A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City

August 2016
Acknowledgments

The development of this strategy was a collaborative effort under the NYC Population Health Improvement Program (NYC PHIP), made possible by funding from the New York State Department of Health. Many individuals made contributions to this report. Above all, the NYC PHIP staff is extremely grateful to the members of the New York City Advanced Primary Care Planning Group for their overall thought leadership and deliberations. Significant thanks is also owed to Anthony Shih, Linda Weiss, Maya Scherer, Kerry Griffin, and Elisa Fisher from New York Academy of Medicine (NYAM) for conducting consumer focus groups to inform this report.

Staff Contributors

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Dear Partner,

I am excited to share with you the attached strategic plan for promoting higher-performing primary care across New York City. This publication is a key contribution of the Advanced Primary Care (APC) workgroup, convened under the New York City Population Health Improvement Program (PHIP) and co-chaired by the New York City Department of Health and Mental Hygiene and The United Hospital Fund.

The New York City PHIP works to develop multi-stakeholder plans and recommendations to improve the health of our communities, prevent premature deaths, and ultimately transform our city’s health delivery system. PHIP’s goals align with the Health Department’s efforts to make injustice visible and eliminate health disparities by creating healthier community environments.

At its core, the New York City PHIP is a collaborative approach to improving population health. Local residents and leaders have played critical roles in each of our major initiatives. PHIP has enabled the Health Department to engage the community more extensively than ever before in Take Care New York, our longstanding blueprint to create a healthier city. As part of the PHIP’s effort to engage more sectors in preventing chronic disease, the multi-sector DASH-NYC workgroup developed a guide describing healthy eating and active living interventions that can be adopted by the healthcare system, community organizations, and others. Finally, this strategic plan, developed with input from health care providers, insurers, consumers, and policymakers, outlines a five-point agenda for ensuring at least 80% of New York City primary care providers are delivering high-quality, patient-centered care. Strengthening primary care is essential for improving the health of our communities and preventing premature deaths.

Health equity cannot be achieved by a single individual, organization, or institution: we do our best work together. As you browse through this plan, please consider not only which interventions you and your organization can take on, but also potential partners with whom you could collaborate.

As always, thank you for your partnership as we work toward a healthier New York City.

Sincerely,

Mary T. Bassett, MD, MPH
Commissioner, New York City Department of Health and Mental Hygiene
Chair, NYC Population Health Improvement Program Steering Committee
Executive Summary

The medical home—a model of high-performing primary care—is critical to improving the health of New York City’s residents and addressing health inequities. There is increasing evidence that the medical home model is effective in improving health care quality, improving patients’ experience of care, and reducing avoidable emergency department visits and hospital admissions. It has particular value in improving the health, quality of care, and overall costs of care for society’s highest-cost and sickest patients, those with multiple chronic diseases.

The distinguishing features of a medical home include expanded access to care, a team-based approach to providing care that is efficient and responsive to patient needs, coordination of care during care transitions and for patients referred to specialty care, improved connections to community-based resources and support, and the use of quality improvement tools to measure and report outcomes. Expanding the medical home model and improving the performance of the state’s primary care system has been a central and unifying theme across New York State’s signature health reform initiatives and is a promising approach for supporting New York City’s Take Care New York 2020 (TCNY) goals. Research has consistently shown a relationship between robust primary care and reduced infant mortality, reduced premature mortality, and better self-reported health status—all three of which are lead indicators for Take Care New York 2020.

The plan outlined in this report is intended to serve as a data-driven strategy for expanding the adoption, and improving the impact of, the medical home in New York City. It sets an aggressive goal—to ensure that 80% of New York City primary care providers achieve medical home status by 2020—and includes specific strategies for addressing the primary barriers to reaching that goal. This strategy is meant to inform a broad group of stakeholders who believe in the vision of a stronger, higher-functioning primary care system, and who have the will and resources to act on that conviction.

The report identifies five broad issues New York City will need to address in pursuing that goal:

- How to set priorities in a city the size of New York, and decide where and how to initially invest resources to transform primary care practices into medical homes;
- How best to enable New York City’s small practices (those with fewer than five providers, for which implementation is most challenging) to adopt the medical home model;
- How best to integrate behavioral health services with primary care;
- How best to avoid the complexity and potential confusion related to having three simultaneous and similar practice transformation initiatives underway throughout New York State; and
- How to assure that payment systems fairly compensate primary care providers for the added costs and value of the medical home model.
This plan considers these challenges, and proposes an agenda for increasing the adoption of the medical home model in New York City:

1. **Prioritize increasing medical home adoption in communities with the greatest health disparities and inequities, and incorporate strategies to ensure those transformation efforts better respond to the needs of those communities’ residents.**
   - City and State government entities, Performing Provider Systems, and large provider systems should prioritize access to transformation resources for communities with the greatest health inequities in New York City.
   - Providers of technical assistance should adjust their practice transformation efforts in order to help primary care providers understand community priorities and address the health conditions that are prevalent in the communities they serve. All entities working in communities with the greatest health inequities should strive to effectively connect community-based efforts with clinical organizations undergoing practice transformation.
   - State and federal government, foundations, and other potential funders of community-based service organizations (CBOs) should identify potential new funding opportunities to increase CBOs’ capacity to adequately address the priorities identified through TCNY community consultations.

2. **Ensure opportunities for medical home transformation are accessible and sustainable for small practices, as small practices are instrumental in serving communities with large health inequities.**
   - Professional associations and other entities interested in the sustainability of small practices should help independent providers better understand the business case for pursuing the medical home model, including potential revenue they could receive under proposed medical home payment methods.
   - Medical societies, Performing Provider Systems (PPSs), and educational institutions that work closely with small practice providers should develop a unified and targeted communication plan to help practices identify and access practice transformation assistance and other resources, like Health Home, to enhance their primary care performance.
   - The New York City Population Health Improvement Program (NYC PHIP) should convene listening sessions to gather input from primary care providers on

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1 In this report, Community-Based Service Organizations (CBOs) refers to two of the three categories defined as a CBO by Medicaid’s Value-Based Payment Social Determinants subcommittee: Medicaid billing, non-clinical service providers (e.g., transportation and care coordination); and non-medical billing, community-based human service organizations (e.g., housing, social services, religious organizations, and food banks). The full definition can be accessed here: www.health.ny.gov/health_care/medicaid/redesign/dsrip/technical_design/docs/2015-10-15_sdh_and_cbo_meeting4.pdf
approaches they could take to achieve recognition as a medical home, including
the potential benefits of sharing key services and infrastructure among primary
care practices.

- PPSs and other trusted entities should convene providers and payers to initiate
a planning process to assess the feasibility of implementing a shared services
model for small practices in New York City.

3. **Support the integration of behavioral health care as part of the medical home.**

- At minimum, medical associations, Performing Provider Systems, delivery
system leaders, and leaders in behavioral health integration should educate
providers on the available models that integrate behavioral health services with
primary care and provide information to primary care providers on the basic
principles and alternative approaches to doing so.

- Leaders in behavioral health integration, practice transformation providers, and
policymakers should work together to support practices in developing effective
integration models, including, if possible, the Collaborative Care model.

- Performing Provider Systems, health plans, and policymakers should work
together to support primary care practices in improving the effectiveness of their
existing methods of care coordination (commonly referred to as screen, refer,
and follow-up) for patients they refer for behavioral health and other community
based support services.

4. **Build on and better coordinate the various medical home initiatives underway across New York State.**

- The NYC PHIP should work closely with the leaders of medical home
initiatives to improve their alignment in program design, mechanics and
communications.

- The New York City Department of Health and Mental Hygiene (NYC
DOHMH), as part of existing structures, should convene and provide local
leadership to the medical home initiatives with a focus on improving the
integration of these efforts within New York City.

- Also as part of its existing activities and programs, NYC DOHMH should
continue to engage major provider associations, academic detailing programs,
and transformation assistance providers to reduce the potential for confusion
among providers about the options available to them.

- Through medical home transformation assistance programs, NYC DOHMH
should work with the New York State Department of Health to establish and
maintain a single, unified statewide database of all practices as they enter and
graduate from the major initiatives outlined in this report to track progress in
practice transformation across the city.
5. Achieve multipayer support to sustain medical home models.

- The New York State Department of Health and Department of Financial Services should initiate regional discussions on Advanced Primary Care with the health plans that collectively cover the majority of New York City commercial and Medicare Advantage insured lives.

- Primary care providers and health plans with large numbers of Medicaid beneficiaries should encourage New York’s Office of Health Insurance Programs to continue medical home payments through New York’s Medicaid program.

- The NYC PHIP should work with a broad group of payers and purchasers (e.g., self-insured groups, other large purchasers, or membership organizations like the Northeast Business Group on Health) in conversations about the value of the medical home and how they can work with payers to support the medical home model in a way that includes payment for behavioral health integration.

- Trusted independent entities should convene providers and payers to develop standardized outcome reports for New York City primary care practices that are linked to value-based payment.
Health reform is well underway in New York City and across the state, focused on improving population health and achieving health system outcomes that New Yorkers desire: healthier individuals and communities; fewer injuries and illnesses; better quality care when health needs do arise; and lower overall health costs. Efforts to reform the health system include two main interventions: implementing innovations that can improve the performance of the health care delivery system, and changing the way health care services are paid for, moving from the prevailing fee-for-service payment system to value-based payment (VBP).

The New York City Population Health Improvement Program (NYC PHIP)\(^2\) embraces the goals of health reform, and has undertaken two related efforts focused on improving the health of New York City’s residents:

-Initiating a series of place-based interventions focused on improving the health of the residents of the city’s most disadvantaged communities; and
-Developing a plan to increase the adoption of the medical home in New York City’s primary care practices.

This report focuses on the second of these initiatives: expanding the adoption of the medical home model. We see expanding the medical home model as a critical means of strengthening primary care across New York City. Strong primary care can increase health equity and help make gains in the health goals articulated in the city’s plan for health improvement, Take Care New York 2020.\(^3\) Research has consistently shown that robust primary care can lead to reduced infant mortality, reduced premature mortality, and better self-reported health status\(^4\)—all three of which are overarching health indicators for Take Care New York 2020.\(^5\)

The medical home has been widely recognized as an important innovation for enhancing the performance of primary care practices and improving the health of the patients they serve. Based in a primary care setting, the medical home emphasizes the provision of comprehensive care focused on patient needs and preferences. Medical homes offer expanded access to care through extended hours of operation and a team approach to providing care, in order to make care more efficient and responsive to a wider range of patient needs. The medical home coordinates referrals and care transitions; connects patients and families to community-based resources and support; provides personalized care management for complex, chronically ill patients; and has a sharp focus on measuring, reporting, and improving quality of care.

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\(^2\) The NYC PHIP is a collaboration led by the New York City Department of Health and Mental Hygiene with the Fund for the City of New York, New York Academy of Medicine, and UHF. For more information about the NYC PHIP’s goals and structure visit http://www.fphny.org/programs/nyc-population-health-improvement-program.

\(^3\) Take Care New York 2020 is New York City’s blueprint for improving every community’s health and for making greater health improvements in groups with the worst health outcomes. TCNY 2020 includes four broad areas of focus: promoting healthy childhoods; creating healthier neighborhoods; supporting healthy living; and increasing access to quality care. For more information visit: http://www1.nyc.gov/site/doh/health/neighborhood-health/take-care-new-york-2020.page.


There is increasingly strong evidence that medical homes are effective in reducing unnecessary health care while improving health care quality and improving patients’ experience of care. In a compilation of research on medical home initiatives published between October 2014 and November 2015, 21 of the 23 studies that looked at cost outcomes suggested that medical homes resulted in reduced costs on at least one cost-saving measure. Similarly, 23 out of 25 studies found medical homes to have a positive effect on reducing unnecessary health care utilization. The review found that the greatest improvements in cost or utilization occurred among more mature initiatives in which medical homes were operating for multiple years, had financial support from multiple payers, and had financial incentives tied to quality, patient experience, utilization, or cost goals.6

Medical homes are particularly effective in improving the health of patients with multiple chronic diseases—like asthma, diabetes, and hypertension—by managing their care more effectively, and by emphasizing preventive care. In their best form, medical homes can facilitate improvements in population health by identifying and responding to the needs of the neighborhoods they serve, tailoring prevention and disease management strategies to meet cultural, demographic, and epidemiological needs.

