels of care based on the acuity of each patient. The training will be funded by the workforce training budget and offered to all partners. The PPS in collaboration with GNYHA has already conducted care coordination training in June, 2016, which was attended by staff from private primary care providers, Article 28 clinics, and FQHCôs.
- ***Aligning Incentives with Evolving Funds Flow Models*** **–** The PPS leadership understands that the DSRIP network will evolve over time and therefore so should the funds flow model. The leadership is committed to updating the funds flow / incentive models to align with primary care deliverables and ensure engagement of all provider types.
- ***Implementation of PPS Best Practices & Evidence Based Medicine Protocols*** **–** All project committees have clinical representation that recommends best practices or evidence based medicine protocols to align with the desired outcomes of the project. The practices or protocols are used as engagement tools with each partner based on the quality outcomes as analyzed by the Rapid Cycle Evaluation team.

The NYP/Q PPS developed a collaborative governing system that offers committee appointments to all provider types based on their project commitments. Each provider is given the opportunity to join committees based on their interest or process of clinical implementation. Primary care providers are members of both organizational and project committees to ensure direct input into the ongoing evolution of the PPS.

Fundamental 4: PPS Strategy to Enable Primary Care to Participate Effectively in VBP

- 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)

As described in previous sections, the NYP/Q PPS is a collaborative model, and will develop a VBP strategy and roadmap based on the foundation of engagement, education, and state resources. The PPS leadership, as advised by legal counsel, must refrain from gathering managed care proprietary information, providing managed care negotiation advice, or sharing any confidential materials as outlined

by federal regulations. The PMO team is partnering with the NYP PPS on Value Based Payment to outline the strategy and roadmap. The VBP PPS survey is currently in process for all partners and will define the next steps of developing an education based strategy for roll-out. It is anticipated the following items will be offered to the network to assist in the move to VBP:

- ***Educational Opportunities*** – The PPS training strategy outlines a VBP educational program that will focus to the needs of VBP, overall strategies of beginning VBP, etc. Such training opportunities will be identified utilizing the partnership with the 1199 Training & Education Fund.
- ***Partner Quality Analysis*** – The Rapid Cycle Evaluation Unit will provide partners quality based summary details based on their internal strategies for risk based contracting. The RCE team will not provide advice on negotiations but will provide summary level data based on data sets received from the DSRIP program.
- ***State-Wide Resources*** – The PPS will continue to provide partners with state resources focused to VBP to include learning symposiums, emails, and or webinars.

Fundamental 5: PPS Funds Flow support Primary Care Strategies

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

The current funds flow model of the NYP/Q PPS incentivizes primary care providers to engage utilizing multiple facets. The funds flow allows for reimbursement for non-covered services based on project commitments, revenue loss based on project implementation, incentives for engagement in non-revenue generated or impacted items such as RHIO Pilot, MAX series, TOM series, or the state-wide HIV collaborative, incentives for the completion of project deliverables such as PCMH 2014 Level 3 certification, and incentives for reporting of engaged patients based on the DSRIP definitions. Primary care providers have multiple incentives with the funds flow model based on their commitments to the DSRIP projects.

The funds flow model was built utilizing a zero based budgeting process per project to ensure incentive alignment with project requirements and quality metric outcomes. The budget process included administrative overhead, revenue loss, non-covered services, contingency, workforce, and incentive payments for all network partners. The budget is used as an accountability tool to ensure compliance with budget category percentage commitments that were outlined by the PPS in the DSRIP application process. Incentive payments for partners are aligned with the biannual DSRIP payments to the PPS. To date, the NYP/Q PPS has paid out $515,000 to partners.

The primary care providers also have access to the PPS training program, which allocates the $517,000 dedicated to workforce spending based on clinical needs. Primary care providers and their staff have

access to multiple training opportunities offered with in person or webinar options to ensure no interference with clinical activity. The Healthstream tool has been purchased by the PPS to provide web-based access to all providers for a robust database of healthcare education ranging from cultural competency & health literacy to clinical safety. Primary care providers will have access to online training as well as staff completion reports for ongoing competency reviews and staff development.

The PPS is committed to the ongoing development of the funds flow model based on the dynamics of the DSRIP program and to offering services to partners that are not directly categorized as ñincentivesò but should be recognized as value add to their practices such as training programs, PMO support, access to state-wide initiatives, etc.

Fundamental 6: PPS Progression towards Integrating Primary Care and Behavioral Health

- This would include both collaborative care and the development of needed community-based providers.

The NYP/Q PPS has identified all sites of care that will integrate primary care and behavioral health. The PPS has selected both integration of primary care into behavioral health (Model 1) and integrating behavioral health into primary care (Model 2). The locations include a combination of community based providers as well as institution based providers and allow for access points at varying geographical areas based on the needs of the community. Additionally, the PPS has chosen a pediatric site to co-locate primary care and behavioral health services to address the largely unmet needs of pediatric behavioral health in the community.

In collaboration with the partners of the integrated sites, the PPS is assisting with:

- ***PCMH Certification*** – The PPS is collaborating with HANYS Solutions, as described in previous sections, to assist primary care network partners in achieving PCMH 2014 Level 3 certification by DY3. The PPS has included the primary care integrated sites in the HANYS Solutions transformation process to ensure that all requirements are met; these sites include both adult primary care practices as well a pediatric primary care practice.

Practice Name	# of Providers	PCMH Level 3 2014 Status
Ma Jesus Calagos, MD	1	Certified
BrightPoint Health	3	Application Submitted ï Pending Certification
Community Health Network (FQHC)	22	Certified

Advanced Pediatrics PC	2	Certified
NYP/Q ï ACC	4	In Progress
NYP/Q ï Jackson Heights	4	In Progress
NYP/Q ï TLCC	6	In Progress
Rite Care Medical Office P C	2	In Progress
Jose Quiwa, MD	1	In Progress

- ***Substance Abuse Screening*** ï The PPS has contracted with CBO partner, Elmcor, to develop a curriculum for substance abuse screening in the primary care setting. The PPS is engaging primary care and mid-level practitioners at partner sites to engage in training specific to substance abuse screening for patients.
- ***Billing Requirements*** ï The PPS has engaged internal legal counsel to assist with determining the proper billing procedures for the integrated sites of care. The PPS is utilizing the guidance from DOH/OMH to ensure that billing will be completed properly and meet all regulatory and legal criteria.
- ***Capital Needs***ï The PPS is collaborating with partners to plan for any site specific capital needs including construction requirements, CON documentation, etc. Although the PPS was not awarded capital funding, it is working with each integrated location to ensure proper regulatory structure in order to maximize patient access and partner engagement.
- ***Recruitment*** ï The PPS is working with partners to identify recruitment needs for the integrated sites. The PPS is currently in the process of facilitating collaboration between partners to staff primary care and behavioral health physicians at reciprocal sites. Any recruitment needs that cannot be filled through this process will be escalated to the workforce committee to provide assistance where available.