NEW YORK STATE OF OPPORTUNITY. Department of Health

NYS Health Innovation Council

Version 2.0 (Distributed 11/28/16)

November 29, 2016

NEW YORK STATE Department of Health Innovation Center

Agenda

#	Topic	Time	Leader
1	**Welcome, Framing the Day**	10:30 – 10:40	Paul Francis Howard Zucker, MD, JD
2	**Federal Update**	10:40 – 10:55	
3	**VBP and Integrated Care Updates**		
	• VBP Updates	10:55 – 11:15	Jason Helgerson
	• Advanced Primary Care (APC) Updates	11:15 – 11:35	Marcus Friedrich, MD
	• Alignment Discussion	11:35 – 12:10	All
4	**Other SIM Updates and Discussion**		
	• Workforce	12:10 – 12:40	Lisa Ullman
	• Transparency, Evaluation, & Health Information Technology	12:40 – 1:00	Val Grey Jim Kirkwood
	• Population Health	1:00 – 1:20	Sylvia Pirani Barbara Wallace, MD
5	**Final Comments and Closing**	1:20 – 1:30	Paul Francis Howard Zucker, MD, JD

Federal Update

VBP and Integrated Care Updates

NEW YORK STATE | Department of Health | Medicaid Redesign Team

DSRIP and Value Based Payment

Jason Helgerson
NYS Medicaid Director

November 29, 2016

Current State of New York Medicaid

New York State Medicaid Transformation

2011: Governor Cuomo created the Medicaid Redesign Team (MRT) which developed a series of recommendations to lower immediate spending and propose future reforms

2014: As part of the MRT plan NYS obtained a 1115 Waiver which would reinvest MRT generated federal savings back into redesigning New York s health care delivery system known as **DSRIP**

NEW YORK STATE DSRIP

2015: As part of DSRIP, NYS undertakes an ambitious payment reform plan working towards 80% value based payments by the end of the waiver period.

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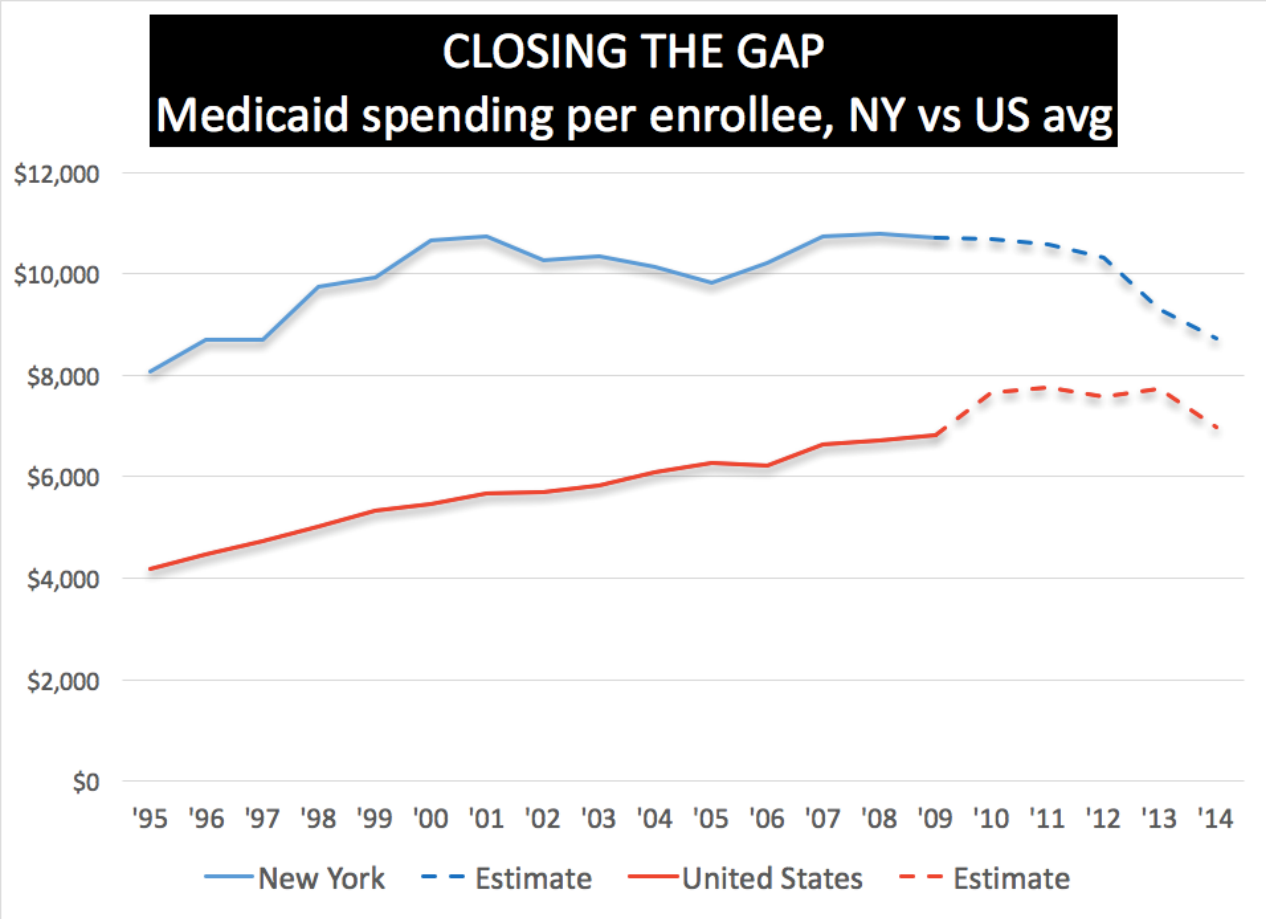


Sources: CMS, Kaiser Commission on Medicaid and the Uninsured

State of Quality - Medicaid

- New York has a well-established system to monitor quality of care for Medicaid managed care enrollees. Over time, measures have evolved from preventive care to measures of chronic care and outcomes.
- Since 2001, a managed care pay for performance program has been a driver of improved care and has focused on quality and patient satisfaction measures.
- The rates of Medicaid performance have:
  - Improved over time;
  - 96% of measures exceeded national benchmarks* based on 2013 data; and
  - Seen a reduction in the gap in performance between Medicaid and commercial managed care.
  - Now 34th in the country in avoidable hospital use end cost.