These core medical home attributes can directly contribute to achieving Take Care New York 2020’s goals for increasing access to quality care. The medical home can contribute to reducing levels of unmet medical need by offering expanded hours and more flexible appointment schedules, thus ensuring that primary care is not the bottleneck preventing New Yorkers from getting the care they deserve. Through quality improvement efforts, medical homes can improve their ability to detect and treat patients with high blood pressure and HIV—two disease areas identified in Take Care New York 2020 as needing improvement. Finally, the city aims to decrease the percentage of adults with serious psychological distress who did not get needed mental health treatment. The medical home provides a solid foundation for routine screening of patients for mental health disorders, and for effectively referring those who need specialized help can routinely occur.

In recent years, expanding the medical home model has been a central and unifying theme across New York State’s signature health reform initiatives. These initiatives build on the success and experiences of several regional multipayer primary care demonstration projects in New York, including projects in the Adirondacks and the Hudson Valley. Three initiatives are currently underway to support the adoption of the medical home:

- New York State’s Delivery System Reform Incentive Payment Program (DSRIP) and the National Committee for Quality Assurance’s Patient-Centered Medical Home (NCQA PCMH): The DSRIP is a $7.3-billion initiative intended to improve the health of the state’s Medicaid beneficiaries and reduce avoidable hospital utilization by 25% over five years. As part of their DSRIP requirements, Performing Provider Systems (PPSs) are required to ensure that their participating primary care practices achieve recognition as medical homes under

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one of two models: as Level 3 Patient-Centered Medical Homes (PCMHs) under NCQA’s 2014 Standards, or as Advanced Primary Care (APC) practices, a medical home model that is being developed under New York’s State Innovation Models (SIM) initiative. Many of the state’s PPSs are currently pursuing recognition for their primary care practices under NCQA’s PCMH program.

- **New York State’s Health Innovation Plan and Advanced Primary Care (APC):** New York’s State Health Innovation Plan (SHIP) has an aggressive goal that 80% of the state’s population will have access to an enhanced primary care model (Advanced Primary Care, or APC), which builds on but goes beyond the PCMH model, by 2020. In December 2014, New York was awarded a $99.9-million grant from the Center for Medicare and Medicaid Innovation. Two-thirds of that grant money will be dedicated to supporting and enabling practice transformation to the APC model. New York State is currently engaging health plans and purchasers in developing new payment models that can help ensure multipayer support for practices that are pursuing the APC model, which in turn would enable those practices to participate in value-based payment.

- **Transforming Clinical Practice Initiative (TCPI):** In Fall 2015 New York State received two additional federal grants to support primary care practice transformation under the Transforming Clinical Practice Initiative (TCPI): a $10 million grant to New York University School of Medicine (which will focus primarily on primary care practices in Brooklyn), and a grant of nearly $50 million to the New York State Practice Transformation Network (NYS-PTN), which has a statewide organization and focus. The TCPI model for practice transformation is slightly different from both the PCMH model and the proposed APC model.

Expanding access to high-quality, coordinated primary care for low-income New Yorkers is a priority for New York City as well, as demonstrated by the October 2015 announcement that the City will fund the creation of 13 new community health centers and the expansion of several others through its Caring Neighborhoods initiative. The state’s three medical home initiatives will provide means to augment the capacities of these new care sites, as well as existing primary care.

There is currently an unprecedented focus on—and resources for—strengthening primary care in New York City. However, as these multiple primary care transformation initiatives unfold in New York City, there is a risk of these efforts colliding, weakening the progress that could be made if all forces were moving in a single direction and in an organized way. There is also a risk that strengthening primary care will continue to be viewed solely as a health care system goal rather than as a unique opportunity to bridge clinical and public health efforts.
The New York City Advanced Primary Care Planning Group

The authors of this report are building on the growing consensus that expanding the adoption of the medical home model is an important investment in improving the health of New York City residents; and we believe that the course of action noted in the pages that follow will help achieve this goal, by improving the performance of New York City’s primary care system.

This report was informed and guided by a diverse group of primarily New York City-based health care leaders, practitioners, and advocates. Over the course of nine months these individuals came together as the New York City Advanced Primary Care Planning Group (see Appendix A) to advise on the development of an action plan for improving New York’s primary care system. With their help, we have developed a five point agenda for stakeholders who believe in the vision of a stronger, higher-functioning primary care system, and who have the will and resources to act on that conviction.

The agenda was also informed by the findings from five consumer focus groups conducted by the New York Academy of Medicine between November 2015 and January 2016. The focus groups were held in Jamaica, Queens; Port Richmond, Staten Island; Brownsville, Brooklyn; East Harlem, Manhattan; and Hunts Point, Bronx. Participants were asked to reflect on their experiences with and perspectives on primary care services, both generally and as they related to specific characteristics of the medical home. Participants were also asked to provide recommendations for the city's primary care services. Those perspectives informed our recommendations and are described in greater detail in Appendix B.

While far from a panacea, this agenda identifies a number of key issues and approaches that can help ensure medical home transformation is pursued thoughtfully and efficiently. This includes maximizing the use of available dollars and resources while encouraging transformation efforts to address the highest-priority health needs of New York’s residents effectively. While not every member of the advisory group agrees with every word in the agenda, they are united by the vision of a stronger primary care system and endorse the spirit and direction of the document.

New York City Primary Care Principles

This report is grounded in shared values. We believe the following principles should guide primary care transformation in New York City and urge leaders in Albany and Washington to similarly be guided by these four guiding principles.

1. **Aim to transform primary care across the whole city, with an early focus on communities with large health inequities.**

While it is important to focus on the goal of having 80% of the population served by a medical home, New York City is a diverse city with significant health disparities. Since the sheer magnitude of the city makes blanketing the city in medical home transformation efforts all at once an impractical proposal, initial efforts can and should be focused in areas with significant health inequities. At the same time, primary care is used by most New Yorkers—young and old, rich and poor—and there is a need to broadly strengthen the entire system.
2. Promote a broad and unified definition of medical home.

New York’s three major medical home initiatives are focused on transforming primary care practices into higher-performing practices with an emphasis on improving population health and quality of care. While each effort has its differences, each of these models provides a means to an end: better health and health care for all New Yorkers.

In recent years some observers of the medical home have contended that medical home recognition is a “diploma” that does not guarantee transformation into strong primary care. Yet the evidence base, as a whole, favors medical home programs. Peer-reviewed research from New York, along with numerous studies from across the country, has demonstrated that primary care practices certified as medical homes deliver results.7 A 2012 study found that NCQA-certified PCMHs reduced Emergency Department visits by adults by 11% and by 17% among children; reduced health care costs by adults by 14.5% and by 8.6% for children; and improved care quality and outcomes.8 And while initial medical home certification was largely based on demonstrating structures and processes, standards for medical home recognition have become increasingly sophisticated in gauging genuine transformation of primary care.

In our work, we have adopted a broad definition of “medical home” that encapsulates the shared attributes among the three major medical home models in New York:

- expanded access to care;
- use of a care team approach;
- coordination of referrals and care transitions;
- connection to community-based resources and support;
- care management for complex, chronically ill patients; and
- quality improvement systems that include the ability to measure and report outcomes.

Practices that have achieved recognition as PCMHs under NCQA’s 2014 standards, practices that will be recognized under the state’s APC program, and those who will have completed the TCPI program should all be considered medical homes. The aim for New York City should be to spread the medical home model as widely as possible.

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7 http://www.pcpcc.net/sites/default/files/PCPCC%20Medical%20Home%20Cost%20and%20Quality%202013.pdf

3. Don’t use a one-size-fits-all approach for practice transformation.

Achieving broad spread of the medical home model will require engaging with New York City’s diverse set of primary care practices. Practices can differ from one another dramatically, varying in their ownership and affiliations, organizational structure, and size, as well as the populations they serve. These differences matter for both how transformation assistance can be structured and offered to primary care practices, and for how transformation efforts might be tailored to be most responsive to the needs of patients. For example, primary care practices that are affiliated with a larger entity, like a hospital system, or that have a partnership arrangement with a broader network, like a Performing Provider System, can be clustered with those within their network for shared training, or even for sharing medical home services. Parent organizations may be a good vehicle for reaching a large number of primary care practices at once, such as in a variant of the train-the-trainer model, in which the parent organization can offer practice transformation services to providers within its network.

The number of providers working in a practice—essentially, its size—also matters. Currently practices with only one or two providers are far less likely to have been recognized through medical home certification because the economics of doing so are particularly challenging for small practices. Practices with five or fewer providers represent over 40% of the primary care providers in New York City, and many serve low-income residents who are not native English speakers. It makes sense to take different practice transformation approaches according to each practice’s unique characteristics and pay special attention to small practices, particularly those with only one or two providers.


What gets measured, gets done. Critical to ensuring that every neighborhood in New York City is served by medical homes is understanding where we are now, and how far we have to go, in achieving widespread adoption of medical home models. Such measurement requires a surveillance method to track and regularly report on progress. Tracking who is receiving transformation assistance is particularly important for two reasons. First, two of the transformation efforts unfolding in New York City—TCPI and APC—have strict non-duplication and eligibility requirements. Second, monitoring involvement in medical home transformation efforts will be essential for tracking progress and measuring the “gap to goal.” It will be essential to monitor whether a broad majority of providers are participating in these medical home models—not just the eager and willing.

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A Goal for New York City: 80% of Primary Care Providers Located in New York City Reach Medical Home Status by 2020

We approached setting a goal for New York City’s medical home expansion with an appreciation of our capacities and limits. While our focus is on improving primary care in New York City, we recognize that many of the levers for rapidly scaling the medical home model—such as changing payments to promote and sustain the medical home model—are driven by state and federal policy. There are, however, pragmatic steps we can take within New York City to promote the medical home while continuing to work with our partners at the state and national level on issues within their control.

The vision is to have 80% of New York City residents served by a medical home, but tracking progress toward that goal would require data on where patients receive primary care, which is not currently available. Instead, we have to rely on information about the health system itself—numbers of providers and sites within a given community that have achieved medical home status. This data answers a slightly different question than “How many residents of New York are receiving care in a medical home?”

As data systems improve, it should be possible to answer that question and measure the extent to which medical home expansion has influenced Take Care New York 2020’s overarching health and clinical indicators. For now, however, we must settle for proxy measures of the population’s access to medical home. This report uses the proxy goal of having 80% of primary care providers located in New York City reach medical home status by 2020.
Where We Are Today: The Health of New York City’s Communities and Their Primary Care Base

Community Health Needs

Collectively, the health of New Yorkers is good compared to that of residents of many major cities. On average, New York City residents can expect to live longer than their fellow Americans by roughly 2 years.¹⁰ But as the New York City Department of Health and Mental Hygiene’s (NYC DOHMH’s) latest edition of Take Care New York and Community Health Profiles illustrates, specific communities in each of the city’s five boroughs experience significantly higher rates of chronic conditions and hospitalization—suggesting areas where residents do not have the same opportunities as others to live healthily. Expanding the availability of medical homes in those communities can support the City’s goals of improving every community’s health and reducing important health inequities, such as premature deaths (death before age 65).

Looking at the health of New Yorkers at a citywide level, or even on a borough-by-borough basis, often obscures important health inequities between communities. In our analysis we took a different approach. Beginning with a selection of key indicators of population health and social determinants of health, we grouped communities with similar health characteristics. What emerged is a profile of New York City with three distinct health zones: Zone A, with the highest burden of disease; Zone B, which is medium-burdened; and Zone C, with the lowest burden of disease. Figure 1 maps the city’s health zones and Figure 2 lists the population health indicators used to develop the zone system. See Appendix C for a list of Community Districts within each Health Zone and Appendix D for health indicator outcomes for each Community District.

