

# A Public Health Approach to Practice Facilitation for Success in Payment Reform

#### **Janice Magno**

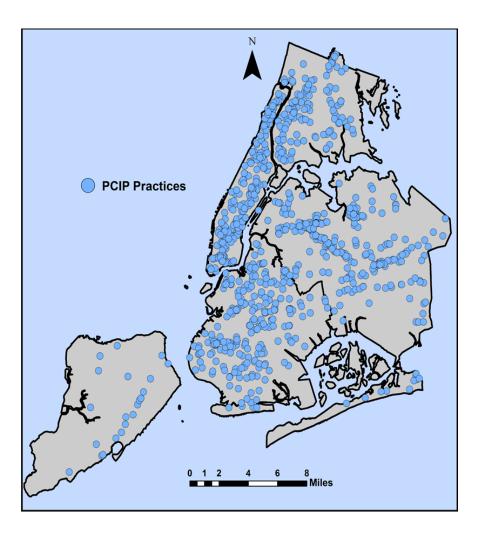
Primary Care Information Project | NYC REACH New York City Department of Health and Mental Hygiene



# **Agenda**

- Primary Care Information Project
- NYC Healthcare Landscape
- Practice Facilitation Approach
- Facilitation Example
- Lessons Learned

# **Primary Care Information Project | NYC REACH**



 PCIP is a bureau of the New York City Department of Health and Mental Hygiene. NYC REACH, the Regional Extension Center for NYC, is housed within PCIP.

 Our mission is to support and promote primary care for all New Yorkers

 Over 23,000 providers joined NYC REACH, representing 1400 independent practices, 114 community health centers and 68 hospitals.

# **NYC** Healthcare Landscape

NYS health expenditures is 2<sup>nd</sup> highest in the US. Per capita spending is 20% higher than national average.

- 60% of primary care providers are in NYC. Many of them are in small practices with limited resources.
- 50% of the population is covered by Medicaid and Medicare.
- There is a lot of fragmentation many organizations and payers.
- Shift to value-based payment is well underway.

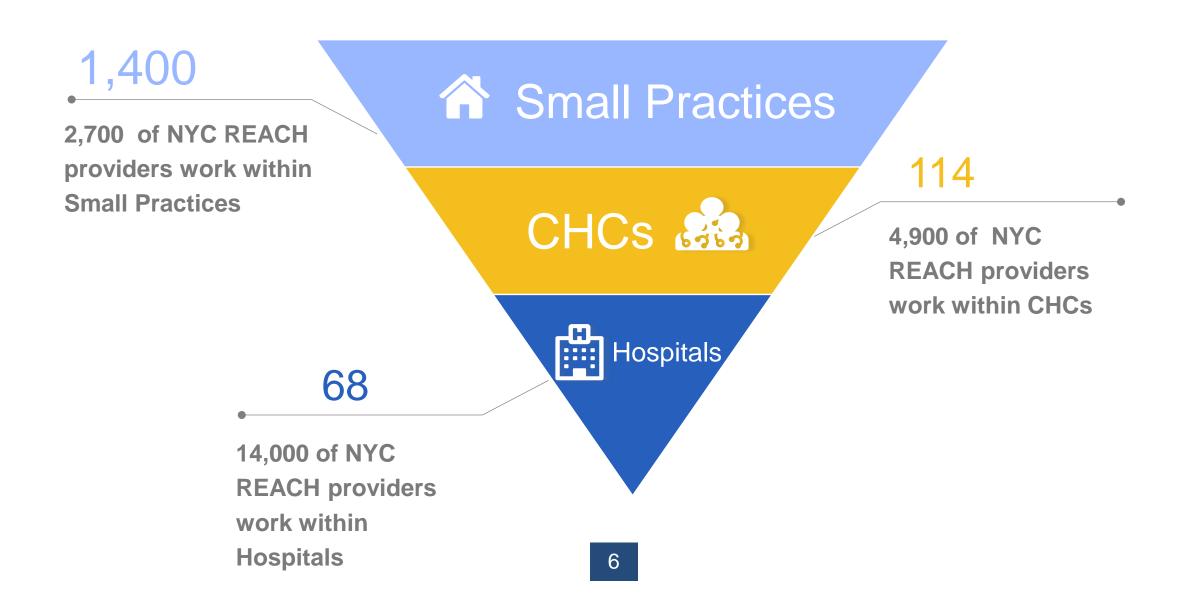


#### **Healthcare Reform**

Reform is a key focus in NY. The shift from fee-for-service to value-based payments is well underway.