** National benchmarks are based on 2014 State of Healthcare Quality report from the National Committee for Quality Assurance (NCQA).*

The 2014 MRT Waiver Amendment Continues to further New York State's Goals

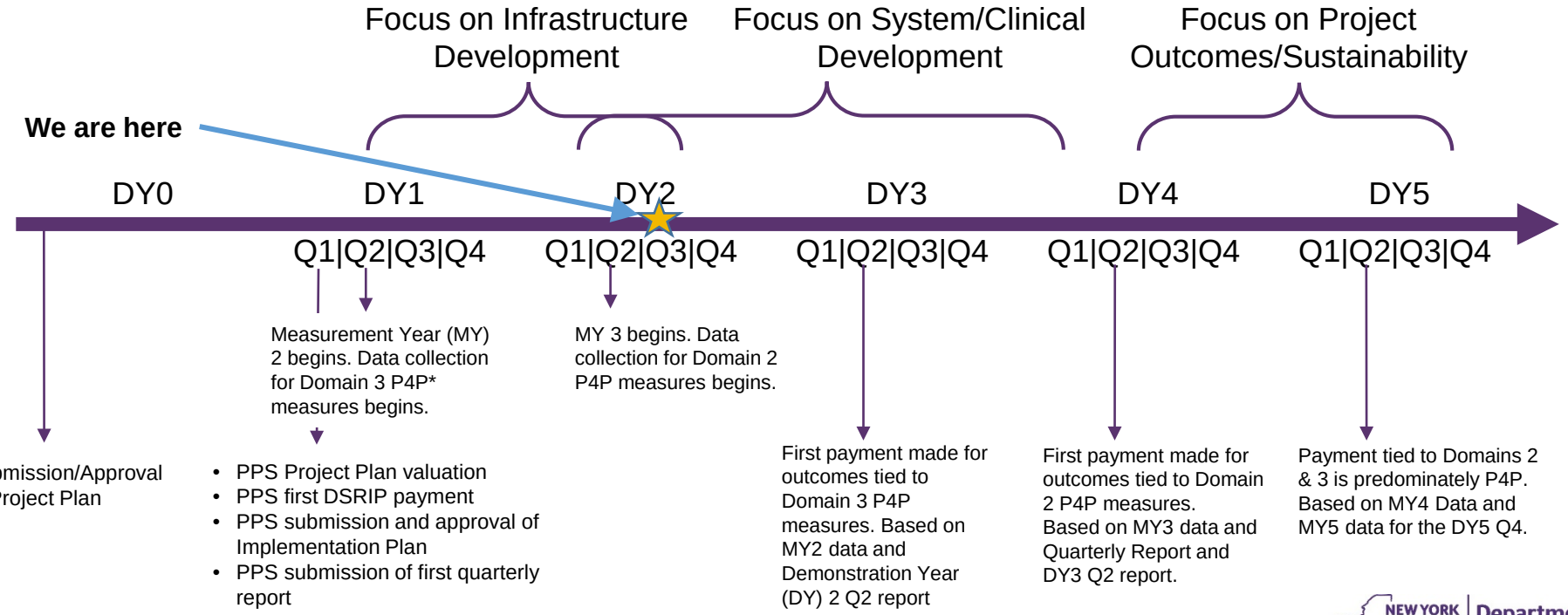
- Part of the MRT plan was to obtain an 1115 Waiver Amendment which would reinvest MRT generated federal savings back into New York's healthcare delivery system
- In April 2014, New York State and CMS finalized agreement on the MRT Waiver Amendment
- Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
- $7 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)
- The waiver will:
  - Transform the State's Health Care System
  - Bend the Medicaid Cost Curve
  - Assure Access to Quality Care for all Medicaid Members
  - Create a financial sustainable Safety Net infrastructure

Delivery System Transformation: Next Steps in Medicaid Redesign

- NYS Medicaid is a health care purchaser not a health care provider.
- If the delivery system is inefficient there are limits to what one payer can do to become more cost effective.
- New York needed delivery system reform and only the state government through the Medicaid program was positioned to make a difference.
- Means to the end: Delivery System Reform Incentive Payment Program (DSRIP)
- $7.3 billion initiative designed to transform health care delivery.

DSRIP: Where Are We Now?

Performing Provider Systems (PPS) have transitioned from planning to implementing projects.



Source: Based on Independent Assessor Project Approval and Oversight Panel Presentation. Nov 9 – 10, 2015. NYS DSRIP Website

** P4P = pay for performance*

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The Move to Value Based Payment

Payment Reform: Moving Towards VBP

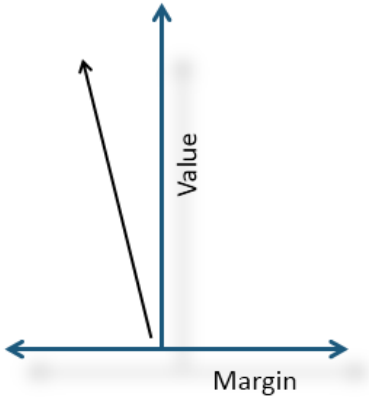
- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver.
- By DSRIP Year 5 (2020), all MCOs must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver).
- The State and CMS are committed to the VBP Roadmap, which core stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in creating and updating.
- If Roadmap goals are **not** met, overall DSRIP dollars from CMS to NYS will be significantly reduced.

Learning from Earlier Attempts:
VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins **by realizing value**

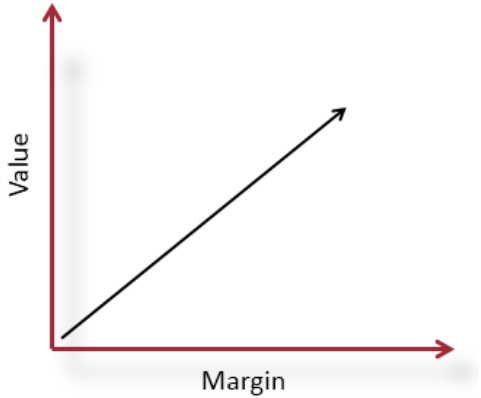
Current State

Increasing the value of care delivered more often than not threatens providers' margins



