OneCity Health

Phase IV Contracting Update

May 6, 2019

NYC HEALTH+ HOSPITALS | ONECITY HEALTH

Phase IV Contracting Goals

- Prepare PPS partners for value-based payments (VBP)
- Establish an infrastructure for high-quality care delivery
- Build sustainable partnerships for a broad, integrated network
- Collect actionable data to evaluate the quality and efficiency impact of a range of services and interventions
- Support local communities through multi-stakeholder collaboration and technical assistance
- Maximize Measurement Year 5 (MY5) DSRIP Revenue

Where are we today?

Phase IV Part One Overview

Phase IV Comprehensive Schedule B (CSB) Part One includes:

- Extension of term of the Master Services Agreement (MSA) through end of DSRIP program and wrap-up of PPS activities (June 30, 2020)
- Composite of PPS participation requirements (workforce survey, compensation and benefits survey, financial assessment, compliance attestation)
  - Metric due dates:
    - April 2019
    - October 2019
    - January 2020
- 155 Partners executed a Phase IV CSB Part One

Second Part of Phase IV:

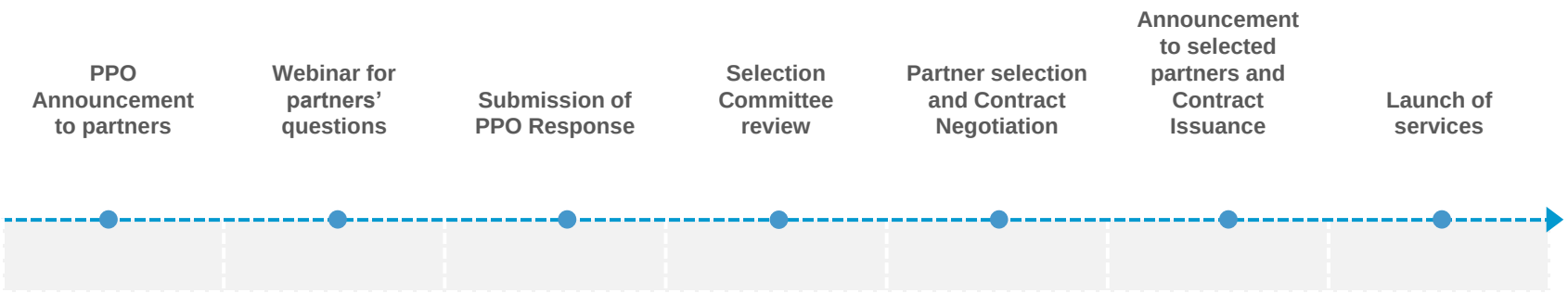
- The second part of Phase IV consists of targeted initiatives to address the needs of the PPS population and meet the goals of Phase IV contracting
- Partners for each initiative will be selected through the Project Participation Opportunity (PPO) process
- Two PPOs have been issued to date:
  - Behavioral Health Intensive Care Transitions Intervention (responses were due Mar 1)
  - Expansion of the Asthma Home-Based Environmental Program (responses were due Mar 27)
- Partners must have executed a Phase IV CSB Part One to be eligible to respond to PPOs
- Today we will review all initiatives approved for contracting by the PPS Executive Committee as of April 2019

How is Phase IV different from Phase III?

- There are two parts to Phase IV:
  - The first part (the Phase IV Comprehensive Schedule B Part One), includes PPS participation requirements, similar to metrics from Phase III
  - The second part of Phase IV will consist only of distinct contracts (distinct schedules B) to fund critical interventions to address the needs of the PPS Population
    - There will not be a **Phase IV Comprehensive Schedule B Part Two** contract sent to partners
- While all eligible partners were sent the Phase IV Comprehensive Schedule B Part One, **only partners who respond to the PPOs and meet the program requirements will be considered for a contract in the second part of Phase IV**
- There will no longer be specific contract metrics or payments tied to reporting on activities that were part of Phase III (e.g. NowPow referrals, administering the PAM® survey and connecting clients to insurance/primary care, Patient Engagement reporting)
- Making referrals through NowPow will be an eligibility requirement for upcoming PPOs (however, there is no contract metric tied to use of NowPow)