Figure 1. Map of New York City’s Community Districts by Health Zone

![Map of New York City’s Community Districts by Health Zone](image)

Figure 2. New York City “Health Zones” by Population Health Indicators

<table>
<thead>
<tr>
<th>Disease Prevalence (CHS 2013)</th>
<th>Zone A Mean (min, max)</th>
<th>Zone B Mean (min, max)</th>
<th>Zone C Mean (min, max)</th>
<th>NYC Total Mean (min, max)</th>
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</thead>
<tbody>
<tr>
<td>% Asthma</td>
<td>15.6 (9.2, 20.6)</td>
<td>12.3 (7.3, 15.6)</td>
<td>9.6 (5.5, 14.2)</td>
<td>12.6 (5.5, 20.6)</td>
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<tr>
<td>% Hypertension</td>
<td>33.8 (30.1, 37.9)</td>
<td>27.6 (18.7, 32.6)</td>
<td>24.0 (16.6, 31.9)</td>
<td>28.7 (16.6, 37.9)</td>
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<tr>
<td>% Obesity</td>
<td>31.2 (26.8, 35.4)</td>
<td>23.4 (10.4, 34.3)</td>
<td>17.2 (8.3, 30.2)</td>
<td>24.2 (8.3, 35.4)</td>
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<tr>
<td>% Diabetes</td>
<td>13.8 (9.5, 17.7)</td>
<td>10.7 (3.7, 15.2)</td>
<td>7.4 (3.4, 13.8)</td>
<td>10.7 (3.4, 17.7)</td>
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<tr>
<th>Avoidable Hospitalizations (SPARCS 2012)</th>
<th>Zone A Mean (min, max)</th>
<th>Zone B Mean (min, max)</th>
<th>Zone C Mean (min, max)</th>
<th>NYC Total Mean (min, max)</th>
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<tbody>
<tr>
<td>Asthma (per 100,00)</td>
<td>484.1 (217.2, 785.9)</td>
<td>198.2 (114.2, 280.8)</td>
<td>106.0 (45.6, 230.6)</td>
<td>276.8 (45.6, 785.9)</td>
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<td>Hypertension (per 100,00)</td>
<td>178.0 (115.5, 316.7)</td>
<td>98.3 (64.9, 136.4)</td>
<td>60.1 (20.4, 101.2)</td>
<td>115.8 (20.4, 316.7)</td>
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<td>Diabetes (per 100,00)</td>
<td>532.8 (334.8, 748.1)</td>
<td>273.7 (155.9, 381.4)</td>
<td>151.2 (54.5, 314.1)</td>
<td>331.1 (54.5, 748.1)</td>
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<th>Social Determinants of Health (ACS 2013)</th>
<th>Zone A Mean (min, max)</th>
<th>Zone B Mean (min, max)</th>
<th>Zone C Mean (min, max)</th>
<th>NYC Total Mean (min, max)</th>
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<tr>
<td>% Foreign-born</td>
<td>34.6 (19.0, 55.0)</td>
<td>36.7 (20.0, 66.0)</td>
<td>37.7 (15.0, 63.0)</td>
<td>36.2 (15.0, 66.0)</td>
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<tr>
<td>% Limited English Proficiency</td>
<td>22.0 (8.0, 46.0)</td>
<td>23.1 (9.0, 53.0)</td>
<td>23.0 (6.0, 48.0)</td>
<td>22.7 (6.0, 53.0)</td>
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<tr>
<td>% Below FPL</td>
<td>30.3 (17.0, 44.0)</td>
<td>19.5 (9.0, 30.0)</td>
<td>14.0 (6.0, 32.0)</td>
<td>21.8 (6.0, 44.0)</td>
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<tr>
<td>% Black or Hispanic</td>
<td>82.6 (30.0, 98.0)</td>
<td>49.7 (17.0, 78.0)</td>
<td>23.0 (8.0, 70.0)</td>
<td>53.0 (8.0, 98.0)</td>
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<tr>
<td>% with Less than HS Diploma</td>
<td>28.0 (16.0, 45.0)</td>
<td>20.0 (5.0, 42.0)</td>
<td>14.0 (3.0, 31.0)</td>
<td>20.9 (3.0, 45.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Health (SPARCS 2013)</th>
<th>Zone A Mean (min, max)</th>
<th>Zone B Mean (min, max)</th>
<th>Zone C Mean (min, max)</th>
<th>NYC Total Mean (min, max)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Hospitalizations (per 100,000)</td>
<td>986.0 (554.0, 2016.0)</td>
<td>592.5 (385.0, 989.0)</td>
<td>415.5 (259.0, 891.0)</td>
<td>682.9 (259.0, 2016.0)</td>
</tr>
</tbody>
</table>
Primary Care Supply and Performance in New York City

New York City has the opportunity to use payment reform and health system redesign to strengthen its primary care system to more effectively respond to community health needs. This can be achieved by using the medical home model to increase the capacity of primary care providers to prevent and manage disease and injury, connect patients and consumers with community-based supports, and better serve New York’s incredible cultural diversity.

There are an estimated 10,171 primary care providers (PCPs) in New York City. The overall supply of PCPs and sites of care are comparable across zones, with 13 PCPs per 10,000 residents in Zone A and Zone B, and 14 PCPs per 10,000 residents in Zone C. An equal distribution of primary care providers across Zones may not be ideal, as neighborhoods with higher disease burdens and greater unmet health care needs, like Zone A communities, may warrant a larger supply of primary care. Figure 3 provides an overview of New York City’s primary care supply.

Approximately 25% of the city’s primary care providers have already made significant strides toward medical home adoption by attaining PCMH 2011 certification—a slightly less rigorous predecessor to PCMH 2014. Yet in many ways New York City’s journey toward widespread adoption of the medical home is just beginning. At the writing of this report, the three major models—TCPI, APC, and PCMH 2014—are in very early stages of development and spread. The Transforming Clinical Practice Initiative officially began in October 2015 and is expected to span a 4-year implementation period. The State-defined Advanced Primary Care model (definition of the APC model is currently in progress) is expected to start engaging practices in mid-2016. PCMH 2014, introduced by NCQA in March 2014 but building on the PCMH 2011 version that has achieved some scale in primary care practices, is considered the “oldest kid on the block.” The major driver of PCMH 2014 adoption in New York City is expected to be the DSRIP program, and that too is only finishing its first year of implementation.

As the three medical home models continue to develop and spread across New York City, lessons for accelerating their spread can be drawn from the city’s experience with PCMH 2011. Uptake of PCMH 2011 across the city reveals significant variation in where medical homes are gaining traction, both by geographic location and practice size. Where the medical

Where we are today:
• There are more than 10,000 primary care providers in New York City.
• Approximately one-quarter of these providers have achieved medical home recognition to date.
• Adoption of the PCMH 2011 medical home model to date has been concentrated in large primary care sites and sites in which Medicaid is a significant payer.
• Primary care providers working in small practices are less likely to have achieved medical home recognition compared to providers working in large sites.

11 This primary care provider definition includes medical doctors (MDs), doctors of osteopathic medicine (DOs), nurse practitioners (NPs), and physician’s assistants (PAs), and it aligns with the NCQA provider definition. The TCPI program uses a broader definition and includes physicians (MDs and DOs), PAs, NPs, clinical nurse specialists, clinical psychologists, and licensed clinical social workers. In its basic definition, the DSRIP program uses a narrower definition of MDs, DOs, and NPs. In certain circumstances, OB/GYNs and other specialists might be considered primary care providers by DSRIP.
home model has—and most importantly, has not—gained a foothold yields important lessons for all those interested in moving primary care into the PCMH 2014, APC, or TCPI models.

Figure 3. Zone Statistics—Primary Care Supply

<table>
<thead>
<tr>
<th></th>
<th>Zone A</th>
<th>Zone B</th>
<th>Zone C</th>
<th>Citywide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>2,953,451</td>
<td>2,214,296</td>
<td>3,234,545</td>
<td>8,402,292</td>
</tr>
<tr>
<td>Primary care providers (PCPs)</td>
<td>3,932</td>
<td>2,847</td>
<td>4,655</td>
<td>10,171*</td>
</tr>
<tr>
<td>PCPs per 10k population</td>
<td>13</td>
<td>13</td>
<td>14</td>
<td>13.6</td>
</tr>
<tr>
<td>Sites by # of PCPs</td>
<td>964</td>
<td>887</td>
<td>1,716</td>
<td>3,581</td>
</tr>
</tbody>
</table>

* The citywide total for primary care providers is less than the sum of primary care providers by zone because some primary care providers work in multiple sites across zones.

** The citywide total for sites with 1–2 providers is greater than the sum of sites by zone because there were 14 sites (with 15 associated providers) that could not be tied to a community district; this also had a small impact on the overall percentages.

Medical Home Adoption by Zone

Current data suggests that, while primary care providers are beginning to adopt the medical home model, more work needs to be done to make the model the standard of care across New York City. The greatest progress has been made in Zone A, where still only 28% of primary care providers work at sites with medical home recognition. This is a higher rate of penetration than in Zones B and C, where 21% and 13% of primary care providers (respectively) are working in sites that have been recognized as a medical home (see Figure 4).

The greater preponderance of PCMH-certified providers in Zone A may be driven by the large presence of hospital clinics and Federally Qualified Health Centers (FQHCs) in Zone A communities. Hospital clinics and FQHCs tend to be large primary care sites that are more likely to have economies of scale and enough infrastructure to adopt innovations, particularly the ability to expand the existing workforce to implement new medical home models. Hospital clinics and FQHCs are also largely supported by Medicaid, which pays PCMH-certified providers more than non-certified providers. Figure 5 shows the analysis of the number of sites in each zone by size (as measured by the number of primary care physicians at the site) and reveals that Zone A has a higher percentage of large sites—most likely hospital clinics and FQHCs—compared to the other two zones. Sufficient scale and financing are two important drivers of medical home adoption and are discussed in further detail below.

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12 PCMH recognition is at the site level. In order to report on provider-level PCMH status, a unique algorithm was applied to attribute site-level PCMH recognition to PCPs.

13 For this section, medical home status refers to PCMH 2011 certification by NCQA, as PCMH 2014 standards were only recently phased in, and the TCPI and APC medical home models are in nascent phases.
Figure 4. Zone Statistics—Medical Home Adoption by Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Zone A</th>
<th>Zone B</th>
<th>Zone C</th>
<th>Citywide</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs who are PCMH</td>
<td>1,100</td>
<td>600</td>
<td>609</td>
<td>2,233*</td>
</tr>
</tbody>
</table>

* The citywide total does not equal a summation across zones because providers can work at multiple sites across zones.

Figure 5. Zone Statistics—Medical Home Adoption by Site Size*

<table>
<thead>
<tr>
<th>PCMH Sites by # of PCPs at Site</th>
<th>Zone A</th>
<th>Zone B</th>
<th>Zone C</th>
<th>Citywide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–2</td>
<td>65 (10%)</td>
<td>59 (9%)</td>
<td>52 (4%)</td>
<td>176</td>
</tr>
<tr>
<td>3–5</td>
<td>45 (30%)</td>
<td>28 (21%)</td>
<td>38 (16%)</td>
<td>111</td>
</tr>
<tr>
<td>6–15</td>
<td>40 (42%)</td>
<td>24 (35%)</td>
<td>22 (20%)</td>
<td>86</td>
</tr>
<tr>
<td>16+</td>
<td>22 (37%)</td>
<td>9 (23%)</td>
<td>7 (15%)</td>
<td>38</td>
</tr>
</tbody>
</table>

Note: An example statement of how to interpret this data: In Zone A, only 10% of the sites (65 total) with 1-2 PCPs have PCMH recognition. In contrast, 37% of the sites with 16+ PCPs in Zone A have PCMH recognition (22 total). It is important to note that among sites with 1-2 PCPs, PCMH penetration is very low across all zones.

Figure 6. Medical Home Distribution by Health Zone

- PCMH Site
- Non-PCMH Site
- Zone A
- Zone B
- Zone C
Drivers of Medical Home Adoption

In 2015, UHF analyzed PCMH 2011 adoption in New York City and identified two primary drivers: provider practice size and payment incentives.

