Primary Care Plan Update 2017

Nassau Queens PPS

September 29, 2017

Introduction

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

Instructions

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

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

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Primary Care Plan Overall Strategic Updates

- Overall PPS strategic changes impacting the Primary Care Plan

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

NQP's implementation of the Primary Care Plan in DY2 assisted in its understanding of where it could continue to improve its process and strategy. These observations and experiences have allowed NQP to enhance its strategic support for the ongoing DYs. NQP did not detour significantly from the original PC Plan submitted in 2016. Below is a list of strategies NQP has enhanced to support successful implementation of its PC Plan:

1. Practice transformation requires significant resources and time. During implementation, NQP realized and experienced firsthand the amount of dedicated time and resources needed to be successful. NQP has concluded that practice transformation will continue beyond DY3Q4 when most of the DSRIP project requirements are to be completed as it continues to implement its PC plan. Furthermore, NQP anticipates its PC providers will continue to undergo practice transformation as they prepare for a value base payment environment beyond March 2018.
2. Practice transformation requires the engagement of all participating stakeholders. Multidisciplinary teams have a significant journey to improving primary care with the goal of improving existing structures, quality and workflow processes. Having MCOs, RHIOs, PCMH and Advance Primary Care Model Technical Assistance representatives at the table early on helps to direct and deliver on these efforts. NQP spends significant time engaging these stakeholders throughout.
3. Having dedicated, qualified resources to help develop these networks of PCPs and implement practice transformation was crucial. It took time to secure the appropriate staff and consultants that could support these efforts which delayed some work due to the needed onboarding and training. As a result, each participating primary care practice varies in their timeline to complete their practice transformation. NQP continues to adapt and re-evaluate its processes to ensure these timelines are met.
4. NQP understands the need to continuously evaluate its plan and reorganize its' priorities as new information arises. Based on lessons learned and the needs identified, NQP will work to ensure the successful implementation of its strategy and adapt to meet the needs of the primary care network.
5. Primary care practices require a significant amount of resources and ability to execute practice transformation. This includes time, staffing, technological sophistication, appropriate physical layout, etc. Smaller practices (1-2 physicians) have limited resources to execute practice transformation. This resulted with NQP's efforts to provide some resources to help providers fill in some of these gaps.

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:

NQP has made significant progress towards addressing primary care capacity by supporting its PCPs (community based and institution based) efforts towards PCMH and/or APC. As a result of these efforts, there have been an increase in primary care access, expansion of care after hours in various locations and improved EHR/RHIO connectivity. Below are some examples of what NQP has achieved:
- To ensure successful practice transformation and improved health care delivery, CHS has contracted with vendors such as HANYS solutions, RR Health to assist their practices towards PCMH recognition.
-NUMC's Omni Clinic (co-located Primary Care Site at their Hempstead flagship hospital site) has delivered services to a total of 24,732 visits since July, 2016. The practice began with 3 providers and added a fourth provider in December, 2016. To ensure better quality and experience of care, ongoing gap and needs assessments are executed, studied and implemented in response to the community.
-Northwell has hired RNs to join its primary care practices, and expand capacity through team-based care.
- Long Island Federally Qualified Health Centers (LIFQHC) have expanded its evening hours M – Th, as well as Saturdays. They are in the process of adding two Primary Care sites: BEST and Oceanside Locations, pending DOH approval to increase primary care access.
- Across the three Hubs, PCPs are being engaged and many are in the process of PCMH Level 3 2014 recognition. As of March 31, 2017, 138 providers have achieved certifications and many more are receiving resources and support from the Hubs to work towards this goal. As we continue to undertake these efforts, we are confident that we will meet the 346 eligible practitioners at PCMH 2014 Level 3.
- LIJ has signed a lease for a primary care practice near LIJ Medical Center to open in 2018.