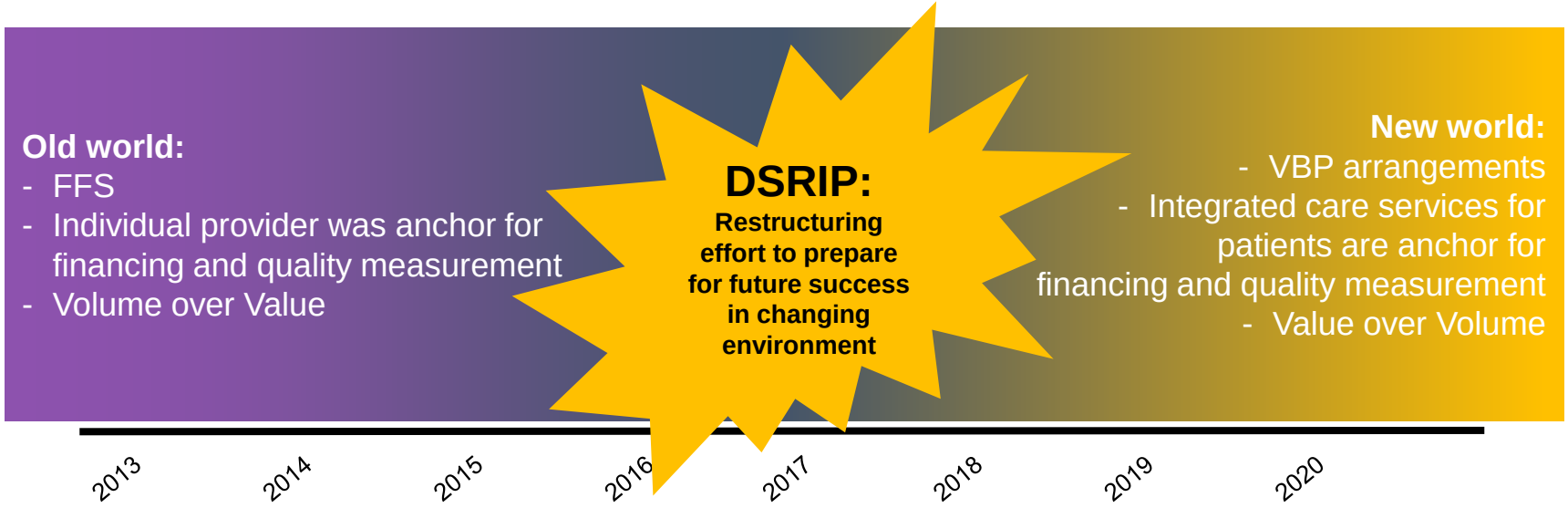
Future State

When VBP is done well, providers' margins go up when the value of care delivered increases



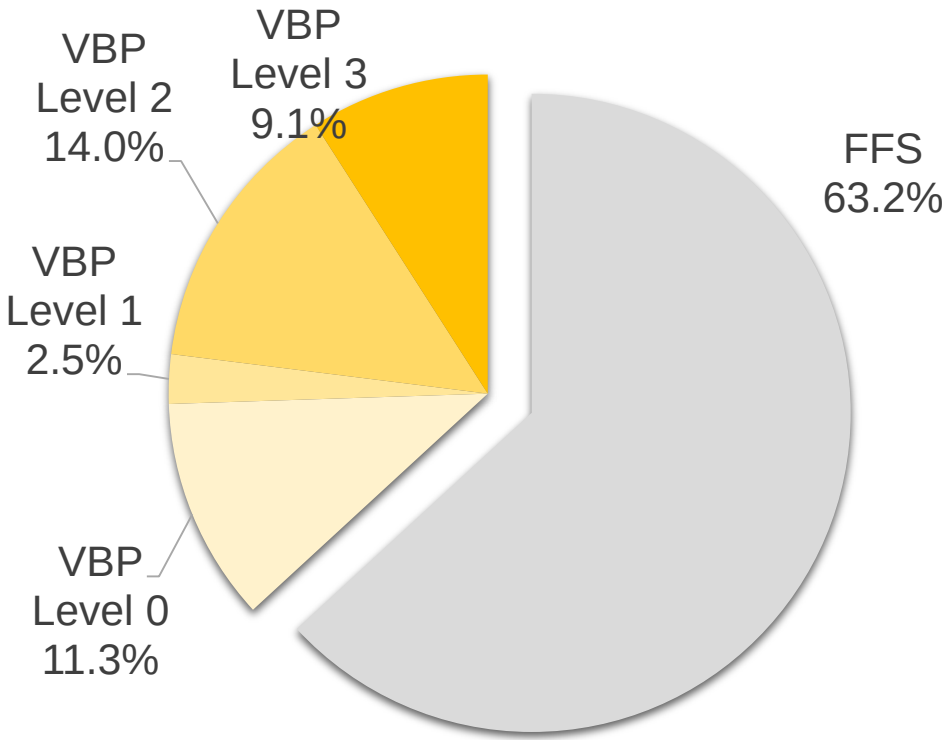
Goal – Pay for Value not Volume

How DSRIP and VBP Work Together



Today: >25% of Medicaid Spend is in VBP Level 1 or Higher

Per Survey, VBP Baseline of Levels 1 - 3 for CY 2014: **25.5%***



VBP Level	Spending or %
Total Spending	$ 22,741 M
FFS	$ 14,372 M 63.2%
VBP Level 0	$ 2,576 M 11.3%
VBP Level 0 Quality	$ 2,036 M 9%
VBP Level 0 No Quality	$ 539 M 2.4%
VBP Level 1	$ 567.5 M 2.5%
VBP Level 2	$ 3,172 M 14%
VBP Level 3	$ 2,062 M 9.1%

*Includes Mainstream, MLTC, MAP, and HIV SNP plans.

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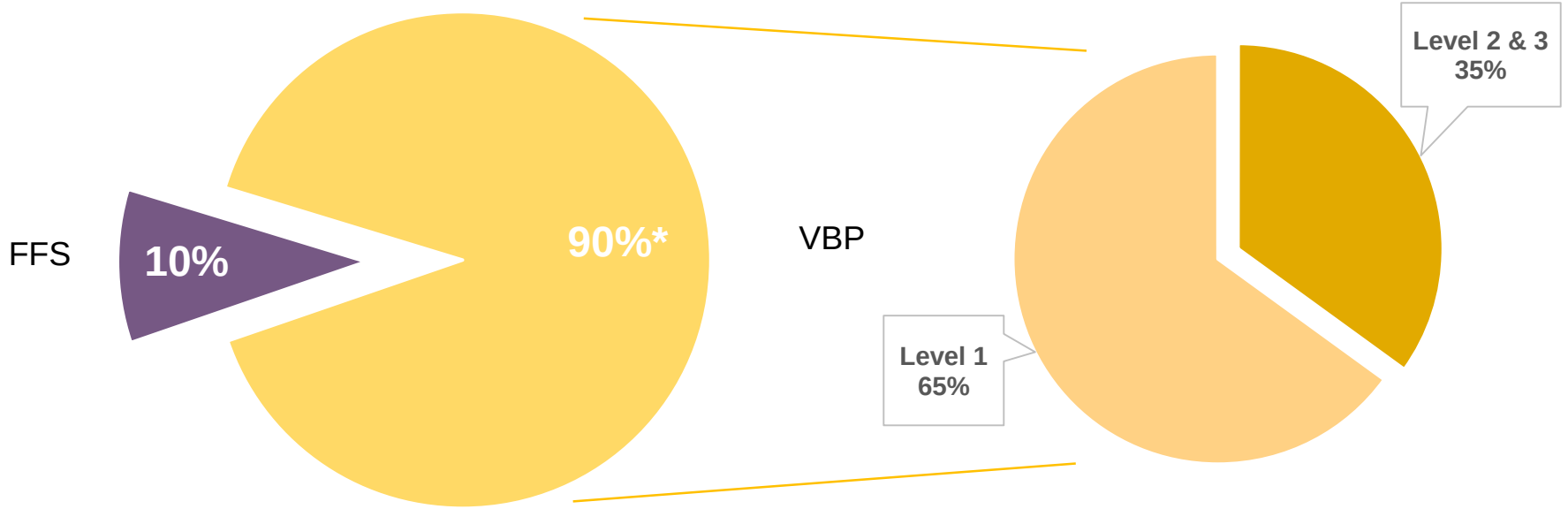
VBP Goals