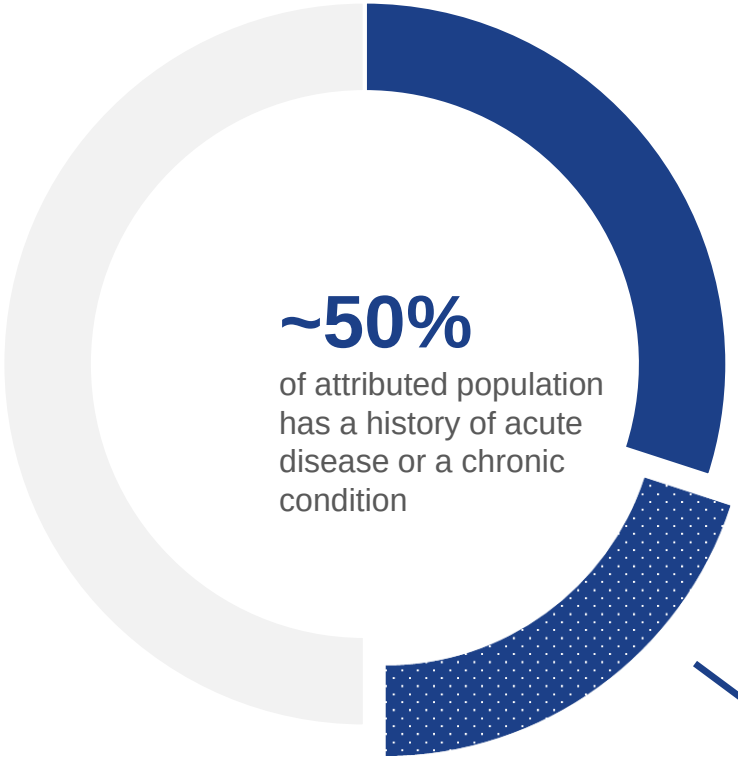
Overview of the PPO process

- Separate PPOs will be issued to identify interested partners who are able to provide the services needed for each targeted initiative
- From each PPO, a distinct Schedule B contract will be issued to selected partner(s)
- All PPOs will be issued from the DSRIPSUPPORT@nychhc.org email address. If you are not currently receiving these emails, please contact the OneCity Health support desk



Drivers of Avoidable Utilization in the PPS Population

~20% of patients account for over 2/3 of avoidable readmissions and 1/3 of preventable ED visits



~50%

of attributed population has a history of acute disease or a chronic condition

750K attributed lives

Prevailing primary chronic conditions:

- Asthma
- Hypertension
- Schizophrenia
- Diabetes
- Cardiovascular Disease
- Depression
- HIV/AIDS

~20%

have multiple chronic conditions

Patients with multiple chronic conditions account for:

- 67% PPRs
- 67% PQI-90s
- 32% PPVs

of recorded adverse events.

Summary of Targeted Initiatives for Phase IV

Today we will review all initiatives approved for contracting by the PPS Executive Committee as of May 2019

Care Transitions	
Initiative description / goals	Care Transitions provides a collaborative care management framework that is patient-centered and longitudinal during the 30 day transition period from time of discharge. The program involves care management activities 30 days post-discharge in a community-based setting. The intervention targets patients at time of discharge from in-patient units defined as “high risk” for readmission based on clinical criteria and history of past readmissions and/or avoidable ED usage.
Partner Eligibility Criteria	**Services** Patient enrollment into the care transitions program, care plan creation, problem list resolution, and weekly outreach to overcome risks to readmission. **Eligibility** • Partners must have demonstrated experience providing these types of services • Connectivity and use of GSI platform for tracking services
Anticipated timeline for PPO	PPO to be issued by June 30, 2019 Partner responses due 30 days from date of PPO issuance

Bridges to Excellence (BTE)	
Initiative description / goals	A recognition program for primary care providers. Program aimed at improving the quality of managing patients with chronic conditions, who are most at risk of incurring potentially avoidable complications. BTE recognitions cover all major chronic conditions to promote comprehensive care delivery and strong relationships between patients and their care teams. Partners will share EMR data on specific clinical interventions and outcomes for patients diagnosed with asthma, coronary artery disease, chronic obstructive pulmonary disease, depression, diabetes, heart failure, hypertension, and/or inflammatory bowel disease.
Partner Eligibility Criteria	**Eligibility** • Record clinical diagnoses and interventions within an EMR • Licensed as a medical doctor (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A.) • Clinicians must have a minimum of 25 patients in at least one disease category for the denominator for individual clinician applicants; a minimum of 10 patients for the denominator is required for each individual clinician in a multi-practice level applicant
Anticipated timeline for PPO	PPO to be issued by May 31, 2019 Partner responses due 30 days from date of PPO issuance

Social Services Contracting: Food Services

Initiative description / goals	The Food and Nutrition Services Program aims to bring the PPS closer to its goal of optimizing access to food resources, minimizing food insecurity and improving the nutritional health of individuals. For purposes of this program, OneCity Health is asking partners to form clusters to easily connect patients to optimal food and nutrition resources. A cluster is defined as a network of organizations within a borough who work closely together, refer and track the outcomes of those referrals under the direction of one lead applicant. Each cluster will embed a Food Navigator in every acute care facility within the borough to screen/assess an individual's food and nutritional needs and make appropriate referrals.