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

The following are challenges NQP faces when addressing primary care capacity needs:
- Extension of practice hours due to limited primary care resources, specifically sites with 1-2 PCPs
- Practice transformation is a laborious task, requiring significant effort, time and energy from providers to integrate enhanced workflows, to incorporating care management, population health analytics, and integration of BH and utilization of RHIOs. These additional requirements limit a provider's capacity to enhance their care as they work at multiple priorities.
- Limited funding exists for capital expenses to expand sites, making it difficult for providers to implement workflows intended for an enhanced physical layout.
- Ongoing challenges with patient appointments, booking more patients due to size of site and capacity of PCPs.
- Funding and enhanced reimbursements often do not cover the full investment that needs to be made to achieve PCMH or APC recognition.
- Limited space at practices where PCPs are sharing space with Non-PCPs without an additional exam room. This limits the ability to increase PCP staffing and as a result limits primary care access due to physical space constraints.

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?

As NQP continues to focus on practice transformation and driving its PCPs to PCMH or APC recognition, only a few strategic changes have been made to Fundamental 1 outlined in the final Primary Care Plan submitted in 2016. This includes the following:
- NQP expressed interest in working with universities to increase the number of mid-level practitioners. This continues to be a work in progress as NQP engages with neighboring universities such as CUNY to encourage mid-level practitioners such as RNs and NPs to pursue additional education and training needed to improve access to primary care.
- NQP continues to address and increases its focus on PCP shortage areas by paying attention to regions of high attribution, high Medicaid utilization (hot spots), and logical relationships that would improve care coordination and management. This information will help NQP in staying abreast to the needs of its community and provide an adequate network that addresses both accessibility and improvement of health outcomes.
- NQP's efforts to assist practices in achieving PCMH or APC recognition requires a great deal of time and investment. Going forward, NQP will continue to focus more energy on developing the PCP network and engaging MCOs around population health management and value based care. Practices have assistance to meet PCMH or APC milestones from project managers—PCMH Certified Content Experts—and may also have a consultant or TA. For instance, LIJ has agreements with HANYS, NYC Reach, PCDC and IPRO to support the practices through in-person support, remote support, training, and documentation review and documentation preparation.

d. Describe what the PPS has done from April 1, 2016 to March 31, 2017 to engage community-based Primary Care Providers:

NQP efforts around contracting providers has been focused on developing a robust network of community based Primary Care Physicians. Presently we have 573 Community based physicians who are engaged in our DSRIP initiatives who have an attribution of over 123,434. Some examples of NQP's engagement are outlined in the following:
- Contracted with AdvantageCare Physicians and engaged 15 locations in Queens and Nassau in the DSRIP project implementation. These practices are all PCMH 2014 Level 3 Recognized and are working to integrate BH services, connect to NYS Smokers' Quitline and utilize the RHIO for notifications.
- Working with ProHealth and engaged 45 practice locations in Queens and Nassau that are pursuing APC Gate 2 Recognition.
- At some of NQP's sites, BH care managers are employed to work in community-based practices. Moreover, practices are encouraged and supported to apply for BH care managers to be placed at their sites through Thrive NYC.
- Additionally, 30 primary care practices that are independently owned are paired with a PCMH transformation consultant (HANYS, PCDC, or NYC Reach) or an APC TA to help them connect to RHIO, trained on distribution of incentive payments, assisted with patient engagement reporting and receive trainings that support the DSRIP projects requirements (examples of trainings: PHQ-2/9, blood pressure measurement, tobacco cessation, patient experience measures and implementation of best clinical practices).
- A Project Manager functions as main contact to support community based PCPs towards practice transformation by providing information and/or connecting to the appropriate resources.

Number of Engaged Primary Care Practitioners in Community-Based Practices as of March 31, 2017:	573

e. Additional Information

Number of Primary Care Practitioners in the PPS-defined Network who are eligible for National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC) as of March 31, 2017:	346
Number of Primary Care Practitioners in the PPS-defined Network who are NCQA PCMH 2014 Level 3 recognized as of March 31, 2017:	138
Number of Primary Care Practitioners in the PPS-defined Network who are pursuing APC recognition as of March 31, 2017:	No data yet

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:

NQP continues to work with its Primary Care practices towards PCMH or APC recognition. The following are examples of NQP's efforts:
- On a monthly basis, NQP's three Hub systems share progress of their status and efforts in getting their employed and non-employed PCPs to PCMH or APC certification. This allows a platform to share best practices and trouble shoot any challenges.
- Each Hub is providing technical assistance, project management and PCMH consultants (HANYS, NYC Reach, IPRO, PCDC, HLCS, etc.) to support their practices to transform and prepare for PCMH evaluation via in-person support, remote support, trainings, documentation review and preparation.
- NUMC purchased 15 ISS survey tools in March to support PCMH level 3 2014 application submissions for their contracted and newly contracted partners.
- LIJ has submitted its corporate PCMH application in DY2Q2 for its PC practices that are on the AllScripts Touchworks EHR and received a high score. As a result, 3 practices received recognition in DY2 and an additional 13 sites are in progress.
- 18 community practices have received PCMH recognition and 12 are in progress. Those practices that are not pursuing PCMH are working towards APC and have been partnered with technical assistance to support the transformation.
- Hubs have provided financial incentives for practices pursuing PCMH recognition.
- Ongoing communication is delivered to PCPs and practices that educate them on clinical, financial and operational benefits. Technical support is also provided to increase RHIO connectivity to Primary Care practices and bi-weekly conversations with Healthix occur to drive and improve these efforts.

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:

NQP's challenges in working with Primary Care Practices to meet NCQA PCMH 2014 Level 3 or APC are:
- Recruiting qualified candidates to provide care management for high risk patients specifically pediatric care managers.
- Practice transformation resources are limited and small practices (1-2 PCPs) cannot meet all demands of PCMH or APC.
- Practices that attempted PCMH were overwhelmed and opted out due to the level of work burden involved.
- Not all practices are savvy with technology. Data collection and reporting is a continuous challenge as PCPs have EHRs with limited functionality and cannot tailor reports, whereas several services (e.g. Eye exams) are scanned into PCP's records and are not captured in reports and many practice staff are not experienced with creating spreadsheets to meet requirements.
- Primary Care practices limited understanding on the financial benefits of PCMH and lack of knowledge regarding the Medicaid reimbursements when becoming PCMH.
- Funding is a constraint because its limited and the enhanced reimbursement does not cover the full investment that is needed for IT resources, new workflows, staffing, and use of existing physical layout among other variables.
- Not all PCPs are adequately connected to the RHIOs.

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?

As outlined in NQP's 2016 Primary Care Plan, NQP has continued to pursue and implement the activities identified to support and strengthen practice transformation. This resulted with the following implementations that are constantly being enhanced and reviewed for better delivery to NQPs participating providers:
- Ongoing web-based education and training tailored to PC physicians and their staff
- PCMH Level 3 Transformation Recognition and Support—Although a small number of providers have "opted out" of the program, our provider relations staff is committed to educating providers on the value and potential of the PCMH model, particularly as it relates to DSRIP outcomes and VBP preparation. We continue to deploy educational outreach programs and emphasize the incentives offered under the DSRIP program to encourage participation and widespread certification.
- Reimbursement and Incentive Payments
- Care Management Resources—HR departments have made the recruitment of care management resources a priority. Our hubs are attempting to reach new graduates, use social media to advertise vacancies, and are exploring internship programs.
- NQP is working with local affiliate universities to expand on educational and training opportunities that would increase case/care managers in the area as well as increase the workforce across different provider types including pediatrics.
- Participation in Statewide Collaborative to Streamline Requirements
- Ongoing efforts by NQP's data team towards development of a more robust Analytics, Reporting, Performance Measurement and Quality improvement at the Provider level.

The above initiatives remain unchanged and continue to be enhanced accordingly.

NQP realizes practice transformation is an ongoing effort and will most likely continue beyond DY3. This anticipation will result with a more thoughtful development of the PCP network that is able to implement care management, integration of BH, have sufficient network support staff and enhanced utilization of EHRs/RHIOs and data reporting.

d. What strategy(-ies) has the PPS found to be the most effective to support PMCH or APC transformation?