By April 2020, 80-90%* of Medicaid Managed Care Spend (Plan to Provider Payments) Will Be in VBP Level 1 and Higher



*Minimum of 80%; includes MLTC and (depending on move to Managed Care) I/DD

VBP Implementation Efforts

The State is providing additional financial incentives and support for early adoption of Value Based Payment as well as for execution of higher-risk contracts through:

VBP Pilot Program

- The goal of the Pilots is to help the State and its participating organizations learn how VBP transformation will work in practice as well as to incentivize early adoption of VBP. This is a voluntary 2-year program. DOH reserves the right to restrict enrollment to those pilots that it deems to be most relevant.

Ongoing Subcommittees

- As VBP is implemented, the State will continue to explore the need for the development of new subcommittees, like a Subcommittee on Children's Health, and reconvene existing groups as needed.

VBP Innovator Program

- The goal of the Innovator Program is to recognize providers that contract high risk Level 2 or Level 3 total cost of care for general and subpopulation arrangements by allowing up to 95% premium pass through.

VBP Transformation: Overall Goals and Timeline

To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

DSRIP Goals

DY2 – April 2017

PPS requested to submit growth plan outlining path to 90% VBP

DY3 - April 2018

≥ 10% of total MCO expenditure in Level 1 VBP or above

DY4 – April 2019

≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher

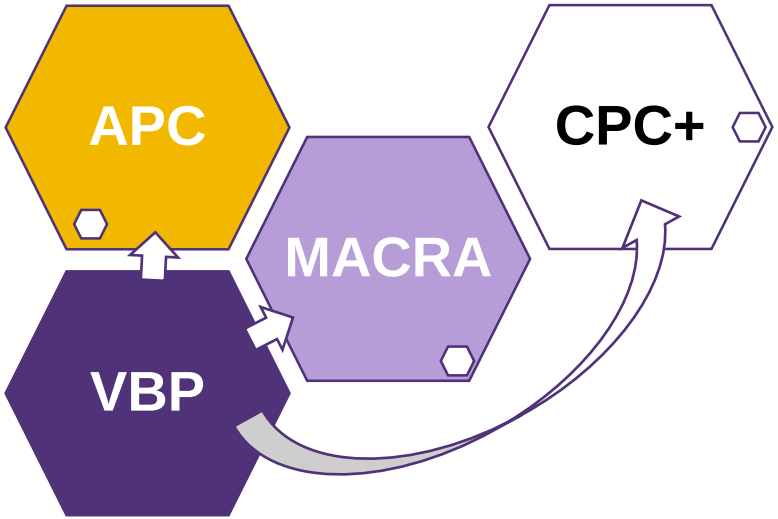
DY5 – April 2020

80-90% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher

Alignment Between Various Initiatives

Moving Forward: Programmatic Alignment

- Our vision for VBP aligns with national programs such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and Comprehensive Primary Care Plus (CPC+), and New York State's Advanced Primary Care (APC) Model



SHIP Alignment

SHIP is NYS' roadmap to achieve the "Triple Aim" for all New Yorkers: improved health, better health care quality and consumer experience, and lower costs.

How does SHIP align with the NYS VBP model?

- Facilitates disease prevention and health improvement within the next five years
- Reduces avoidable hospital admissions and readmissions within five years
- Generates savings by reducing unnecessary care, administering appropriate care and curbing the per unit cost of care.
- Establishes a set of quality measures that informs the Integrated Primary Care (IPC) VBP arrangement

Questions?

Additional information available at:

https://www.health.ny.gov/mrt

https://www.health.ny.gov/dsrip

Contact:
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Integrated Care – Advanced Primary Care (APC) Update

Marcus Friedrich, MD, MBA, FACP
Medical Director, Office of Quality and Patient Safety, NYSDOH

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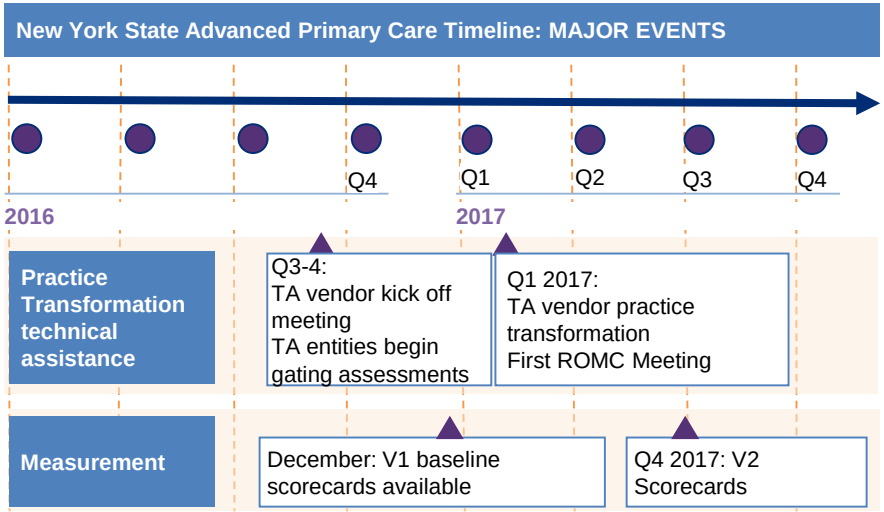
APC Updates

- Governance structure
- Core measure-set: finalized (1.0)
- State-wide practice transformation database
- TA vendor contracts awarded
- Independent Validation Agent (IVA) to be procured
- Consumer engagement
- Practice enrollment starts Q4 2016