**Provider Practice Size:** Adoption of the PCMH model is greatest in larger practices, many of which are operated by hospitals and FQHCs. These organizations typically have the scale required to implement and sustain the additional costs and functions of a medical home. Achieving PCMH recognition is less common among small practices (see Figure 7).

**Figure 7. New York’s PCMH 2011 Providers by Practice Type**

![Figure 7. New York’s PCMH 2011 Providers by Practice Type](image)

**Payment Incentives:** New York was among the first states whose Medicaid program gave specific financial incentives to primary care providers who adopted and implemented a medical home model. Currently, New York State Medicaid pays $8 per member per month to any practice serving Medicaid beneficiaries that achieved recognition under NCQA’s PCMH standards. This payment is in addition to their fee-for-service or capitation payments. There seems to be a strong correlation between those payments and higher numbers of PCMH providers. Over 70% of New York City’s PCMH providers are based in a hospital clinic or an FQHC. Medicaid, the dominant payer in these settings, pays an enhanced payment rate for PCMH recognition. A number of the state’s private payers, including Empire BlueCross BlueShield and Capital District Physicians’ Health Plan (CDPHP), also sponsor their own medical home programs. They and several other payers are participating in one of the state’s two multipayer demonstrations that provide additional support to practices that are medical homes. Data from across New York State show that provider participation in the PCMH model is greatest in regions where major payers are participating in multipayer demonstration projects in support of the medical home.

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[^14]: Medicaid currently provides PCMH incentive payments of $6–$8 per member per month for each Medicaid managed care member enrolled in an NCQA-recognized practice that has achieved recognition as a PCMH under NCQA’s 2014 Standards.
It also seems likely that strategic partnerships—affiliations or sponsorships by organizations with the incentive and capacity to strengthen their primary care base—will play an increasingly important role in driving medical home adoption. As part of the DSRIP program, primary care practices participating in a Performing Provider System may receive assistance from their lead organization for practice transformation, as the lead organizations are mandated to achieve nearly universal PCMH 2014 or APC status among their affiliated primary care practices within three years.
Greatly increasing medical home adoption, and ensuring that medical home growth will translate into genuine health and health care improvements for New York’s residents, will require significant attention in at least five areas.

1. Prioritize increasing medical home adoption in communities with the greatest health disparities (e.g., Zone A neighborhoods) and incorporate strategies to ensure that transformation efforts better respond to the needs of those communities’ residents.

Resources to support practice transformation are finite. In keeping with one of our four guiding principles, spending those resources wisely demands that transformation efforts focus initially on communities where the medical home model can have the greatest impact: those communities with the greatest health burdens and inequities. Such an approach could result in greater health improvements earlier and help consolidate the gains of the medical home model. With more than 10,000 primary care providers and nearly 9 million residents, the sheer size of New York City makes achieving anything at a citywide level a daunting task. To gain a sense of momentum and to take action, we propose that transformation efforts in the city start with assessment and deployment of resources to the communities with the biggest health disparities, those in Zone A (see prior section).

Entities that can deploy practice transformation resources include Performing Provider Systems (PPSs), large provider systems, practice transformation technical assistance providers, and the NYC DOHMH through the Bureau of the Primary Care Information Project. Each of these entities can ensure that Zone A communities are accounted for and prioritized within its own organization’s capacities and constraints. If all Zone A primary care providers reach the 80% medical home status goal, an estimated 3,932 providers will have done so—brining the citywide penetration level to 39%.

While spreading the medical home model in Zone A communities is an important and necessary step in improving population health, additional strategies are needed to ensure that providers working in those communities have the tools to be responsive to the health needs and priorities of local residents. Through the Take Care New York 2020 community consultations, the health priorities of residents across many of the city’s communities are being documented and better understood. The findings from those consultations can be used...
to inform practice transformation activities, like quality improvement efforts, so practices work on improving aspects of their care that are of most import to the communities they serve. An important dimension of responding to the needs of local residents is recognizing and embracing the wonderful diversity that is a feature of many New York neighborhoods, particularly in Zone A. Our focus groups in five Zone A communities revealed that too many primary care users have experienced feeling disrespected by their primary care providers and have encountered significant communication barriers. There is a heightened need for primary care providers to embrace and follow the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care—a set of guiding principles intended to improve health care access and quality.

Finally, improving the health of many Zone A residents will require access to both high-performing primary care and community-based services that can meet their broader health and human service needs. Much more can be done to ensure that strong referrals between primary care and community-based organizations are created and sustained.

**Recommendations**

- **City and State government entities, Performing Provider Systems, and large provider systems should prioritize access to transformation resources for Zone A communities.**

  At the local level, NYC DOHMH, through the Bureau of the Primary Care Information Project (PCIP) and in collaboration with other practice transformation technical assistance providers, can expand efforts to reach and assist providers in Zone A—many of whom have already engaged with PCIP and others for PCMH 2011 recognition. At the State level, to the extent that it is possible, applications for SIM transformation resources that articulate a compelling vision for reaching Zone A providers should be rewarded. Performing Provider Systems (PPSs) that have a clear incentive to not only transform the primary care providers within their networks into medical homes but also to focus those efforts in areas with the highest levels of avoidable hospitalizations, should prioritize Zone A communities in their primary care implementation plans for DSRIP. Similarly, many New York City hospitals—even those that are not PPS leads—have a substantial presence in Zone A communities and can assist the primary care providers affiliated with them in transforming into medical homes.

- **Practice transformation technical assistance providers should tailor their practice transformation efforts to help primary care providers better understand community priorities and address health conditions that are prevalent in the communities they serve.**

  As NYC DOHMH conducts listening sessions as part of TCNY 2020, a wealth of information is being gathered about the health priorities of neighborhoods. Practice transformation providers can use this information to help providers understand the priorities of the communities they serve and identify ways in which specific practice transformation activities (such as quality improvement activities) can help address community health priorities. For example, mental health issues have emerged as a top concern across many of the Take Care
New York 2020 community consultations. As part of the quality improvement activity that must take place in order to gain medical home recognition, providers in those communities could focus their improvement work on depression screening. In addition to TCNY 2020’s listening sessions, there may be other opportunities to identify shared priorities between community residents and local primary care providers. The focus should be on encouraging primary care activities that mirror the health and wellness priorities of the communities they serve.

- **All entities working in Zone A communities should strive to effectively connect community-based efforts with medical homes.**

As many of the underlying causes for health inequities may arise from unmet social needs, like income supports or access to healthy foods, connections between primary care and community-based organizations are needed to support and sustain healthy living. The NYC DOHMH, which is engaged in both medical home transformation and many community-based services, can continue to align those efforts and ensure that in its high-priority communities—particularly those most closely connected to the District Public Health Offices—local primary care providers have the means to directly refer patients to community-based initiatives. Private foundations that have traditionally funded community-based service organizations in Zone A communities can work to ensure that primary care providers are aware of the community-based organizations operating in their community and help develop referral systems between clinical and community service providers.

- **State and federal government agencies, foundations, and other potential funders of community-based service organizations should identify potential new funding opportunities to increase the capacity of community-based organizations to adequately address the priorities identified by TCNY community consultations.**

Referrals from primary care providers to community-based service organizations alone may not be enough to ameliorate health inequities and social determinants unless those community organizations have sufficient capacity to respond to increased demand, which is an inevitable outcome of establishing effective referral systems from primary care. New funding and supports for community-based organizations increases the likelihood that they can sustain and expand their operations to better meet the need of patients in their communities. In addition to identifying sources to increase funding for community-based services, potential funding could focus on colocation of medical homes with community action partners. We would use this opportunity to identify best practices and lessons learned to optimize the medical home model with a focus on bridging gaps in communication and improving social cohesion.

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15 In this report, Community-Based Service Organizations (CBOs) refers to two of the three categories defined as a CBO by Medicaid’s Value-Based Payment Social Determinants subcommittee: Medicaid billing, non-clinical service providers (e.g., transportation and care coordination); and non-medical billing, community-based human service organizations (e.g., housing, social services, religious organizations, and food banks). The full definition can be accessed here: www.health.ny.gov/health_care/medicaid/redesign/dsrip/technical_design/docs/2015-10-15_sdh_and_cbo_meeting4.pdf

16 The NYC PHIP also has a role to play in strengthening clinical-community linkages, and is beginning that work through joint brainstorming sessions between the PHIP NYC Advanced Primary Care Planning Group, the PHIP Designing a Strong and Healthy New York City (DASH NYC) and the New York Academy of Medicine (NYAM).
2. Ensure that opportunities for medical home transformation are accessible and sustainable for small practices, as small practices are instrumental in serving communities with large health inequities.

Forty percent of New York City’s primary care providers work in small practice settings and many provide an important source of care for ethnically and linguistically diverse populations across the city. Ensuring small practices can participate in medical home transformation—and, ultimately, alternative payment methods—is necessary for improving access to high-quality health care. Without a strategy for purposely including small practices by addressing their economic and resource challenges, it will not be possible to achieve 80% penetration of the medical home model in New York City—nor will it be possible to reach populations living in the city’s highest-need communities who rely on small practices.

In planning for the expansion of the medical home model in New York City, the city’s small, independently owned practices cannot be ignored. A national survey of provider groups found that small practices (those with one or two physicians) serve a significant number of high-need patients, caring for significantly more patients of racial or ethnic minorities, more dual-eligible patients, and patients with more chronic conditions than larger practices. The patients of small practices were also found to have significantly fewer preventable hospitalizations than larger practices, suggesting that, despite the challenges of running a small physician office, small practice providers can provide high-quality care for patients. Nonetheless, small practices face major challenges in obtaining recognition and sustaining the medical home model.

Each of the three prevailing medical home models being implemented in New York State requires substantial changes in the organization and function of a primary care practice. These changes include expanding hours to improve access to care; developing effective care teams; creating and using registries; hiring new staff (care managers) to help better manage the care of high-risk complex patients across all health care needs (e.g., specialists, diagnosticians, and behavioral health providers); and implementing programs designed to improve quality and reduce preventable utilization, and being able to measure and report the practices’ outcomes.

Though many of the smaller practices already preform some medical home functions, they may not have the resources and scale to implement all components of the medical home without a significant source of capital or new revenue. Becoming a medical home requires a practice to assume new costs, such as setting up and purchasing electronic medical records, researching and identifying vendors or software tools that fit their needs and match their long-term business operations, hiring new staff for care coordination or management, training existing staff on registry functions and outcomes reporting, and hiring or expanding staff for quality improvement activities and systems support.

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Payment reform opportunities also present an information imbalance between small practice providers and larger organizations that may have dedicated staff to determine how value-based payment (VBP) will provide the necessary financial support for sustaining medical homes. VBP offers providers an opportunity to be better paid for, and even incentivized to pursue, medical home capacities that are typically not reimbursed in traditional fee-for-service systems. To participate in many of the VBP efforts, however, primary care practices will need to be able to document, analyze, and report on their performance against a series of benchmarks of quality and costs of care. This, in turn, requires a series of new internal capacities, and sufficient volume to yield statistically reliable results.

Many of the current VBP models anticipate savings or value based on volume. One advantage of smaller practices is that they do not have high volumes of members covered by a given health plan; however, this limits the ability of health plans to generate statistically valid measures that determine eligibility for participation in VBP programs. In addition, payers look for formal recognition to qualify a practice as a medical home. The NCQA PCMH recognition requires a significant time investment, including the effort of documenting processes and collecting reports, to demonstrate the required capabilities. These time-intensive activities may be prohibitive for small practices with limited time and resources to conduct activities in addition to providing medical care.

Barriers—volume of patients and time constraints—represent particular challenges for small practices participating in alternative payment methods. Most payment methods will likely require both medical home recognition and use of outcomes-based measurement.

There are several proposed solutions to reduce barriers for VBP participations by small practices. One model promoted by health policy researchers involves smaller practices joining hospital systems or medical groups in order to access the capital and infrastructure required to obtain medical home capacities. This is the approach being pursued by a number of small practices statewide. However, for many physicians that own their small practices, maintaining independence has a high value; employment by a hospital or group is not a desirable option. Another approach would be for small practices to self-organize into a shared-service organization that enables them to participate in new care delivery and payment models.