NQP has identified the following strategies that is most effective to support PCMH or APC transformation:
- Establish organizational capacity via dedicated resources to support providers and practices. This includes points of contact for different needs in which participating providers can reach out for assistance such as EHR vendors, RHIO, consultants, BH, etc.… For instance, LIJ has PCMH Certified Content Experts who provided expertise to supporting practices seeking PCMH certification. In addition, CHS and NUMC expanded the number of staff focused on contracting, onboarding and managing their contracted PCPs. All Hubs have a project manager to help support practices as well as direct them to the appropriate resources.
- Identified Physician champions who have transformed their practices to PCMH and can provide coaching, trouble shooting, and advice to PCPs who are seeking PCMH certification.
- Share best practices among providers who are succeeding with practice transformation together with those who are beginning or having challenges so can learn and get support from that provider's experience. Ongoing communication across the multidisciplinary team provides opportunities for open discussions to encourage and troubleshoot any challenges as well as provide successes that help move the PCPs along the path towards certification.
- Ensure optimal utilization of consultants by giving providers access and 1:1 on-site support. This has shown effective in practices achieving understanding of PCMH or APC requirements due to immediate response time and support.
- Provide clear expectations of the amount of effort/work involved to meet PCMH or APC with ongoing transparency that builds trust to work collaboratively to all stakeholders involved (e.g. multidisciplinary teams at the practice site).

e. Additional Questions:

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

Number of Primary Care Practitioners who have or are receiving vendor support for PCMH recognition from vendors contracted by the PPS as of March 31, 2017:	110
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:	99

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

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

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

Number of Engaged Primary Care Practitioners	564

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:

In DY2, Primary Care was at the center of NQP's efforts to implement an integrated delivery system. The PPS worked with Primary Care Practices on the following:
- Contract and engage PCPs: NQP was focused on expanding the network of engaged PCPs in DY2, and has more than 500 PCPs now engaged.
- Identify high-risk patients: The goal was to identify high-risk patients so that the PPS and its partners can better coordinate medical, behavioral and social supports to help these individuals. Using Salient and MAPP Dashboards, the NQP data team has done significant data analysis to identify these high-risk patients.
- Increase access to care: The goal is to expand hours and increase capacity so that patients can be seen same-day and the practice can accommodate new patients. For many patients, outcomes are better if their entry to the IDS is through the PCP. Some of NQP's sites have expanded care hours and locations to ensure access to our patients.
- Connect PCPs to the RHIO and teach them how to use it: The goal is to allow PCPs to securely access and share information with other providers on the patient's care team. Ongoing trainings and education throughout the year is offered to providers when they are connected.

In addition to working with Primary Care Practices, NQP has taken steps to support the role and expansion of Primary Care and care coordination, such as:

- Placing health coaches in the Emergency Dept. who help patients connect to primary care.
- Using case managers in the inpatient teams to engage high-utilizing patients and connect them to primary care.
- Placing care managers in the practices, provide the practice with resources to make linkages to social services and necessary secondary and tertiary services. Care managers will engage high-risk patients, who are identified through diagnoses, psycho-social risk factors and follow-up with them to provide education, discuss medication adherence, or connect them to other healthcare/social services.
- Increasing resources to engage with non and low-utilizing Medicaid recipients via our community health workers and patient navigators deployed through our 2di project. NQP has contracted with multiple Community Based Organizations and providers to hire and train individuals who help connect patients to primary care and other support services while educating these patients on the importance of preventive care. In addition, navigators and coaches attempt to answer any questions, help patients through barriers accessing primary care, and follow-up with patients to ensure they are connecting with primary care services.
- Acknowledging the critical role of care manager to expand care coordination. As discussed in Fundamental 2 above, our human resources departments have plans to recruit more care managers, improve outreach efforts to address workforce shortages, and prioritize care coordination.

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:

Challenges include:
• Administrative Burden - Practices were asked to change multiple workflows, run additional reports, work with new partners and integrate with the RHIO in a short period of time. This poses a heavy administrative burden on busy practices – especially smaller, community practices.
• Training Needs - Practices need a lot of training to understand the role that care management can play to help patients that is different from a social worker or nurse. The practice also needs education on how to identify social factors that are interfering with a patient's ability to be healthy.
• Access and availability - Some secondary and tertiary providers have limited appointment availability for new Medicaid patients.
• Staffing limitations- Staffing limitations within some of the HUBs that resulted in limiting network development and contract execution in DY2.
• Connectivity to RHIO- Healthix has not always been able to keep up with the demand for connections or provide needed training

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?