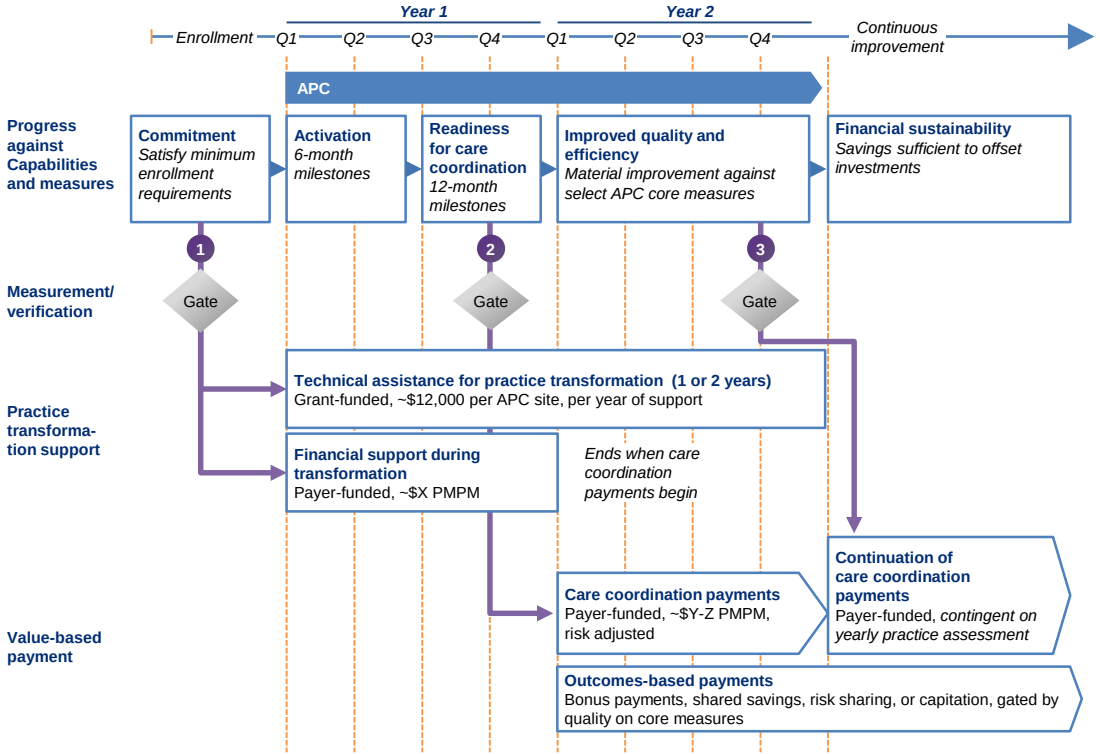
Timeline


New York State Advanced Primary Care Timeline: MAJOR EVENTS
Q4
Q1
Q2
Q3
Q4
2016
2017
Practice Transformation technical assistance
Q3-4:
TA vendor kick off meeting
TA entities begin gating assessments
Q1 2017:
TA vendor practice transformation
First ROMC Meeting
Measurement
December: V1 baseline scorecards available
Q4 2017: V2 Scorecards

APC VBP Payment Goals

- Support primary care practice as they transition from FFS to VBP
- Support primary care practices as they put new services in place (advanced primary care) that are not reimbursed by FFS and which may, during the transition period, reduce revenue from FFS
- Create a viable payment replacement which rewards value using aligned metrics

APC VBP Payment Model



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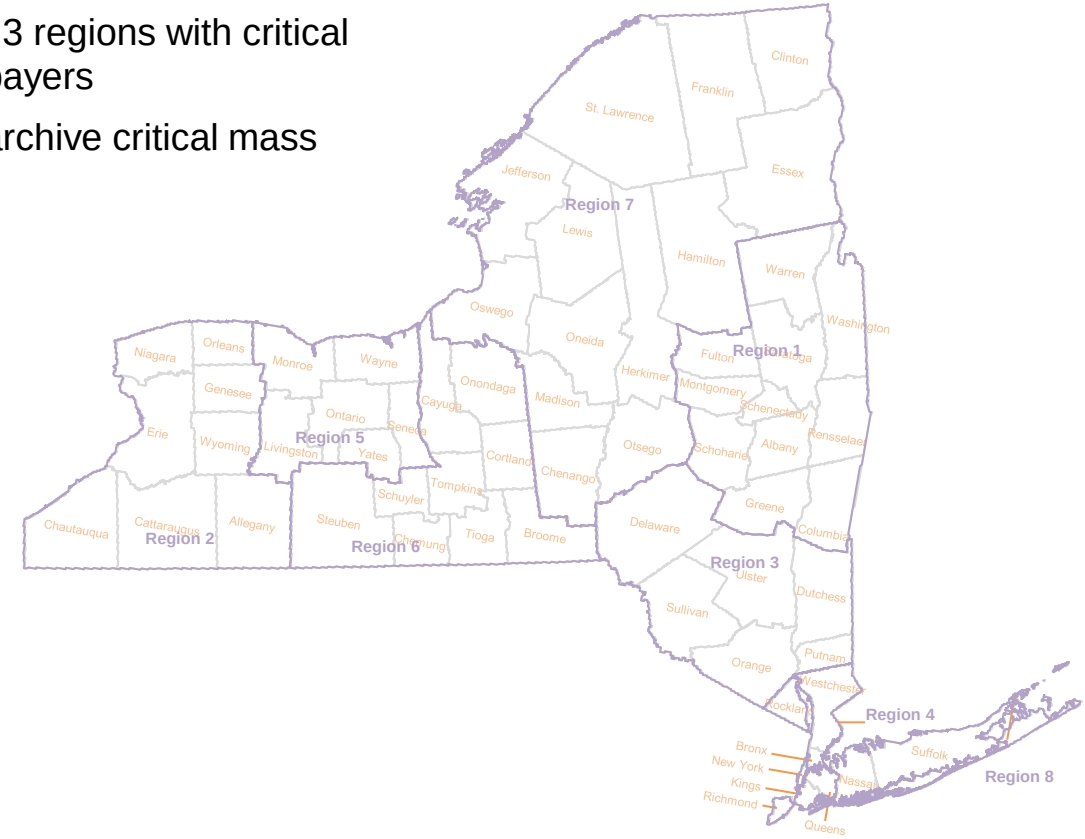
SIM/APC Payer involvement: Critical mass of payers

- Currently 3 regions with critical mass of payers
- Goal: to archive critical mass statewide



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NY State Practice Transformation Programs: Alignment with SHIP

DSRIP	SIM/APC	TCPI	CPC +	MACRA
Primary care transformation: Towards PCMH or APC	**Primary care transformation:** SIM/APC primary care model	**Primary care transformation:** TCPI developed transformation program	**Primary care transformation:** Own transformation program	**Primary care transformation:** Own transformation program
VBP: Medicaid VBP roadmap	**VBP:** commercial payers provide prospective, risk adjusted PMPM payments	**VBP:** No VBP component	**VBP:** CMS, commercial payers provide prospective, risk adjusted PMPM payments	**VBP:** advanced APM as part of CMS Medicare programs

Medicaid/DSRIP Update: PCMH incentive payments

- All Primary Care practices in a PPS must be 2014 PCMH Level 3 certified or APC recognized by March 31, 2018 (end of DY3)
- Gate 2 APC will satisfy the DSRIP requirement for meeting APC milestones
- Medicaid is looking for ways to align the resources being spent on practice incentives
- Connect PCMH/APC incentives to value

SIM/APC – TCPI Alignment Opportunities

- Transformation agents work on similar curriculum, best practices to be shared
- Discussion about recognizing TCPI as a possibility to achieve APC milestones
- Using the PTTS for identification of practices
- Working on guidance from state to providers which program serves best

SIM/APC – CPC+ Alignment Opportunities

- CPC+/ APC/ Medicaid VBP roadmap broadly align
    - VBP payments to primary care practices allowing them for increase in funding and upfront investment in necessary capabilities
    - Focused on cost and quality
    - Defined but limited set of quality metrics
    - Practice transformation resources
- CPC+ consistent with SIM/APC goals
- CPC+ is Medicare's contribution to APC
- Payers engaged in CPC+ show interest in APC

SIM/APC – MACRA Alignment Opportunities

Medicare Access and CHIP Reauthorization Act (MACRA) identifies new ways of paying physicians for caring for Medicare beneficiaries.