Small practices are an important, valued part of New York City’s primary care community and many provide care in New York’s most ethnically and linguistically diverse neighborhoods. Small practices face significant challenges in obtaining recognition for and sustaining the medical home model. One option for bolstering their ability to become medical homes is working with small practice providers to design and test a shared-service organization that enables them to participate in new care delivery and payment models.

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19 Over the past few years, value-based payment (VBP) has emerged as a central element in federal and state strategies for health reform. Citing the need to move away from traditional fee-for-service (FFS) payment, health plans (including Medicare, Medicaid and commercial payers) and policy makers are enthusiastically embracing new value-based approaches to paying for health care services.

In VBP, payments are tied to outcomes by way of performance measures, a significant change from the traditional FFS model, in which services are reimbursed for being completed, regardless of the result. VBP seeks to increase quality and decrease excess utilization and cost. VBP includes a variety of payment system innovations—ranging from pay-for-performance to shared savings and shared risk arrangements—that change the way providers are paid for services they deliver, giving them incentives to deliver care in ways that increase quality and reduce unnecessary utilization and cost, actions that are not rewarded under FFS.

“pods,” pooling resources to build and deliver key services to their participating practices. A third approach would be for a trusted entity to build a shared service capacity (e.g., care management and data analytics) that they could offer to interested practices, perhaps including the ability to pool outcome data, to enable those practices to participate in VBP.

The APC Workgroup discussed the pros and cons of these models of sharing resources or workforce across small practices as options to achieve the scale and capacity to operate as medical homes and participate in VBP. A summary of those considerations is included as Appendix E. The common theme among all of these models is that those services to be shared are organized as a specific module, and offered as shared services to small practices by an existing, trusted and capable organization.

In several listening sessions, small practice providers have voiced skepticism that anticipated payment changes will allow them to thrive or generate margins in the new way of delivering comprehensive primary care. The success of shared resources or workforce depends on a clear pathway to enhanced revenues; small practices must be able to generate sufficient revenue under the new payment models to invest in a pod. Payers and regulators of health care services will need to provide clear payment schedules and timing of payments for practice owners to plan and predict whether making changes and investments will have payoffs, not only in the short term, but for sustaining processes and activities after transformation as well.

**Recommendations**

- **Professional associations and other entities interested in the long-term sustainability of small practices should establish classes and tools to help independent providers better understand the business case for pursuing medical home recognition, including through shared services models.**

  In advance of pursuing shared services, primary care providers need information to assess whether transformation and participation in a pod will meet their needs. As part of this training, various calculator tools, similar to online mortgage calculators, could be used to assist primary care providers in assessing the necessary investments, monetarily, to transform.\(^{21}\) Such tools can assist practices in determining whether participation with a specific health plan, hospital, or other offerings can assist in their transformation and ultimately provide enough funds to afford the additional staffing and resources needed to maintain high-performing primary care.

- **Medical societies, PPSs and educational institutions that work closely with small practice providers should develop a unified and targeted communication plan to practices identify resources and access important information to enhance their primary care performance.**

  This includes connecting small practices to Health Homes, sharing information about opportunities to join New York’s practice transformation programs (SIM, TCPI, DSRIP), and

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\(^{21}\) An example of one such tool is the Primary Care Development Corporation’s “PCMH Sustainability Toolkit”: http://www.pcdc.org/performance-improvement/special-content/pcmh-sustainability-toolkit-1.html
forging collaborations with graduate programs and capstone courses that can provide small practices with new training and connections to potential short and/or long-term assistance.

- **The NYC PHIP should convene listening sessions to gather input from primary care providers on the desired structure and included services that would constitute a shared-services model.**

  Primary care providers are the key constituents for shared services models. Integrating their feedback into the design and implementation of the model can ensure its applicability and success in New York City. Listening sessions would include designated voting sections for provider attendees and results would be shared to encourage the consultative approach to model design.

- **PPSs and other trusted entities should convene providers and payers to jointly initiate a planning process to assess the feasibility of implementing a shared services model for small practices in New York City.**

  Given the importance of small primary care practices in the city, and the appeal of the pod model to primary care providers, payers and policymakers, New York City PPSs could initiate a planning process to assess the feasibility of the shared services model in the city. If indicated, New York City should consider supporting some pilot or demonstration programs—involving primary care providers and the payers whose members they serve—to test the broader applicability and effectiveness of this model. Once the model has been appropriately piloted and proven effective, NYSDOH and private foundations can support the design and initial capitalization of primary care shared service arrangements statewide.

3. **Support the integration of behavioral health care as part of the medical home.**

Depression, anxiety, and substance use disorders are common in primary care settings, occurring in approximately 20% to 25% of all patients seen in a primary care practice. Rates of behavioral health conditions are even higher among patients with chronic disease. Approximately one in ten women experience depression after giving birth, with profound consequences for their health and the health of their newborns. While research shows that most patients have expressed preference for treatment by their primary care doctor, behavioral health disorders go unrecognized as much as half of the time (even more often among African-American patients), and when identified in primary care are typically treated ineffectively.

Untreated depression affects a person’s quality of life and his or her ability to function. When it occurs in patients who have chronic physical illnesses, it also compromises their ability to participate effectively in the management of their physical illnesses. Such patients have significantly worse physical health and higher rates of emergency department and hospital inpatient utilization than patients with only chronic physical diseases. For these reasons, there has been an increased emphasis on integrating behavioral health services into primary care to better serve patients with low to moderate mental health needs and on integrating primary care services into behavioral health settings for patients with severe mental illness.
Each of the medical home models, to varying degrees, acknowledges the importance of equipping primary care practices to better respond to common behavioral health conditions. At a minimum (such as under the PCMH 2014 standards), this includes an expectation that the primary care provider screens for behavioral health conditions then coordinates and follows up on the referral for the patient to a trusted behavioral health provider. Under more robust standards, such as the highest level in draft APC standards, primary care practices are expected to fully integrate behavioral health—that is, in addition to care coordination, they will provide services to treat some behavioral health conditions. Both primary care and behavioral health providers share the responsibility of providing adequate services to patients who need them. Primary care providers, at a minimum, need to screen and refer for behavioral health disorders; for their part, behavioral health specialists need to ensure adequate capacity to accept those referrals.

In settings where integration has been achieved, the identification and management of behavioral health conditions has been key to ensuring that the medical home is optimally successful at improving patients’ overall health, reducing unnecessary health care utilization, improving outcomes, and controlling chronic disease. An evidence-based model of integration, collaborative care, has been shown to be effective in the management of depression in the primary care setting. A core element is employing an on-site care manager and mental health consultant who, together, function as members of the primary care team. This enables primary care providers to provide more effective patient engagement, more frequent patient follow-up, better tracking and monitoring of outcomes, and more timely referrals to mental health specialists when necessary. For substance abuse, the emerging expectation is that primary care providers screen for substance use, using an intervention known as SBIRT (Screening for results, Brief Intervention for alcohol/substance use, and Referral to specialty care for Treatment), when appropriate. In addition, primary care providers should have the capacity to prescribe pharmacotherapy, relapse prevention assistance, and harm reduction services.

The integration of behavioral health into primary care is a new and complex component of the medical home model with which few primary care practices or transformation assistance providers in New York City have experience. Some primary care practices have the organizational capacity to implement the Collaborative Care and SBIRT models but may not have the necessary training and support required to implement them.

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22 Components of the collaborative care model include consistent use of a validated depression screening tool; systematic patient follow-up, using a patient registry; use of evidence-based guidelines and a stepped-care treatment approach (i.e., changes in treatment for patients who do not show improvement in specified periods of time); patient self-management and relapse prevention; an on-site care manager to educate, coordinate, and troubleshoot services for patients with depression; and weekly psychiatric consultation and caseload review, when depression scores are not improved.
Other practices may not be large enough to maintain full-time, on-site staff to adopt and implement the Collaborative Care model as currently described in the literature. As New York City has a high proportion of smaller primary care practices, alternative models will need to be developed with an evidence-based strategy that will allow for varying physical office space, panel sizes, and patient populations.

In January 2015, New York City announced an unprecedented commitment to improve mental health: *Thrive NYC: A Mental Health Road Map for All*, which organizes 54 initiatives around six guiding principles. Under the fourth guiding principle, “Partner with Communities: Embrace the wisdom and strengths of local communities by collaborating with them to create effective and culturally competent solutions,” *Thrive NYC* proposes one of its largest investments: funding for 400,000 additional hours of service by behavioral health experts in communities where improved behavioral health services are needed most, in primary care settings where most New Yorkers receive their regular medical care. Known as the NYC Mental Health Service Corps, this new workforce will be composed of approximately 400 physicians and recently graduated master’s and doctoral-level clinicians who will work in substance use programs, mental health clinics, and primary care practices in high-need communities throughout the city. The NYC DOHMH will also lead efforts to train primary care providers to increase their skills in managing the care of patients with substance use.

If we are to maximize the city’s investments in improving the infrastructure and resources for mental health, it is essential that we strengthen connections between primary care and behavioral health and, where possible, integrate behavioral health into primary care. Technical resources will be needed to assist providers and their practices in navigating the complex steps toward integration and, eventually, new payment models will be needed to sustain that expansion of services.

**Recommendations**

- **At a minimum, medical associations, Performing Provider Systems, delivery system leaders, and leaders in behavioral health integration should educate providers on the models available for integrating behavioral health services with primary care and provide information to primary care providers on the basic principles and alternative approaches to doing so.**

  This work should have two features. First, primary care providers need information about the two broad options available to them: building on-site capacity to directly manage a subset of behavioral health conditions, or strengthening co-management relationships with community-based behavioral health specialists. Second, primary care providers need training and education to improve their capacity to identify and better manage patients with behavioral health conditions. Web-based guides and online learning sessions on evidence-based approaches to integrating behavioral health into primary care could be particularly useful.

- **Leaders in behavioral health integration, practice transformation providers, and policymakers should work together to support practices in developing effective integration models, including, if possible, the Collaborative Care model.**
Those with experience teaching behavioral health integration to others can expand their efforts by working with private foundations or professional societies to organize and host “train the trainer” seminars or retreats to develop behavioral health technical assistance capacity within Performing Provider Systems and other large health systems. Efforts are also needed to ensure that practice transformation technical assistance providers are adequately equipped to provide the practices with whom they are already engaging with effective behavioral health integration training. That training for practice transformation technical assistance providers should be provided by leaders in behavioral health integration. Finally, New York State policymakers can ensure that the design of future primary care payment models includes support for the initiation and ongoing support of these expanded behavioral health services (e.g., the hiring of a social worker or care coordinator specializing in behavioral health) in the primary care setting.

- Performing Provider Systems, health plans, and policymakers should work together to support primary care practices in enhancing the effectiveness of their existing methods of care coordination (e.g., screen, refer, and follow-up) for patients they refer for behavioral health and other community-based support services.

The first step in this process is to leverage existing structures (such as health plans or PPSs) to obtain data on the availability and quality of community-based behavioral health providers. This information, once gathered, can either be used to improve existing referral sources for behavioral health services or be collected into a centralized referral system for primary care providers. An example of a referral source that could be augmented with data on the availability and quality of behavioral health providers includes NYC Support, a new program outlined in Thrive NYC. As part of the second Thrive NYC principle—“Close Treatment Gaps: Provide New Yorkers in every neighborhood with access to proven programs when and where they need them, including those at greatest risk”—the city will launch NYC Support, which will serve as a point of entry to the City’s behavioral health services. New Yorkers will be able to access NYC Support via phone, text messaging, or the web. In addition to robust crisis counseling, NYC Support will provide referrals, help New Yorkers schedule appointments with mental health providers, and follow up with New Yorkers until they find the appropriate care.23

4. Build on and better coordinate the various medical home initiatives underway across New York State.

New York State has actively supported the adoption of the medical home model for the past five years. Between Medicaid’s additional payment to PCMH adopters and the ingenuity of several multipayer medical home demonstrations, New York State has led the nation in the number of providers working in sites that have achieved NCQA recognition as PCMHs.