NQP remains committed to PC practice transformation and our original strategic focus. To address the challenges mentioned above, the PPS has taken the following actions:
• Administrative Burden and Training Needs: LIJ has trained staff to become PCMH content experts to support their providers. All Hubs have continued to develop onboarding processes and tools for PCPs/Practice that includes provider/patient engagements strategies, IT connectivity and data reporting and project initiatives.
• Access and availability: NQP is in development of an initiative dedicated to supporting CBOs.
• Staffing limitations: NUMC has hired a Director of Managed Care and two Directors for Network Development and Provider Relations who will work with providers and the MCOs to expand their network. CHS has hired a new CIO who has extensive experience in population health and DSRIP as well as hired dedicated staff to support their evolving network of contracted providers.
• Connectivity to the RHIO: NQP is working with Healthix to develop processes and resources to more effectively onboard providers and their practices to ensure more effective use of RHIO.

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:

From April 1, 2016 to March 31, 2017 NQP and its three Hubs, Nassau University Medical Center, Long Island Jewish Medical Center, and Catholic Health Services of Long Island have taken action to support their associated PCPs with EMR implementation and reaching Meaningful Use Stage 2. These actions include:

1. IT Current State Assessment- Each Hub performed their own IT Current State Assessment of contracted providers to determine if practices were using an EHR, the compatibility of EHR systems, and whether practices were using systems that were MU2 certified.
2. Assistance with EHR upgrade- When a practice did not have an EHR or needed to upgrade to a certified EHR, Hubs developed varying programs to assist practices. This included subsidy assistance and access to systems such as eClinicalWorks, Allscripts, or EPIC.
3. Support and training- Hubs worked with practices to provide support and training during EHR implementation and migration. For practices that already had an EHR, Hubs provided support to enhance current systems to meet DSRIP requirements and enhance RHIO utilization and connectivity.

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):

An integral part of the PCP plan is connecting PCP's with the PPS RHIO, Healthix in order to enable the ability for PCP's to share patient information. NQP facilitates a reoccurring monthly meeting with leadership from Healthix and NQPs three associated Hubs: Nassau University Medical Center, Long Island Jewish Medical Center, and Catholic Health Services of Long Island. During this call, best practices, lessons learned, and PCP connectivity statistics are shared.

More specifically, this effort has been focused on:
1. Ensuring that all Safety Net PCPs are engaged in Healthix implementation with a signed Participation Agreement;
2. Implementing rules-based alerts related to patients in particular categories (missing services, Health Home enrolled or eligible, ED or hospital utilizing), at both the PPS and the Hub level; and
3. Managing a process to systematically study RHIO utilization patterns among connected PCPs in an effort to increase utilization to improve user satisfaction and clinical outcomes.

Each Hub has developed their own approach to supporting PCP practices with RHIO connectivity including in-person meetings with PCPs to discuss issues related to Healthix, education and training for practices on RHIO utilization and consent, adding a "technical onboarding" to the standard DSRIP onboarding process, and providing financial support and incentive to connect to the RHIO.

Number of Primary Care Practitioners connected to RHIO/QE as of March 31, 2017:	39 practices

f. Additional Information

Number (percentage) of Primary Care Practitioners engaged in PPS governance as of March 31, 2017:	28
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are institution-based as of March 31, 2017:	19
Number (percentage) of Primary Care Practitioners engaged in PPS governance that are community-based as of March 31, 2017:	9

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:

NQP administered a 22 question VBP Needs Assessment to its providers to determine the current state of VBP contracting versus a Fee for Service model, identify needed resources for care coordination, identify knowledge areas where additional education and training was needed, and assess technology and analytic resources across the PPS network partners. This survey also served to identify opportunities to support the transition from FFS to VBP and providing a better understanding of NQP's capacity to implement VBP arrangements throughout DSRIP.