- SIM/APC VBP models should align with criteria for alternative APM's
- SIM/APC as one option for practices to fulfill certain MIPS criteria

Medicaid and SIM/APC Response to CMMI RFI

- Multi-payer scale and alignment are critical to transformation
- Primary care changes require support over time
- Transformation requires data and should make use of SHIN-NY and APD

Group Discussion

Discussion Questions

1. How do you see the alignment issues across programs? Any specific recommendations in our power to do, that would reduce complexity and confusion? How do you think these initiatives are being perceived by clinicians?

2. How important do you think it will be to bring together DSRIP VBP, APC, and MACRA? What are the most important components requiring alignment?

3. As practices increasingly become either employees, or part of larger organizations (PPS, ACO, PHO, IPA), how do we need to re-think our initiatives to support primary care practices?

4. Insurers/employers are reluctant to make prospective payments to practices without a clear ROI. Practices are reluctant to re-invent themselves without a business case and some assurance that changes are good for patients, and good for their practices. In addition to our current strategies, any thoughts as to how to continue to chip away at this potential impasse?

5. How can the delivery and payment reforms include accountability for the health outcomes of a population to help address social determinants of health and achieve Prevention Agenda goals?

Workforce

Lisa Ullman
Director, Center for Health Care Policy and Resource Development
Office of Primary Care and Health Systems Management
NYSDOH

Supporting Transformation through SHIP/DSRIP Workforce Workgroup

- Workforce is one of the underlying enablers for the State Health Innovation Plan (SHIP), supporting the five pillars and helping achieve the SHIP objective of moving towards the Advanced Primary Care model
- The Workforce Workgroup also serves the goals of the Delivery System Reform Incentive Payment (DSRIP) Program and the work of Performing Provider Systems (PPS), supporting efforts to reduce avoidable hospital use and achieve the sustainable transformation of the delivery system
- The charge of the Workforce Workgroup is to promote a health workforce that supports comprehensive, coordinated and timely access to care that will improve the health and well-being of New Yorkers, consistent with these transformational initiatives

Identifying Barriers to Performance of Care Coordination Functions

- Workgroup Subcommittee # 1 is reviewing the scope of care coordination functions carried out by licensed and non-licensed workers as well as non-licensed family and friends
- The subcommittee has concluded that the scope of practice for licensed professionals generally does not preclude them from carrying out tasks related to care coordination
- However, there are some barriers (e.g., because licensed practical nurses are supervised by registered nurses, they cannot carry out some tasks on their own whereas such tasks can be performed by unlicensed individuals)
- The subcommittee will continue examining how to address these barriers
- Subcommittee # 1 is also discussing the role of community health workers, who assist individuals in adopting healthy behaviors, help community residents communicate with health care providers and social services agencies, and conduct outreach and implement programs to improve individual and community health

Recommending Care Coordination Concepts for Licensed Practitioners

- Workgroup Subcommittee # 2 is working to identify core concepts in care coordination that can be recommended for inclusion in the educational curricula for licensed professionals
- The subcommittee has been assessing the extent to which care coordination concepts already exist in the curriculum for training physicians and other health care professionals
- For example, the subcommittee determined that approximately two-thirds of New York State medical schools report covering some type of care coordination in their curricula, although there is some variation in content
- Subcommittee # 2 will continue this work, with the ultimate goal of identifying and recommending core care coordination concepts for use by education and training institutions
- Incorporation of these concepts will be recommended to promote consistency across institutions and professions

Developing Core Curriculum Guidelines for Care Coordination

- The Workgroup recognized the need to identify consistent training guidelines for workers who carry out care coordination functions and charged Subcommittee # 3 with developing such guidelines
- Subcommittee # 3 reviewed literature on care coordination training available from various sources throughout the country and curricula in use by different training entities across the state
- Using the training content drawn from these sources with the most overlap, the subcommittee identified key concepts to serve as the basis for developing core curriculum guidelines for training workers who provide care coordination
- These core curriculum guidelines, consisting of nine modules, are available at https://www.health.ny.gov/technology/innovation_plan_initiative/docs/core_curriculum_train_ccw.pdf

Addressing Gaps in Health Care Workforce Data

- The Workgroup noted that there is insufficient information available about the health care workforce, particularly with respect to the distribution of practitioners throughout the State
- The Workgroup charged Subcommittee # 4 with identifying gaps in available information about the health care workforce and recommending potential data collection strategies
- The New York State Physician Profile is a publicly available online resource that provides information about individual licensed physicians
- The subcommittee recommends a statutory change to support the collection of additional information from physicians through the Physician Profile for workforce planning purposes
- The additional data elements would be excluded from the public profile where appropriate

Addressing Gaps in Health Care Workforce Data (continued)

- Subcommittee # 4 also noted that some data is available on a small number of professions through voluntary surveys as part of professional registration
- However, response rates vary and information is not sought from all health care practitioners
- The subcommittee recommends adopting a data collection approach recently implemented for nurse practitioners
- This would require a statutory change requiring all health care practitioners to provide information through brief surveys completed upon registration and re-registration with the State Education Department
- The information would be based on federal Minimum Data Set guidelines and focus on key demographic, educational, and practice characteristics
- The information would be used for health care workforce research and planning with de-identified, aggregate information made available on the DOH website