Currently, the three major medical home initiatives poised to be implemented in New York State offer an unprecedented pool of investment capital for transforming primary care practices across the state. They have the potential to bring practices to a new level of

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23 https://thrivenyc.cityofnewyork.us/
In parallel, major efforts to promote value-based payment in health care offer the promise that changes are possible in the way primary care providers are paid for what they do: managing and improving the care of the patients they serve. This confluence of resources focused on primary care and payment changes represents an enormous opportunity to transform the way the state’s primary care system performs—but aligning these initiatives will be a challenge.

The three transformation programs are intended to serve the state’s primary care providers and practices. They will likely employ a common set of practice transformation technical assistance providers. However, although they are all CMS-funded programs, each proposes a slightly different model; each has its own definition of “eligible providers” (see Figure 8); each has its own mechanisms for delivering and paying for practice transformation; and each has its own accounting processes and reporting timelines.

**Figure 8. New York State Practice Transformation Initiatives Underway**

<table>
<thead>
<tr>
<th>Program Focus</th>
<th>TCPI—Practice Transformation Network Program (PTN)</th>
<th>SIM–APC</th>
<th>DSRIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYSPTN</td>
<td>Primary Care and Certain Specialty Practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NYU PTN</td>
<td>Primary Care and Certain Specialty Practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Council for Behavioral Health</td>
<td>Behavioral Health Providers Serving the Seriously Mentally Ill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIM / APC</td>
<td>Excluded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSRIP—PPS</td>
<td>Eligible *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Geographic Focus**

<table>
<thead>
<tr>
<th>Program</th>
<th>NYSPTN</th>
<th>NYU PTN</th>
<th>SIM / APC</th>
<th>DSRIP</th>
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<tbody>
<tr>
<td>NYSPTN</td>
<td>Statewide</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NYU PTN</td>
<td>Brooklyn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIM / APC</td>
<td>Excluded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSRIP</td>
<td>Excluded</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall Exclusions**

Practices served by or currently enrolled in other CMMI-funded practice transformation programs:

- Medicare Shared Savings Program, Pioneer ACO: Excluded
- Multipayer Advanced Primary Care Program (MAP-CP): Excluded
- Comprehensive Primary Care Initiative (CPC): Excluded
- FLHSA CMMI HClA project: Excluded

**TCPI Cross-Program Interaction**

<table>
<thead>
<tr>
<th>Program</th>
<th>TCPI—Practice Transformation Network Program (PTN)</th>
<th>SIM–APC</th>
<th>DSRIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYSPTN</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NYU PTN</td>
<td>Excluded</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>National Council for Behavioral Health</td>
<td>Excluded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIM / APC</td>
<td>Excluded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSRIP—PPS</td>
<td>Eligible *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Primary care practices in PPSs may be eligible for practice transformation support from NYSPTN, with priority given to PPSs that invest in related capacities in those practices.
The simultaneous implementation of these three different programs raises the potential for substantial confusion among primary care providers and providers of practice transformation consultation, which itself could undermine any momentum toward practices engaging in these programs.

The challenge New York faces is to align and integrate these three models as much as possible. This is needed in order to maximize their effectiveness and increase their individual and collective impact; to reduce potential confusion about the programs among the affected providers and practice transformation agents; and to clearly communicate these programs and their intent to providers, payers, policymakers and to the people who will be served by those enhanced practices.

It is essential that these efforts work together seamlessly, using the available public funds most effectively to achieve the greatest result.

**Recommendations**

- **The NYC PHIP should work closely with the leaders of medical home initiatives to improve their alignment in program design, mechanics and communications.**

  Ideally, leaders of the three programs will determine how these programs can best fit together and align them so that the PCMH, TCPI, and APC models are all elements of a single articulated program. This will require, where feasible, using common approaches across DSRIP, TCPI, and APC:

  - Messaging and communication to providers
  - Creating and using a common practice assessment tool
  - Selecting and contracting with vendors
  - Agreeing on a core measure set across programs
  - Establishing milestones and measuring progress
  - Auditing vendor reported outcomes

- **NYC DOHMH, as part of existing structures, should convene and provide local leadership to the medical home initiatives with a focus on improving the integration of these efforts within New York City.**

  NYC DOHMH should continue its leadership role in convening and working with practice transformation providers participating in the three practice transformation initiatives in the city, to help coordinate their efforts, and track progress toward the city’s goal for increasing adoption of medical home model by primary care providers across the city as part of their involvement in the TCPI initiative.

- **NYC DOHMH, as part of existing activities and programs, should continue to engage major provider associations, academic detailing programs, and**
transformation assistance providers to reduce the potential for confusion among providers about the options available to them.

At a minimum, clear and consistent communication to primary care practices about the eligibility requirements for each program is needed. Primary care providers need a clear and unified set of messages about what these programs are and what providers they are best suited for. If appropriately resourced and staffed, NYC DOHMH could serve as a local TCPI-SIM-DSRIP information clearinghouse, available to practices and providers who are interested in receiving practice transformation support, but are unclear as to which program would best meet their needs. Such a function could help reduce provider confusion, and increase the participation of primary care practices in these programs.

- NYC DOHMH, through medical home transformation assistance programs, should work with NYSDOH to establish and maintain a single, unified, statewide database of all practices as they enter and graduate from the three initiatives (TCPI, APC, and PCMH) to track progress in practice transformation across the city.

Through its current leadership role as part of TCPI, the NYC DOHMH has made significant strides in developing a database for tracking citywide transformation efforts. With the appropriate resources, this database could be extended to track practices across all three initiatives.

5. Achieve multipayer support to sustain the medical home model.

Multipayer support is critical to sustaining the medical home model. Payers and providers both desire a high-performing primary care system that is accessible, meets the needs of patients, and continuously strives for better outcomes. Currently, however, many primary care providers and payers are at an impasse—unable to embark on widespread transformation activities and investments until there is collective multipayer agreement to support the new care model.

Primary care providers, particularly providers working in small practices, find it difficult to make the transformative changes needed to achieve higher performance without the financial and technical resources to help them through that transition. The three major initiatives underway in New York State address some of that need. However, once the practices have transformed, they will have higher ongoing operating costs from providing more sophisticated care. These costs need to be covered through changes in payment systems that recognize and compensate practices adequately.

Payers, on the other hand, are wary of making additional investments in primary care practices unless they can be assured that those investments will translate into genuine transformation of Enhanced payment for primary care is essential for achieving higher-performing primary care. Over the next year, the focus in New York City should be on working with purchasers and payers to ensure adequate and consistent payment for the medical home model.
care, better care and, ultimately, lower overall costs for the population they cover. Some payers feel their use of value-based payment arrangements, like accountable care contracts, indicates they have moved beyond paying for medical home models because they can now pay directly for better performance. This position does not acknowledge, however, that in order to achieve better performance, many primary care practices will require upfront investment in new infrastructure and skills—or that they often need support for two or three years before generating cost savings. In comparison, value-based payment arrangements like shared-savings and shared-risk typically pay out at the end of a 12-month budget cycle once cost savings and quality benchmarks have been achieved.

Finally, both payers and providers require scale to benefit from engaging in these transformation activities. Payers need enough of their primary care providers operating as medical homes for them to receive measurable improvement in the quality and costs of care. Conversely, providers need enough of their payers to pay more for higher-performing care; they need clear signals or incentives from payers. Multipayer alignment is especially important in New York City, where it is common for providers to accept payment from seven to ten different plans. In such an environment, no payer dominates enough to establish its own clear incentives for providers. A multipayer commitment to paying for medical homes is necessary to send a clear signal to providers.

In the near future, much of the work to increase payer support for the medical home will likely focus on New York’s commercial plans. New York’s Medicaid program already consistently pays a higher rate for the NCQA- medical home model (which, as discussed previously, has yielded significant uptake among providers serving Medicaid enrollees) and is expected to maintain that commitment going forward. Medicare is another important payer in New York. Decisions regarding how Medicare pays for medical home, however, are made at the federal level. Some also argue that through Medicare’s new care management fee it has made an initial step toward supporting the medical home.

Negotiating with commercial plans on their approach to paying for medical homes will largely be led by the New York State Department of Health and Department of Financial Services. These discussions are important and deserve full support. At the same time, because enhanced payment rates are so critical for sustaining medical homes, New York City may wish to explore levers for encouraging payment reform.

**Recommendations**

- **The New York State Department of Health and Department of Financial Services should initiate regional discussions on Advanced Primary Care with the health plans that collectively cover the majority of New York City commercial and Medicare Advantage insured lives.**

The payment approach being developed as part of Advanced Primary Care relies on a regional approach, in which a majority of payers in a region collectively agree to change how they pay for primary care. New York City is considered one region. Achieving agreement across such a large and complex region will be challenging, but will be most realistically achieved if
negotiations are focused on health plans that have the largest commercial and Medicare Advantage market share in the city. Figure 9 displays one estimate of the health plans that collectively cover 90% of commercial and Medicare Advantage insured lives.

**Figure 9. New York City Health Plans Ranked by Estimated Commercial and Medicare Advantage Market Share**

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Commercial + Medicare Advantage Market Share in New York City</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 EmblemHealth</td>
<td>36.8%</td>
</tr>
<tr>
<td>2 UnitedHealth Group</td>
<td>18.7%</td>
</tr>
<tr>
<td>3 Anthem</td>
<td>16.7%</td>
</tr>
<tr>
<td>4 Aetna</td>
<td>9.0%</td>
</tr>
<tr>
<td>5 Healthfirst (NY)</td>
<td>5.2%</td>
</tr>
<tr>
<td>6 Cigna</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Note: Market share estimates were obtained by NYC DOHMH’s Bureau of Primary Care Access and Planning on 12/9/15 from Decision Resources Group.

- Primary care providers and health plans with appreciable numbers of Medicaid beneficiaries should encourage New York’s Office of Health Insurance Programs to continue medical home payments through New York’s Medicaid program.

  While Medicaid is expected to continue paying a higher rate for medical homes, stakeholders should make efforts to ensure that it does so as Medicaid evolves toward value-based payment.

- The NYC PHIP should work with a broad group of payers and purchasers (e.g., self-insured groups, large purchasers, or a membership organization like Northeast Business Group on Health) in conversations about the value of the medical home and how they can work together to support the medical home model that includes payment for behavioral health integration.

  Several large purchasers, such as union health plans, may want to consider how they can work with private payers to both incentivize and reward providers for medical home adoption, and alter their benefit design and communications to encourage consumers to make better use of the strengthened primary care system that is emerging in the city.

- Trusted independent entities should convene providers and payers to develop standardized outcome reports for New York City primary care practices that are linked to value-based payment.

  Such an approach would make the process of reviewing outcome reports more efficient for the end-user, increasing the likelihood that providers can interpret payer reports and understand where they need to improve care.
How Will We Know If We Are Making Progress?

Knowing whether the city is making progress toward widespread achievement of advanced primary care requires the ability to identify providers and practice sites, determine when they have engaged with or completed transformation efforts, and measure aggregate change in advanced primary care adoption over time. For this reason, in collaboration with the Center for Health Workforce Studies as part of the forthcoming statewide Practice Transformation Reporting System, the NYC DOHMH will regularly publish (on a quarterly or semi-annual basis) scorecards on the status of medical home adoption across New York City’s communities as part of its leadership role related to TCPI. Each scorecard will contain a clear “gap to goal” measure on how much more work needs to be done to reach the goal of 80% of providers in each Zone and as a city total.

The tracking system has some obvious benefits. It may help the organizers of the medical home initiatives and providers of transformation assistance avoid duplication of effort, which would be both inefficient and, in some cases, in violation of federal grant regulations. More important, the tracking system will provide all parties invested in achieving widespread adoption and implementation of the medical home model with a comprehensive view of the progress that is being made in New York City.

The true mark of progress, of course, is whether the health of New York City residents has improved and health inequities have been reduced. In addition to tracking progress on practice transformation efforts, the NYC PHIP will closely examine progress on TCNY 2020’s overall lead health indicators and access to health care quality indicators. We expect that, in combination with community-based initiatives, a strengthened primary care system will meaningfully contribute to better health outcomes for New Yorkers.

