**Overview: Small Practice Shared Services Focus Groups**

**Purpose:** There are major changes underway for primary care in New York City, including substantial state and federal funding for practice transformation, to assist primary care practices to become higher-performing medical homes; and a major shift in payment for health care services towards value-based payment based on performance across quality, cost savings, and other factors. These changes are challenging for primary care providers in small practices.

To function as medical homes, and to participate in new payment models, providers must have certain capacities that come with scale. 40% of the City’s primary care providers work in small practices that lack the scale required to hire and support the staff and services required. As part of the NYC-PHIP planning process, there was a proposal to organize those functions – capacities that a small practice may need, but cannot afford on their own – as shared services.

**Focus Groups:** In June and July, 2016, the NYC PHIP partnered with the state’s three primary care specialty societies (NYACP, NYAFP, NYAAP) on two efforts focused on better understanding the perceptions of physicians in small practices regarding their needs and the potential value of a shared services approach. In mid-June, NYACP designed a web-based survey which the three societies conducted among their NYC-based members, and tabulated the results.

This then helped frame the agenda for a series of focus groups held in each of the City’s five boroughs (participants invited by the three specialty societies and the respective county medical societies) to “market-test” the idea of shared services with representatives of small practices. Over 50 providers and office staff attended the meetings.

**Common Themes:** Across all the boroughs, providers indicated a need for one, or more, of the shared services discussed at the meetings. The full suite of services that surfaced from the discussions is listed on the next page. Many participants were concerned that small, independent primary care practices did not have a place in the new payment environment; and they felt that a range of shared services could be very helpful in not only providing better care for the patients, but ensuring their ability to compete in a value-based payment environment.

Common concerns noted included: added costs in the absence of new revenues, preserving their independence, the importance of trust.

**Potential Opportunities**: The following were noted as the type of services providers in small practices often need, which they could potentially share:

1. **Health Information Technologies**
   1. Electronic Health Record acquisition and optimization / use
   2. Electronic Health Record maintenance and technical assistance
   3. Registry setup and management (see care mgmt., below)
   4. Regional Health Information Organization (RHIO) connection and use
2. **Technical / Administrative Services**
3. Managing Costs: Group purchasing of business supplies or other services
4. Enhancing Revenues: Consultation/assistance in pursuing revenue opportunities
5. Workforce development / staff training
6. **PCMH/VBP Support**
   1. Claims data analytics (for analysis, reporting; and to guide QI action)
   2. Data aggregation to ensure adequate patient population for VBP
   3. Documenting/reporting quality and utilization measures/outcomes
   4. Billing documentation – specifically to demonstrate activities to meet CCM or other bundled service codes
7. **Quality improvement staff and services**
   1. Shared staff to support quality improvement
   2. Shared QI, learning collaboratives, sharing best practices
   3. Aggregating quality measures and outcomes, across participating practices
8. **Shared professional staff who interact with patients**
9. Nutritionists/diabetes educators
10. Behavioral health professionals
11. Care Coordination
12. Care management
13. Patient engagement and outreach

**How Services Could Be Organized and Provided:** It was generally felt that physicians in small practices would have difficulty organizing and managing the desired shared services as a new entity; the start-up costs and required expertise required were viewed as particular challenges.It was generally agreed that these services could be provided by a trusted entity, that had demonstrated expertise; but perceptions of the desired “host” organization to organize and manage the services differed for each borough.

* **Host Organizations:** 
  + IPAs: Certain boroughs identified IPAs as potential hosts, but most saw their current role as limited only to negotiating fee-for-service payment rates with payers, noted substantial differences in the capabilities of various IPAs.
  + Hospital (local to each borough): Two of the boroughs indicated that they might be comfortable receiving services from hospitals in their areas
  + Medical Societies: One of boroughs indicated the medical societies (the statewide specialty societies and county medical societies) as potential host organizations due to their trusted relationship with providers in the borough.
  + Government Entity (eg. NYC Health Department): Certain boroughs surfaced a government entity (specifically citing NYC REACH) as a potential host, but recognized their role may be limited because of funding constraints and limited resources.
  + Central Service Organization: One group suggested a “pay as you use” model where an umbrella organization would have the suite of services and you could just pay when you used a certain service, similar to a time-share model.

**Next Steps:**

* + NYC-PHIP will organize a webinar, in early-mid October, with leaders of the Adirondacks POD, to discuss their shared services model, its successes and challenges
  + An analytic report will be developed during the Fall-Winter, reviewing the concept of shared services in more detail, noting key features in the design of such arrangements and potentially leading to one or more pilots of shared services for small practices in NYC.