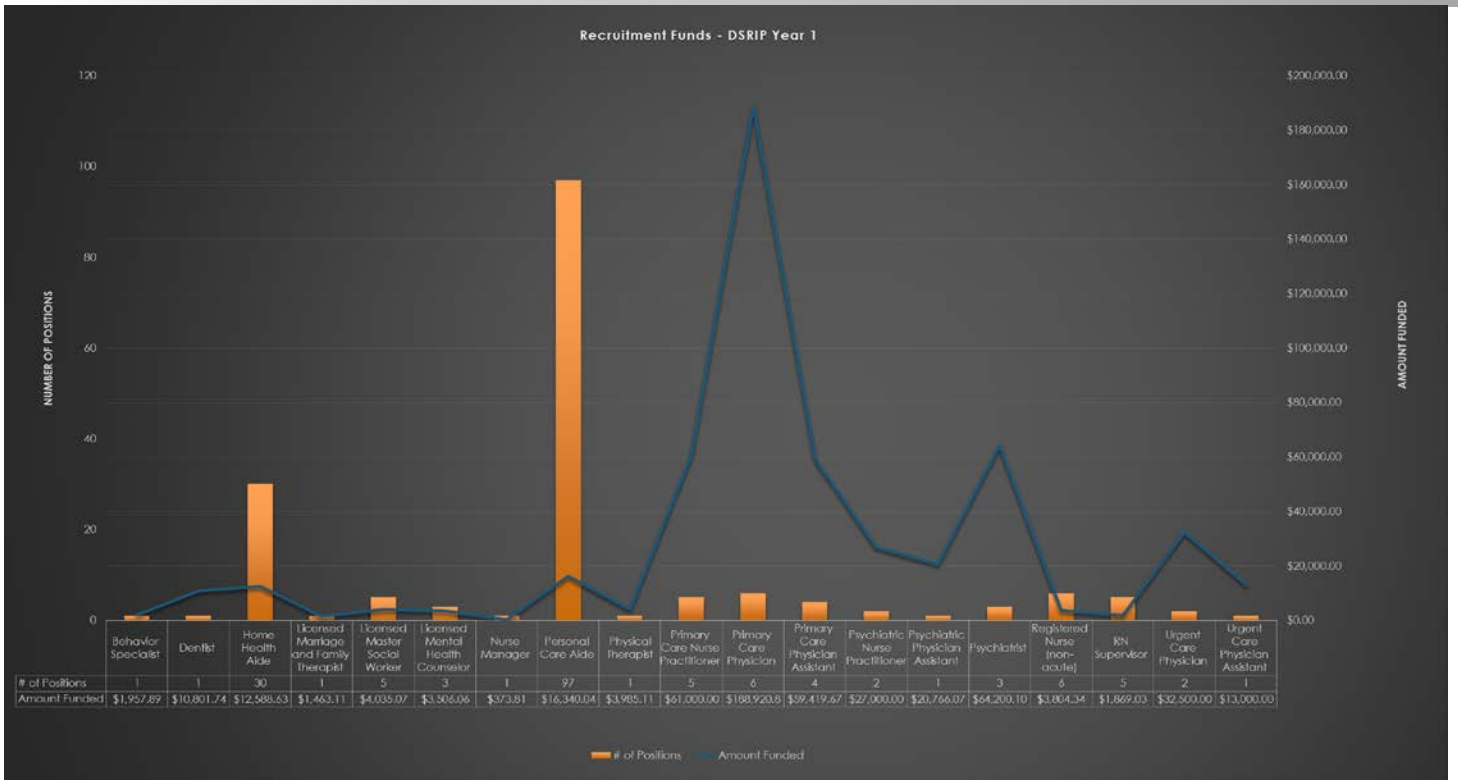
Supporting Workforce Components of DSRIP

- DSRIP funding supports initiatives to implement workforce transformation
- PPS will dedicate approximately $415 million of DSRIP funding to workforce activities over the five year DSRIP period
- DSRIP workforce funds may not be used to supplant existing funding or to fund salaries
- PPS spent $67.3 million in DSRIP Year 1 (ending March 31, 2016) on various workforce initiatives

Implementing PPS Workforce Initiatives

- PPS workforce initiatives developed and implemented to date include activities such as:
  - developing innovative ways to recruit and retain for positions that have been challenging to fill
  - recruiting new workers and training existing workers in care coordination and care management functions and positions
  - building job pipelines by working with institutions of higher education to develop relevant and/or revised curricula to ensure the incoming workforce is job ready
  - using community health workers and community-based organizations to help connect individuals with needed health and social services in a culturally competent manner
- Examples of PPS workforce activities follow

Recruitment Funds – DSRIP Year 1



	Behavior Specialist	Dentist	Home Health Aide	Licensed Marriage and Family Therapist	Licensed Master Social Worker	Licensed Mental Health Counselor	Nurse Manager	Personal Care Aide	Physical Therapist	Primary Care Nurse Practitioner	Primary Care Physician	Primary Care Physician Assistant	Psychiatric Nurse Practitioner	Psychiatric Physician Assistant	Psychiatrist	Registered Nurse (non-acute)	RN Supervisor	Urgent Care Physician	Urgent Care Physician Assistant
# of Positions	1	1	30	1	5	3	1	97	1	5	6	4	2	1	3	6	5	2	1
Amount Funded	$1,957.89	$10,801.74	$12,588.63	$1,463.11	$4,035.07	$3,506.06	$373.81	$16,340.04	$3,985.11	$61,000.00	$188,920.8	$59,419.67	$27,000.00	$20,766.07	$64,200.10	$3,804.34	$1,869.03	$32,500.00	$13,000.00

Albany Medical Center PPS Workforce Achievements

Goal: Create a healthcare workforce that offers the same quality of care across the 3-PPS region

- Collaborated with Alliance for Better Healthcare (AFBHC) to provide preparation courses for employees eligible to sit for the Certified Asthma Educator exam
- Workforce leads from AMCH, AFBHC, and Adirondack Health Institute PPS meet monthly to collaborate on:
  - Curriculum development
  - Training coordination
  - Emerging titles development
- Will bring together leads for workforce and cultural competency to
  - Create consistency and efficiencies in training
  - Share resources and ideas
  - Eliminate duplication of training efforts for partners

COMMUNITY BASED COLLABORATION

CARE COMPASS NETWORK

- Adoption of direct contracting model –47 non-hospital community organizations, totaling more than $2M in commitments through March 2017 for DSRIP projects.