Closing Thoughts

A high-performing primary care system is foundational to achieving health reform and improving the health of residents in New York City. This is an extraordinary moment to strengthen New York City’s primary care system. Never before has there been as clear of an opportunity to reform the health care system to make it more responsive to the health needs of our communities, to bridge public health and clinical efforts, and to ensure that all New Yorkers have access to accessible, high-quality primary care. While a primary care-focused strategy on its own cannot resolve the health inequities that too many of our city’s communities face, it is an essential tool in improving population health. All New Yorkers who believe in a stronger primary care system can and should use this document as a road map for making high-performing primary care a commonplace feature across New York City.

Additional funding and support may be needed to sustain NYC DOHMH’s tracking effort beyond the duration of TCPI if its continuity represents a significant burden to internal resources.
Appendix A: New York City Advance Primary Care Planning Group Membership

Melinda Abrams  
Vice President, Delivery System Reform  
The Commonwealth Fund

Joe Baker  
President  
Medicare Rights Center

Susan Beane  
Vice President and Medical Director  
HealthFirst

Neil Calman  
President and Chief Executive Officer  
Institute for Family Health

Lawrence Casalino  
Professor of Healthcare Policy and Research  
Weill Cornell Medical College

Dave Chokshi  
Assistant Vice President  
Office of Ambulatory Care Transformation  
Health and Hospitals Corporation

Henry Chung  
Chief Medical Officer  
Montefiore Care Management Company

Kathy Ciccone  
Executive Director, Quality Institute  
HANYS Benefit Services

Louise Cohen  
Chief Executive Officer  
Primary Care Development Corporation

Tara Cortes  
Executive Director  
Hartford Institute of Geriatric Nursing at NYU

Vito Grasso  
Executive Vice President  
NYS Academy of Family Physicians

Valerie Grey  
Executive Vice President  
The Healthcare Association of New York State

Mark Hannay  
Director  
Metro New York Health Care for All Campaign

Robert Hayes  
President and Chief Executive Officer  
Community Healthcare Network

Tim Johnson  
Senior Vice President  
Greater New York Hospital Association

Steven Kaplan  
Associate Chief Medical Officer  
Ambulatory Care and Patient Experience  
NewYork-Presbyterian Hospital

Munish Khaneja  
Vice President, Medical Management  
Emblem Health

Hillary Kunins  
Assistant Commissioner  
Bureau of Alcohol, Drug Prevention & Treatment  
NYC Department of Health and Mental Hygiene

Linda Lambert  
Executive Director  
New York Chapter, American College of Physicians

Robert La Penna  
Network Director for Payment Innovation Programs  
Empire Blue Cross Blue Shield

Alan Mitchell  
Director, Center for Primary Care Transformation  
Primary Care Development Corporation

Robert Morrow  
Associate Clinical Professor- Department of Family & Social Medicine/Associate Director of Interventional CME—Center for CME  
Albert Einstein College of Medicine

Carla Nelson  
Senior Director  
Ambulatory Care & Population Health  
Greater New York Hospital Association

Karen Nelson  
Senior Vice President, Integrated Delivery Systems  
Maimonides Medical Center

Laurel Pickering  
President and Chief Executive Officer  
Northeast Business Group on Health

Arnold Saperstein  
President and Chief Executive Officer  
MetroPlus Health Plan

Alan Shapiro  
Senior Medical Director  
The Children’s Hospital at Montefiore

Alan Silver  
Medical Director  
IPRO

William Streck  
Chief Medical & Health Systems Innovation Officer  
Healthcare Association of New York State

Elizabeth Swain  
President and Chief Executive Officer  
Community Health Care Association of New York State

Salvatore Volpe  
Physician  
Staten Island Performing Provider System
Appendix B: Community Perspectives: Focus Group Report

Community Perspectives on Advanced Primary Care was published by the New York Academy of Medicine in April 2016. It is included as a separate pdf. Citation follows.

## Appendix C: List of Community Districts by Health Zone

<table>
<thead>
<tr>
<th>Zone A Neighborhoods (Highest Burden)</th>
<th>Zone B Neighborhoods (Medium Burden)</th>
<th>Zone C Neighborhoods (Lowest Burden)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manhattan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD 110: Central Harlem</td>
<td>CD 103: Chinatown, East Village, Lower East Side, NoHo, Two Bridges</td>
<td>CD 101: Battery Park City, Civic Center, Ellis Island, Governors Island, Liberty Island, South Street Seaport, Tribeca, Wall Street, World Trade Center</td>
</tr>
<tr>
<td>CD 111: East Harlem, Harlem</td>
<td>CD 104: Chelsea, Clinton, Hudson Yards</td>
<td>CD 102: Greenwich Village, Hudson Square, Little Italy, NoHo, SoHo, South Village, West Village</td>
</tr>
<tr>
<td></td>
<td>CD 109: Hamilton Heights, Manhattanville, Morningside Heights, West Harlem</td>
<td>CD 105: Flatiron, Gramercy Park, Herald Square, Midtown, Midtown South, Murray Hill, Times Square, Union Square</td>
</tr>
<tr>
<td></td>
<td>CD 112: Inwood, Washington Heights</td>
<td>CD 106: Beekman Place, Gramercy Park, Murray Hill, Peter Cooper Village, Stuyvesant Town, Sutton Place, Tudor City, Turtle Bay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD 107: Lincoln Square, Manhattan Valley, Upper West Side</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD 108: Carnegie Hill, Lenox Hill, Roosevelt Island, Upper East Side, Yorkville</td>
</tr>
<tr>
<td><strong>Bronx</strong></td>
<td>CD 201: Melrose, Mott Haven, Port Morris</td>
<td></td>
</tr>
<tr>
<td>CD 202: Hunts Point, Longwood</td>
<td>CD 204: Concourse, Concourse Village, East Concourse, Highbridge, Mount Eden, West Concourse</td>
<td>CD 208: Fieldston, Kingsbridge, Marble Hill, North Riverdale, Riverdale, Spuyten Duyvil</td>
</tr>
<tr>
<td>CD 203: Claremont, Crotona Park East, Melrose, Morrisania</td>
<td>CD 205: Fordham, Morris Heights, Mount Hope, University Heights</td>
<td>CD 210: City Island, Co-op City, Country Club, Edgewater Park, Pelham Bay, Schuylerville, Throgs Neck, Westchester Square</td>
</tr>
<tr>
<td>CD 207: Bedford Park, Fordham, Kingsbridge Heights, Norwood, University Heights</td>
<td>CD 206: Bathgate, Belmont, Bronx Park South, East Tremont, West Farms</td>
<td>—</td>
</tr>
<tr>
<td>CD 209: Bronx River, Castle Hill, Clason Point, Harding Park, Parkchester, Unionport, Soundview, Soundview-Bruckner</td>
<td>CD 207: Bedford Park, Fordham, Kingsbridge Heights, Norwood, University Heights</td>
<td></td>
</tr>
<tr>
<td>CD 211: Allerton, Bronxdale, Indian Village, Morris Park, Pelham Gardens, Pelham Parkway, Van Nest</td>
<td>CD 208: Fieldston, Kingsbridge, Marble Hill, North Riverdale, Riverdale, Spuyten Duyvil</td>
<td></td>
</tr>
<tr>
<td><strong>Brooklyn</strong></td>
<td>CD 303: Bedford-Stuyvesant, Stuyvesant Heights, Tompkins Park North</td>
<td></td>
</tr>
<tr>
<td>CD 309: Crown Heights South, Prospect Lefferts Gardens, Wingate</td>
<td>CD 311: Bath Beach, Bensonhurst, Gravesend, Mapleton</td>
<td>CD 311: Bath Beach, Bensonhurst, Gravesend, Mapleton</td>
</tr>
<tr>
<td>CD 312: Bergen Beach, Canarsie, Flatlands, Georgetown, Marine Park, Mill Basin, Mill Island, Paerdegat Basin</td>
<td>CD 313: Brighton Beach, Coney Island, Gravesend, Homecrest, Sea Gate, West Brighton</td>
<td>CD 312: Borough Park, Kensington, Ocean Parkway</td>
</tr>
<tr>
<td>CD 314: Ditmas Park, Flatbush, Manhattan Terrace, Midwood, Ocean Parkway, Prospect Park South</td>
<td>CD 315: Gerritsen Beach, Gravesend, Homecrest, Kings Highway, Manhattan Beach, Plumb Beach, Sheepshead Bay</td>
<td>CD 315: Gerritsen Beach, Gravesend, Homecrest, Kings Highway, Manhattan Beach, Plumb Beach, Sheepshead Bay</td>
</tr>
</tbody>
</table>
### List of Community Districts by Health Zone (continued)

<table>
<thead>
<tr>
<th>Zone A Neighborhoods (Highest Burden)</th>
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<th>Zone C Neighborhoods (Lowest Burden)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Queens</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD 412: Hollis, Jamaica, Jamaica Center, North Springfield Gardens, Rochdale, South Jamaica, St. Albans</td>
<td>CD 404: Corona, Corona Heights, Elmhurst, LeFrak City</td>
<td>CD 401: Astoria, Astoria Heights, Queensbridge, Dutch Kills, Long Island City, Ravenswood, Rikers Island (BX), Steinway</td>
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<tr>
<td></td>
<td>CD 413: Bellaire, Bellerose, Brookville, Cambria Heights, Floral Park, Glen Oaks, Laurelton, New Hyde Park, Queens Village, Rosedale, Springfield Gardens</td>
<td>CD 403: East Elmhurst, Jackson Heights, North Corona</td>
</tr>
<tr>
<td><strong>Staten Island</strong></td>
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</table>

A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City 34
Appendix D: Health Indicators Used to Identify Health Zones by Community District

<table>
<thead>
<tr>
<th>CD</th>
<th>Neighborhoods</th>
<th>Avoidable Hospitalizations per 100,000</th>
<th>Percentage of Population</th>
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<tr>
<td>206</td>
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<tr>
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<tr>
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<td>CD</td>
<td>Neighborhoods</td>
<td>Avoidable Hospitalizations per 100,000</td>
<td>Percentage of Population</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>Asthma</td>
<td>Diabetes</td>
</tr>
<tr>
<td>313</td>
<td>Brighton Beach, Coney Island, Gravesend, Homecrest, Sea Gate, West Brighton</td>
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<tr>
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<td>Arlington, Castleton Corners, Clifton, Elm Park, Fox Hills, Graniteville, Grymes Hill, Howland Hook, Livingston, Mariners Harbor, New Brighton, Old Place, Park Hill, Port Ivory, Port Richmond, Randall Manor, Rosebank, Shore Acres, Silver Lake, St. George, Stapleton, Sunnyside, Tompkinsville, Ward Hill, West Brighton, West New Brighton, Westerleigh, Willowbrook</td>
<td>314.7</td>
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</tbody>
</table>