Partner Eligibility Criteria	• Experience providing the identified services directly or through sub-contractors:
	  ○ Health Bucks – access to fresh produce;
	  ○ Evidence-based chronic disease self-management program;
	  ○ Food pantry;
	  ○ Group Meals (including soup kitchens);
	  ○ Nutrition counseling provided by a licensed individual;
	  ○ Medically Tailored Meal Delivery;
	  ○ Food benefits enrollment (SNAP and/or WIC enrollment)
	
	• Connectivity and use of NowPow for tracking services

Anticipated timeline for PPO	PPO to be issued by May 31, 2019 Partner responses due 30 days from date of PPO issuance

Social Services Contracting: Housing Services Domain | Respite Services

Initiative description / goals	OneCity Health anticipates contracting with partners to provide several types of short-term respite services for PPS patients to prevent avoidable hospitalization and ED utilization and facilitate connections to housing resources.

Partner Eligibility Criteria	• Partners must have demonstrated experience providing a specific type of respite service:
	  • **Medical respite:** Short-term services that help to stabilize medical and social needs for patients who no longer require acute hospitalization but cannot be discharged to a stable home or shelter
	  • **Behavioral health respite:** Short-term respite care with trained Peer support that provides an alternative to hospitalization for people experiencing mental health crises
	  • **Caregiver respite:** Temporary support and relief for family caregivers provided in a variety of settings
	• Connectivity and use of NowPow for tracking services

Anticipated timeline for PPO	PPO to be issued by May 31, 2019 Partner responses due 30 days from date of PPO issuance

Social Services Contracting: Housing Services Domain | Housing Navigator Bundled Services

Initiative description / goals	Through this PPO partners will form clusters to easily connect patients to a constellation of housing-related services to meet their needs, improve their health, and reduce their healthcare costs. A cluster is defined as a network of organizations within a borough who work closely together, refer and track the outcomes of those referrals under the direction of one lead applicant. The goal of this program is to meet the housing needs of patients who are homeless and at-risk for homelessness through connection to appropriate housing and other social services.

Partner Eligibility Criteria	• Partners must have demonstrated experience providing the following services:
	  • Ability to embed a housing navigator in an acute care facility to engage homeless and housing-unstable patients to connect them to transitional and permanent housing, and other needed services.
	  • Ability to provide access and transport to safe-haven beds, and have access to the NYC Department of Homeless Services Data System (CARES or StreetSmart)
	  • Expertise in completion of the HRA 2010e Supportive Housing Application
	  • In-depth knowledge of Homebase eviction prevention criteria and ability to refer appropriate patients to identified Homebase providers
	• Connectivity and use of NowPow for tracking services

Anticipated timeline for PPO	PPO to be issued by May 31, 2019 Partner responses due 30 days from date of PPO issuance

Planetree	
Initiative description / goals	• For hospital partners to support a certification in patient centered excellence • The goal is to improve patient experience and health outcomes
Partner Eligibility Criteria	• TBD
Anticipated timeline for PPO	PPO to be issued by June 30, 2019 Partner responses due 30 days from date of PPO issuance

Two PPOs have already been issued

	Behavioral Health Intensive Care Transitions Intervention	Expansion of the Asthma Home-Based Environmental Program
Initiative description / goals	Intensive care management and transition services for patients diagnosed with serious mental health disorders who are in the process of being discharged from either an inpatient or emergency department setting back to the community. The goal of the program is to reduce avoidable hospital use related to behavioral health diagnoses.	The Program serves children and adults with uncontrolled asthma by remediating asthma triggers and connecting patients to needed social services. The goal of the program is to reduce avoidable hospital use related to asthma and COPD diagnoses.
Initiative Timeline	PPO responses were due March 1st 2019 Anticipated launch of services: June 1st 2019	PPO responses were due: March 27th 2019 Status: Partner selection in progress Anticipated launch of services: June 1st 2019

Additional Questions about Phase IV?

There are several resources available on the OneCity Health website:

Previous Phase IV update slides posted here: https://www.onecityhealth.org/wp-content/uploads/Mar-12_OneCity-Health-Phase-IV-Contracting-Update-Webinar-Slides_vf-1.pdf

Phase IV Contracting and PPO FAQ posted here: https://www.onecityhealth.org/wp-content/uploads/20190416_Phase-IV-FAQ_vf21.pdf

After today's webinar, you can continue to contact the OneCity Health support desk with additional questions about Phase IV

By Phone: (646) 694-7090 (Monday through Friday, 9 a.m. - 5 p.m. ET)

By Email: ochsupportdesk@nychhc.org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