The VBP Needs assessment identified knowledge gaps and a subsequent VBP Support Implementation Plan was developed which includes a VBP training plan specific to PCPs. Proposed trainings for PCPs include:

- Introduction to VBP (Overview of Level 1, 2 and 3)
- Introduction to DSRIP and related performance standards and quality measures
- Managed Care Organization rate settings and provider bonus potential
- Provider performance requirements
- Care Management, Care coordination, and Services offered in Transitions of Care to support the care continuum
- Orientation to unmet behavioral health needs and social determinants of health as key drivers of high cost medical utilization
- Practice performance score cards and provider integration collaboration models
- Introduction to provider data analytics
- Provider performance requirements under VBP Levels 2 & 3

Timeline for VBP Partner Engagement Education and Trainings Schedule (aligns with Financial Stability Milestone 5 and 6):

Training/Education Topic	**Timeframe**
Introduction to Value-Based Payments	DY3Q3
Introduction to DSRIP and Related Quality Measures	DY3Q3
Introduction to DSRIP and Quality Measures for Tier 1 CBOs	DY3Q3
Provider Performance Requirements under VBP Level 1	DY3Q4
Introduction to DSRIP and VBP for Tier 1 CBOs	DY3Q4
Introduction to Care Management, Care Coordination, and Transitions of Care	DY4Q1
Tier 1 CBOs in a Network of Care	DY4Q1
Social Determinants of Health and Behavioral Health Needs as Key Drivers of Medical Utilization	DY4Q2
Practice Performance Scorecard, Provider Integration, Collaboration Models, and Data Analytics	DY5Q1
Infrastructure Needs for Tier 1 CBOs	DY5Q1
Provider Performance Requirements under VBP Level 2/3	DY5Q2
Role of Tier 1 CBOs in Future VBP Arrangements	DY5Q2

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

Results of VBP survey showed a lack of understanding or experience with VBP arrangements for a significant part of our network of contracted providers, examples included;
• 80% of the respondents are not participating in MSSP or ACOs.
• 52% of the respondents do not receive revenue from commercial payers linked to VBP arrangements.
• 46.94% of the respondents do not receive Medicaid revenue linked to VBP arrangements.

PCPs expressed many concerns and barriers to VBP readiness, including:
- Concerns about capacity to assume risk in VBP Level 2 and 3 arrangements
- Challenges coordinating care outside of their practice sites and across provider types
- Potentially facing penalty for outcomes out of their control
- Upfront cost of implementation
- Significant changes in workflow and staffing

NQP Hubs will continue to support PCP practice transformation through efforts such as PCMH/ACP certification. In addition, the Hubs will provide VBP education on topics aforementioned in 4a.

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?

NQP has made a significant strategic change from the original submission in 2016 in that NQP is no longer pursuing a contract with Cerner for a population health software solution. Rather, NQP has changed its strategy to leverage all available data management tools from DOH and OMH such as the Medicaid Data Warehouse, PSYCKES, Salient and MAPP. In addition to data provided through the state, each Hub is investing in its own analytical tools and/or Population Health software to support their contracted PCPs. This allows each Hub to develop their own population health strategy based on their specific provider community as they transition into VBP.

The Hubs are actively reaching out to Managed Care Organizations to develop contractual arrangements that are consistent with DSRIP milestone requirements regarding VBP. NQP and the Hubs continue their focus to support the PCP's with PCMH/APC, RHIO connectivity and transitions of care programs.

NQP will implement the VBP Support Implementation Plan to address the needs of the PPS network partners. The plan includes measurable activities that the PPS will employ to support its provider network in moving towards VBP, based on specific needs by provider type.

In addition, NQP will continue to gather feedback from the provider network on emerging trends, issues, and ongoing needs to support the successful and sustainable implementation of VBP.

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:

Each Hub is currently working to support PCP VBP readiness and engagement with MCOs.

Nassau University Medical Center (NUMC)
Network development and provider education have posed a challenge in NUMC's efforts towards VBP readiness in the past. With the addition of two newly hired Network Development and Provider Relations Directors and a Director of Managed Care, the NUMC Hub is now equipped to engage with MCOs, expand NUMCs network, and support PCPs in engaging with MCOs and VBP contracts.