**Zone B**

<p>| | | | | | | | | | | | | | | | |
|    |                                                                 |                        |                                     |                           |                           |                           |                           |                           |                           |                           |                           |                           |                           |                           |                           |
|----|----------------------------------------------------------------|-------------------------|-------------------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| 103| Chinatown, East Village, Lower East Side, NoHo, Two Bridges     | 265.2                   | 274.9                               | 85.3                      | 13.6                      | 11.8                      | 25.0                      | 12.0                      | 36.0                      | 30.0                      | 32.0                      | 28.0                      | 27.0                      | 723.0                     |
| 104| Chelsea, Clinton, Hudson Yards                                | 160.9                   | 155.9                               | 64.9                      | 14.2                      | 3.7                       | 18.7                      | 10.4                      | 26.0                      | 9.0                       | 24.0                      | 13.0                      | 5.0                       | 989.0                     |
| 109| Hamilton Heights, Manhattanville, Morrisania Heights, West Harlem | 258.2                   | 329.3                               | 110.7                     | 12.9                      | 8.5                       | 29.5                      | 25.4                      | 34.0                      | 21.0                      | 69.0                      | 28.0                      | 21.0                      | 788.0                     |
| 112| Inwood, Washington Heights                                    | 217.9                   | 334.4                               | 136.4                     | 10.6                      | 9.6                       | 28.0                      | 22.1                      | 48.0                      | 39.0                      | 78.0                      | 27.0                      | 30.0                      | 497.0                     |
| 208| Fieldston, Kingsbridge, Marble Hill, North Riverdale, Riverdale, Spuyten Duyvil | 192.3                   | 248.4                               | 93.9                      | 15.6                      | 6.1                       | 28.7                      | 19.7                      | 32.0                      | 22.0                      | 55.0                      | 17.0                      | 19.0                      | 546.0                     |
| 210| City Island, Co-op City, Country Club, Edgewater Park, Pelham Bay, Schuylerville, Throgs Neck, Westchester Square | 235.1                   | 271.7                               | 90.0                      | 12.4                      | 13.0                      | 29.9                      | 34.3                      | 20.0                      | 11.0                      | 60.0                      | 12.0                      | 17.0                      | 394.0                     |</p>
<table>
<thead>
<tr>
<th>CD</th>
<th>Neighborhoods</th>
<th>Avoidable Hospitalizations per 100,000</th>
<th>Percentage of Population</th>
<th>Rate of Psychiatric Hospitalizations per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>Asthma</td>
<td>Diabetes</td>
<td>Hypertension</td>
</tr>
<tr>
<td>301</td>
<td>East Williamsburg, Greenpoint, Northside, Southside, Williamsburg</td>
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<td>276.4</td>
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<td>302</td>
<td>Boerum Hill, Brooklyn Heights, Clinton Hill, Downtown Brooklyn, DUMBO, Fort Greene, Fulton Ferry, Navy Yard, Vinegar Hill</td>
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<td>381.4</td>
<td>109.3</td>
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<tr>
<td>307</td>
<td>Sunset Park, Windsor Terrace</td>
<td>280.8</td>
<td>307.9</td>
<td>92.9</td>
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<td>173.4</td>
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<td>103.8</td>
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<tr>
<td>318</td>
<td>Bergen Beach, Canarsie, Flatsands, Georgetown, Marine Park, Mill Basin, Mill Island, Paerdegat Basin</td>
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<td>351.8</td>
<td>107.9</td>
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<tr>
<td>404</td>
<td>Corona, Corona Heights, Elmhurst, LeFrak City</td>
<td>114.2</td>
<td>197.6</td>
<td>89.2</td>
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<td>410</td>
<td>Howard Beach, Lindenwood, Old Howard Beach, Ozone Park, South Ozone Park</td>
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<td>120.5</td>
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<tr>
<td>502</td>
<td>Arrochar, Bloomfield, Bulls Head, Chelsea, Concord, Dongan Hills, Egbertville, Emerson Hill, Grant City, Grasmere, Heartland Village, Lighthouse Hill, Manor Heights, Midland Beach, New Dorp, New Dorp Beach, New Springville, Old Town, South Beach, Todt Hill, Travis, Willowbrook</td>
<td>146.2</td>
<td>186.9</td>
<td>101.6</td>
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</tbody>
</table>

**Zone C**

|    | Battery Park City, Civic Center, Ellis Island, Governors Island, Liberty Island, South Street Seaport, Tribeca, Wall Street, World Trade Center | 79.7         | 98.1         | 36.1        | 11.8         | 3.4          | 21.5         | 8.9      | 24.0         | 6.0                          | 12.0                 | 8.0        | 4.0                          | 259.0               |
|    | Greenwich Village, Hudson Square, Little Italy, NoHo, SoHo, South Village, West Village | 45.6         | 54.5         | 20.4        | 11.8         | 3.4          | 21.5         | 8.9      | 24.0         | 6.0                          | 8.0                  | 8.0        | 4.0                          | 300.0               |
|    | Flatiron, Gramercy Park, Herald Square, Midtown, Midtown South, Murray Hill, Times Square, Union Square | 61.2         | 71.9         | 42.8        | 14.2         | 3.7          | 18.7         | 10.4     | 26.0         | 9.0                          | 12.0                 | 13.0       | 5.0                          | 504.0               |

A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City
<table>
<thead>
<tr>
<th>CD</th>
<th>Neighborhoods</th>
<th>Avoidable Hospitalizations per 100,000</th>
<th>Percentage of Population</th>
<th>Rate of Psychiatric Hospitalizations per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>106</td>
<td>Beekman Place, Gramercy Park, Murray Hill, Peter Cooper Village, Stuyvesant Town, Sutton Place, Tudor City, Turtle Bay</td>
<td>51.5 78.2 36.5 7.7 3.4 17.4 8.3 22.0 6.0 12.0 10.0 3.0</td>
<td>891.0</td>
<td>107 Lincoln Square, Manhattan Valley, Upper West Side</td>
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<td>108</td>
<td>Carnegie Hill, Lenox Hill, Roosevelt Island, Upper East Side, Yorkville</td>
<td>46.3 81.6 40.2 13.9 3.8 17.3 10.7 23.0 6.0 10.0 7.0 3.0</td>
<td>364.0</td>
<td>109 Carroll Gardens, Cobble Hill, Columbia St, Gowanus, Park Slope, Red Hook</td>
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<tr>
<td>306</td>
<td>Bay Ridge, Dyker Heights, Fort Hamilton</td>
<td>93.9 154.2 65.7 8.2 6.4 28.3 19.4 38.0 28.0 16.0 16.0 20.0</td>
<td>423.0</td>
<td>310 Bath Beach, Bensonhurst, Gravesend, Mapleton</td>
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<tr>
<td>312</td>
<td>Borough Park, Kensington, Ocean Parkway</td>
<td>107.5 172.9 66.4 9.4 8.7 25.6 23.0 32.0 15.0 15.0 32.0 23.0</td>
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<td>315 Gerritsen Beach, Gravesend, Homecrest, Kings Highway, Manhattan Beach, Plumb Beach, Sheephead Bay</td>
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<td>401</td>
<td>Astoria, Astoria Heights, Queensbridge, Dutch Kills, Long Island City, Ravenswood, Rikers Island (BX), Steinway</td>
<td>202.6 202.2 76.0 10.4 10.1 26.1 22.2 41.0 25.0 38.0 19.0 18.0</td>
<td>530.0</td>
<td>402 Blissvile, Hunters Point, Long Island City, Sunnyside, Sunnyside Gardens, Woodside</td>
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<td>East Elmhurst, Jackson Heights, North Corona</td>
<td>114.2 195.6 86.7 7.5 9.5 24.7 20.1 63.0 48.0 70.0 22.0 31.0</td>
<td>366.0</td>
<td>404 Glendale, Maspeth, Middle Village, Ridgewood</td>
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<tr>
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<td>Forest Hills, Forest Hill Gardens, Rego Park</td>
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<td>408</td>
<td>Briarwood, Fresh Meadows, Hillcrest, Holliswood, Jamaica, Jamaica Estates, Jamaica Hills, Kew Gardens Hills, Pomonok, Utopia</td>
<td>93.9 179.3 60.4 9.3 9.6 28.4 16.2 47.0 27.0 31.0 16.0 14.0</td>
<td>497.0</td>
<td>409 Kew Gardens, Ozone Park, Richmond Hill, Woodhaven</td>
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<tr>
<td>411</td>
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<td>53.6 110.2 42.9 8.4 4.8 22.9 13.7 43.0 30.0 12.0 9.0 11.0</td>
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<td></td>
<td>Asthma</td>
<td>Diabetes</td>
<td>Hypertension</td>
</tr>
<tr>
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<td>Annadale, Arden Heights, Bay Terrace, Butler Manor, Charleston, Eltingville, Fresh Kills, Great Kills, Greenridge, Huguenot, Oakwood, Oakwood Beach, Oakwood Heights, Pleasant Plains, Prince's Bay, Richmond Town, Richmond Valley, Rossville, Sandy Ground, Tottenville, Woodrow</td>
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<td>151.1</td>
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</table>
Appendix E: Shared Services to Support Small Practices

As part of its considerations, the NYC Advanced Primary Care Planning Group reviewed New York’s experience to date with shared service organizations for small practices. This review included examining a number of different models for sharing resources or workforce across small practices, which in turn enabled those practices to achieve the scale and capacity needed to operate as medical homes and participate in Value-Based Payment. The common theme among the different models is that shared services need to be organized as specific modules and offered to small practices by an existing, trusted organization.

One of the best-developed examples of such an arrangement in the state is the “pod” model developed as part of the Adirondacks Medical Home demonstration to share resources and workforce across a group of small practices participating in that program. In that model, a number of small practices (ranging from two to twelve providers) agreed to work together to organize, govern, and support a physician-supported, physician-led virtual group (housed in a management services organization operated by the region’s hospital) to provide a range of shared services to its members.

The core functions of a shared service organization can vary (see chart below) but could include providing small practices with key personnel, like care managers, and important services (e.g., consulting, employee training, data analytics support, quality improvement, and reporting on outcomes) that small practices need but cannot individually afford.

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing or Implementing a Shared Service Organization</td>
<td>Convener, Project manager, Trusted organization / host, Trusted leader (physician or non-physician)</td>
</tr>
<tr>
<td>Functioning as a Medical Home (APC, TCPI, or PCMH)</td>
<td>Care coordinator, Care manager, Consultation with social workers or pharmacists, Nutritionist, Behavioral health specialist, Psychiatrist</td>
</tr>
<tr>
<td>Participating in VBP</td>
<td>Documentation, Data analytics, Risk stratification, Clinical quality monitoring, Reporting on performance and outcomes, Sufficient scale/aggregation (to ensure a larger unit of analysis for VBP), Data aggregation (SHIN-NY, APD, MAPP), Data validation</td>
</tr>
<tr>
<td>Practice Infrastructure</td>
<td>Electronic health record (EHR) software adoption, Assistance with EHR use, Health information exchange (HIE), Data exchange</td>
</tr>
<tr>
<td>Business Operations</td>
<td>Payer negotiation or group purchasing, Operational management, Cost/revenue cycle management</td>
</tr>
</tbody>
</table>

Developing shared service organizations that serve groups of independent practices could enable the involved providers to provide, share, and retain control over important services they
need to care for their patients as medical homes; to gain economies of scale and operate more
cost-effectively; and to organize and support quality improvement programs, data analytics,
and reporting.

A shared service organization, however, requires substantial capitalization and access to
market-scarce health and health information technology (HIT) personnel. It is not clear
whether small practices will be able to organize or support such organizations on their own, as
new, freestanding associations. In the most likely scenario, in order to be affordable and
sustainable, such an organization would need to be developed in concert with a host
organization that could provide the basic infrastructure (e.g., human resources, finances, HIT)
that the pod requires, while the practices—the pod’s sponsors and clients—retain some
governance and operational authority.

Potential host organizations could include independent practice associations; management
services organizations organized and sponsored by hospitals or group practices; health plans;
third-party administrators and consulting groups; and potentially, Performing Provider Systems
(PPSs) organized as part of the State’s DSRIP program. Such arrangements would, however,
need to be seen by the small practice providers as offering reasonably priced, necessary, high-
value, and reliable services, over which they would have influence or control. These are
options that are being considered and pursued by small practices and larger provider
organizations across the state.

Shared-service organizations can also help participating small practices overcome the patient
volume and time constraint barriers that are associated with VBP. Aggregating small practices
for reporting purposes would allow them to achieve the scale and volume required to generate
statistically valid measures, enabling them to participate in payer-sponsored VBP programs.

Finally, small practice providers remain skeptical that anticipated payment changes will allow
them to thrive or generate margins in the new way of delivering comprehensive primary care.
The success of shared resources or workforce depends on a clear pathway to enhanced
revenues; small practices must be able to generate sufficient revenue under the new payment
models to invest in a pod. Payers and regulators of health care services will need to provide
clear payment schedules and timing of payments for practice owners to plan and predict
whether making changes and investments will have payoffs, not only in the short term, but for
sustaining processes and activities after transformation as well.