- NYS Medicaid Redesign
  - Delivery System Reform Incentive Payment (DSRIP) Program
  - New York State (NYS) Roadmap to Value-Based Payment
- Medicare Quality Payment Program
- Commercial Plan VBP arrangements

### **Our Practices**



#### **Our Structure**

Through a partnership between FPHNYC and NYC DOHMH, we are able to acquire grants to provide practice facilitation support to primary care providers and to advance public health priorities.





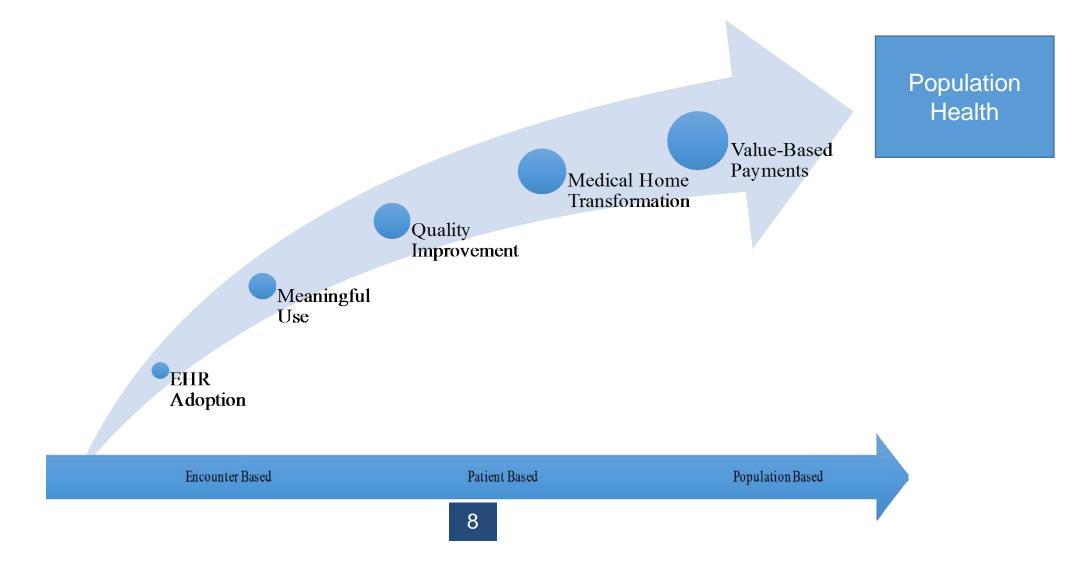
DOHMH subsidizes overhead costs through City funds.



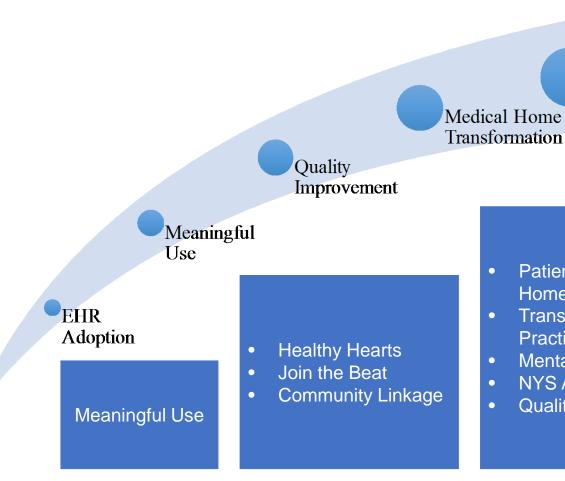
FPHNYC funds direct costs of practice facilitation through grants.

# **Our Approach**

There are critical steps to building a foundation for population health.