Catholic Health Services of Long Island (CHS)
CHS focused on the development of managed care contracts with major Medicaid payers in the Long Island region to extend those contracts to providers in its network. CHS has developed a variety of IPA partnerships which have a significant number of practices who serve Medicaid recipients. As a VBP contractor, these payer arrangements further the ability of CHS to support PCPs with value based care strategies.

Long Island Jewish Medical Center (LIJ)
LIJ has existing risk-based agreements with MCOs that include employed PCPs. To support PCPs in participating in these contracts, LIJ provides assistance with contracting, provides data analytics, and provides care management services.

While some of the major Medicaid MCOs operating on Long Island are actively engaging in VBP dialogue and preparation with NQP, not all are as active as expected. NQP has raised this issue with the State and in other healthcare forums to leverage their connections to MCO leadership. NQP continues to engage with MCOs and aims to achieve greater responsiveness going forward.

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):

NQP is taking several approaches to support PCPs in addressing social determinants of health and engaging Tier 1 CBOS:

Outreach, Contracting and Education: To build out network capacity to address social determinants of health, NQP has put intense focus on outreach and contracting with Tier 1 CBOs. The NUMC hub has hired additional staff for CBO outreach and LIJ has assigned a Project Manager whose role includes educating PCPs about Tier 1 providers and ensuring they have mechanisms to refer to these services. CHS has a built large network of PCPs and are educating them on DSRIP and VBP payment incentives that includes addressing social health determinants of health in the primary care setting.

Care Management Screening and Referrals: Care managers are integrated in the primary care practices and have roles in screening for social needs and referring to appropriate Tier 1 providers.

Transitions of Care: NQP and partners have developed Transitions of Care programs. These programs include staff that are trained in identifying high risk patients who are assigned to a PCP and screening for social determinants of health issues. As part of the Transitions of Care services, staff is actively referring patients to Tier 1 CBOs and following up with assigned PCP.

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:

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:
NQP's three Hubs (NUMC, LIJ, and CHS) contract with their community based PCPs and each are responsible for its own funds flow model. Across the Hubs, as identified in the 2016 Primary Care Plan have similarities in supporting the provider in how they flow funds to support primary care. This includes the following financial assistance and incentives to PCPs: - Engagement payments - Technical On-boarding payment - Clinical improvement payment - Clinical outcome measures - PCMH certification While each Hub has its own contracting strategy, the Hubs agree to financially assist PCPs to further the goals of the DSRIP program. The incentive structure is based on attainment of a variety of performance factors including EHR/RHIO connectivity, PCMH certification, supporting clinical improvement programs (3ai,3bi,3ci), and outcome measures including reporting actively engaged patients. The incentive payments are a function of several factors, including safety net status and the estimates of their Medicaid attributed lives. These payments are designed to offset the expenses of implementing the DSRIP program.

b. Funds Flow	*Total Dollars Through DY2Q4*	*Percentage of Total Funds Flowed*
Total Funds Distributed	83,442,755	**100%**
Primary Care Provider	4,340,400	5.2
Hospital-Ambulatory Care	-	0
Federally Qualified Health Centers (FQHCs)	1,088,928	1.3
Primary Care Practitioners	3,251,472	3.9

PMO Spending to support Primary Care	1,880,346	2.3

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?

There have been no strategic changes to the funds flow model. The greatest challenge has been to contract with PCPs so funds can flow based on their performance and participation as identified in 5a. Developing a network has taken time and required the Hubs to add staff who can be dedicated to PCP contracting and engagement.

NQP is strategically looking to shift its focus towards pay for performance and value based payments. This will help drive the conversations between the Hubs and their PCPs when reassessing financial incentives that drive performance and pivots towards negotiating risk based contracts with Manage Care Organization.