# **Our Programs**



Patient-Centered Medical Home

Value-Based Payments

- Transforming Clinical Practices Initiative (2 PTNs)
- Mental Health Service Corp
- NYS Advanced Primary Care
- Quality Payment Program

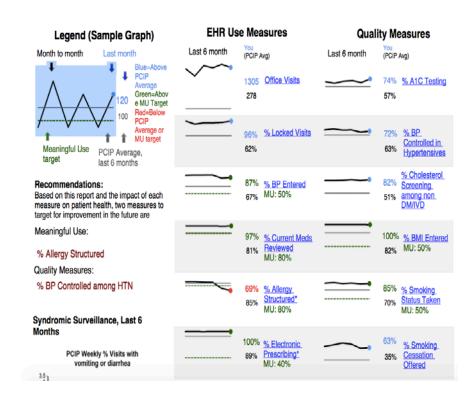
We administer these programs through practice facilitation:

- On-site and Remote one-on-one support
- Learning
  Collaboratives
- Office Hours

#### Resources

As a part of the health department, we have a range of resources to draw upon.

- Data we have access to different sources of data (EHR, MU, claims) and a informatics team that creates dashboards that we use for facilitation.
- EHR vendors
   — we partner with vendors to link
   practices to resources and to have a direct line for
   practices.
- Advisory Groups we have access to internal DOHMH experts and external stakeholders to inform us of needs, interventions and plan/design future programs.



# **Facilitation Example**

site visit via call, webinar or email



#### **Lessons Learned**

- Stay on top of key trends to align with practice strategic goals/priorities
- Create a roadmap for practices that align programs
- Build a long-term partnership with practices
- Use levers where you can or collaborate with others



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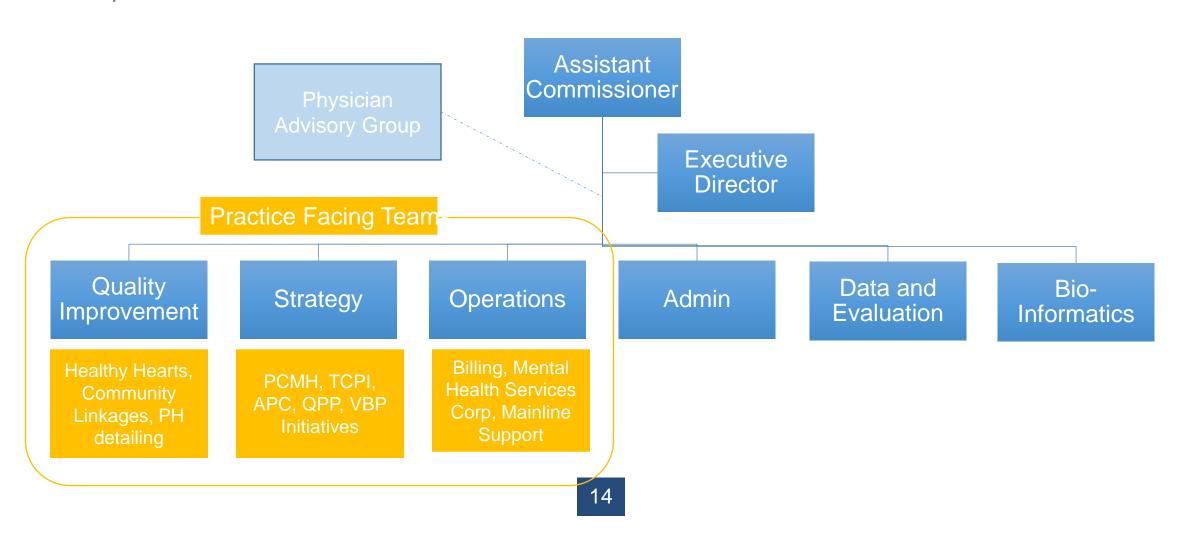
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jmagno@health.nyc.gov

347-396-4952

#### **Our Structure**

We have field teams that provide direct practice facilitation. Teams are divided by programs and provider intervention.



# **Our Approach**

- •View practices as long-term partners
- •Integrate public health priorities
- Advocate for policy change
- •Collaborate with stakeholders to link practices to resources

Strategic Approach

# Operational Approach

- Align programs and measures
- Maximize billing opportunities
- Leverage data and technology
- Serve as policy translator/ advisor to practice
- Create standardized process for implementing best practices

- •Start with getting leadership buyin and commitment
- Assess practice capabilities
- •Set goals and develop work plan
- Create a project charter
- Deliver technical assistance
- •Work on a sustainability plan

Implementation