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):

NQP has taken several specific actions to effectively reinforce the IBH Model including:
1. Expanded Contracting: NQP has expanded its primary care and behavioral health care provider network and is currently exploring options with Article 31 satellite clinics.
2. Integrated Behavioral Health (IBH) Champions: NQP connected 55 IBH Champions with new providers who share experiences, encourage best practices, and provide trainings on screening protocols and documentation, to support implementation.
3. Interdisciplinary team: NQP's LIJ Hub established an interdisciplinary team to coordinate and implement IBH, including the following:
a. Training primary care staff members in administration and scoring of screening tools, which led to an increase in use
b. Developing an integrated care toolkit for PCP staff
c. Creating integrated care workflows
4. Behavioral health care managers (BHCM): Licensed behavioral health professionals are placed in participating sites; work closely with PCPs to screen, assess, and treat behavioral health conditions; and consult with psychiatrists regarding treatment and medication. BHCMs document within the PCP's EHR, track patient progress in a registry, refer patients to CBOs, and follow-up to ensure successful linkage.
5. Mental Health Service Corps (MHSC): Several of NQP's practices in Queens have applies to MHSC, a key initiative of THRIVE NYC focusing on recruitment, training, and support of social workers and psychologists to become fully licensed, while enhancing the behavioral health workforce and the use of evidenced based practices in New York City.

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

NQP has identified three major challenges to integrating Primary Care and Behavior Health. These challenges include:

Physician Buy-in: Administrative burden, space constraints, building trust in behavioral health providers, comfort with allowing an outside provider to document in a PCPs EHR, comfort in prescribing psychotropic medication, and fatigue from other initiatives (PCMH, RHIO, MU2, etc.), are all barriers to achieving physician and staff buy-in.

Workforce Shortages: The shortage of LCSWs, specifically those that are bilingual, impacts the ability to appropriately serve the patient population. In addition, there has been a challenge with sourcing enough behavioral health organizations to manage the administrative and supervisory capacity of the satellite care delivery model.

EHR Infrastructure: NQP has encountered challenges with building an EHR infrastructure that allows for both the PCP and the BH providers to access and document patient information. Challenges with sharing patient information across the interdisciplinary care team are further exacerbated when each provider utilizes a different EHR system. Moreover, the Healthix onboarding process timeline has incurred a backlog of practices with QE Agreements waiting for implementation.

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

The PPS has encountered several regulatory challenges throughout the pursuit of implementing the IBH Model across the provider sites. Supervisory and billing restrictions in OMH licensed clinics prevent BHCMs and social workers to bill for services, affecting the financial viability of the project. CFR-42 adds additional confidentiality laws on the exchange of patient health information containing substance use conditions, which creates a barrier to information exchange impacting proper collaborative patient-centered care among providers. Additionally, limitations on telehealth and the lengthy turnaround for the Satellite Article 31 application process which significantly delays satellite providers from being embedded and on boarded within practice sites.

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?

To overcome identified challenges, NQP has done the following:

Physician Buy-in: NQP continues to support the PPS and their partners in overcoming these challenges. The PPS is reinforcing the Train the Trainer Program through the IBH Champions to positively encourage physician/staff buy-in. Practices that are not yet integrated have realized the need to add behavioral health services because they have seen the volume of positive PHQ scores increase. In practice sites where space and resource capacity is low, the PPS is pursuing the Satellite Model to deliver behavioral health services through social workers from offsite locations. The PPS is also in negotiations with behavioral health organizations to increase capacity for PCPs at behavioral health sites to ensure that preventative care services are available to behavioral health patients.

Workforce Shortage: To overcome these challenges, NQP has investigated other options such as the Mental Health Service Corps and the Satellite Model to gain access to behavioral health staff that are both culturally competent and financially viable.

EHR Infrastructure: NQP is implementing its Data Sharing and Interoperable System Strategy to improve connection to the RHIO and promote an increase in EHR functionality and data sharing. To address issues concerning the Healthix onboarding process timeline, the PPS and Healthix are developing a streamlined and standardized process for initiating practice connections, to ensure practices are properly prepared on Day 1 of implementation. A pilot program is currently in place to test these processes and make necessary

e. Model	*Number of Sites Planned*	*Number In Progress*	*Number Complete*
Model 1	74	51	23
Model 2	5	3	2
Model 3 IMPACT	0	0	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): Click or tap here to enter text.
☐ Other

Describe:

Click or tap here to enter text.

GLOSSARY OF TERMS

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

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

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

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

Primary Care Practice: Individual sites providing primary care services

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

Primary Care Provider: Entity providing primary care services

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