- Trained 26 staff members as Community Health Advocates as part of Health Navigation Services (2.c.i) program

- CBO recruitment of positions, such as LCSW, to address workforce needs

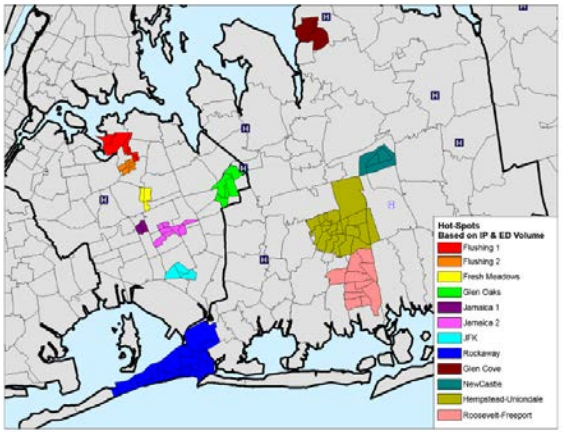
- Training 17 CBO PAM Survey Master Trainers

Nassau Queens PPS

Nassau Queens Performing Provider System
An Alliance for a Healthy Community

Hot-Spotting Analysis Drives Strategy for CBO-Delivered Community Member CCHL Education

- CBO Train the Trainer Model
- Training delivery embedded in CBO agreements
- Patients empowered to be active partners in their healthcare through education:
  - Impact of social, cultural factors, health beliefs and behaviors on health outcomes
  - Ask Me3Translation services and iSpeak Cards
  - Importance of accurate REL data capture
- Trained over **940** persons on diverse CCHL topics



New York-Presbyterian PPS

Care Transitions (Project 2.b.iv) Progress:

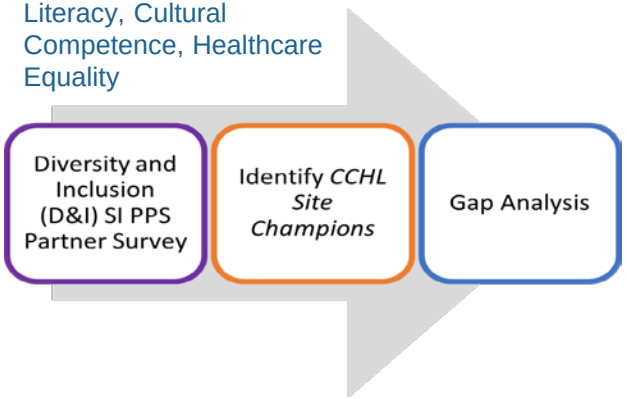
- Hired 8 RN Transitional Care Managers and developed an evidenced based protocol to standardize the level of care for over 500 patients touched by the project
- Continued collaboration with internal and external partners to maximize care transitions resources.
- Established contracts with 3 CBOs and on-boarded 6 Community Health Workers - program implemented in August 2016 to include home and follow-up appointment visit accompaniment

North Country Initiative - Workforce

- **Leveraging Long-term Pipeline**
  - *Career exploration programs*
- **Collaborating with Institutions of Higher Education**
  - *Bachelors & Masters Programs at community college (i.e. Nurse Practitioner & Social Worker)*
  - *Development of North Country Care Coordination Certificate Program with SUNY Jefferson & SUNY Canton*
- **Customized Training Videos** *(DSRIP 101, Blood Pressure Measurement, Health Literacy & MEB)*
- **Provider Incentive Programs**
  - ***Approximately $3 million for recruitment of 11 Primary Care Physicians, 3 Nurse Practitioners, 2 Physician Assistants, 2 Psychologists, 2 Psychiatrists & 2 Dentists***
  - ***Licensed Clinical Social Worker & Certified Diabetes Educator***
- **Regional Expansion of Graduate Medical Education**
  - *Providing financial support of residency spots at local GME Program, rotations at regional sites, minimum 3 year commitment to work in region*

Use of Data to Inform Cultural Competency and Health Literacy Plan

Diversity and Inclusion: Language Access, Health Literacy, Cultural Competence, Healthcare Equality



- Plans, policies, procedures
- D&I initiatives
- Staff development and training
- Monthly meetings
- Develop programs, share best practice
- Report all information to site leadership
- Organizational capacity
- Training: status, ability and needs
- Service improvement

Findings:	Action:
50% partners without language access	✓ Contracted vendor for interpreting and translating needs; supplying sites with Video Remote Interpreting Equipment
85% partners identified need for Medical Interpreter Training	✓ Contracted 2 Medical Interpreter training vendors specializing in hospital and community interpreting
65% partners seek LGBT and Disability sensitivity training	✓ Contracted with CBO- Pride Center of Staten island to provide PPS-Wide LGBT Healthcare Equality training
	✓ Contracting with CBO PCCS to deliver sensitivity training for working with persons with developmental disabilities
90% partners identified Health Literacy as area for improvement	✓ Developing Health Literacy provider and community training

Surveying PPS on Compensation and Benefits

- Each PPS is required to participate in a Compensation and Benefits Survey three times during the five year period for the purpose of identifying workforce trends
- Due to antitrust considerations, data is only collected by a third party, is reported in the aggregate and is only reported for titles when responses are provided by at least five PPS partners
- A consistent set of data elements will be collected from all PPS for DSRIP Years 1, 3 and 5
- The aggregate data is currently being used to:
  - inform education and training requirements for PPS lead organizations and their partners
  - guide retraining for redeployed workers and employee support programs
  - advance health care workforce research and policy development while demonstrating DSRIP impact

Surveying PPS on Compensation and Benefits (continued)

- The DSRIP Year 1 survey requested data for a set of required elements, which covered 66 titles and 10 organization types and included:
  - Current staff numbers and vacancies
  - Average compensation for each title
  - Average benefit percentage for each title
- The data is not complete, as some PPS partners did not complete the survey
- The data is imperfect, as some data cannot be consistently aggregated (e.g., there is no consistent definition of fringe benefits)
- Nevertheless, the data gives a valuable snapshot of vacancies for PPS throughout the State and gives a sense of regional trends

High Vacancy Rates by Job Title in 20 PPS

PPS	# of PPSs with 8%+ Vacancy Rate
Primary Care Physician	12
Primary Care Nurse Practitioner	14
Psychiatric Nurse Practitioner	16
Staff Registered Nurse	8
Licensed Practical Nurse	8
RN Care Coordinators/Case Managers/Care Transitions	10
Psychiatrist	13
Psychologist	4
Medical Assistant	7
Social and Human Service Assistants	4
Substance Abuse and Behavioral Disorder Counselors	6

PPS	# of PPSs with 8%+ Vacancy Rate
Nursing Aide/Assistant	9
Certified Home Health Aide	5
Personal Care Aide	6
Licensed Clinical Social Worker	13
Bachelor's Social Worker	2
Licensed Master's Social Worker	9
Social Worker Care Coordinator/Case Manager/Care Transition	6
Care Manager / Coordinator	6
Care or Patient Navigator	10
Community Health Worker	7
Peer Support Worker	15

Fewest PPS — Most PPS

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Questions and Discussion

Transparency, Evaluation, and HIT

Jim Kirkwood
Deputy Director, Division of Health Care Innovation, NYSDOH

Valerie Grey
Executive Director, New York eHealth Collaborative

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Gameplan & Draft Target Timelines

NYeC
NEW YORK eHEALTH COLLABORATIVE

ORIENTATION & LISTENING TOUR

9/16 - 11/16

LONG-TERM VISION

12/16 - 3/17

MULTI-YEAR ROADMAP

12/16 - 7/17

Stakeholder engagement throughout

Year 1

- Implementation of To be Determined Priorities
- NYeC Governance Changes
- NYeC/RHIO Contracting

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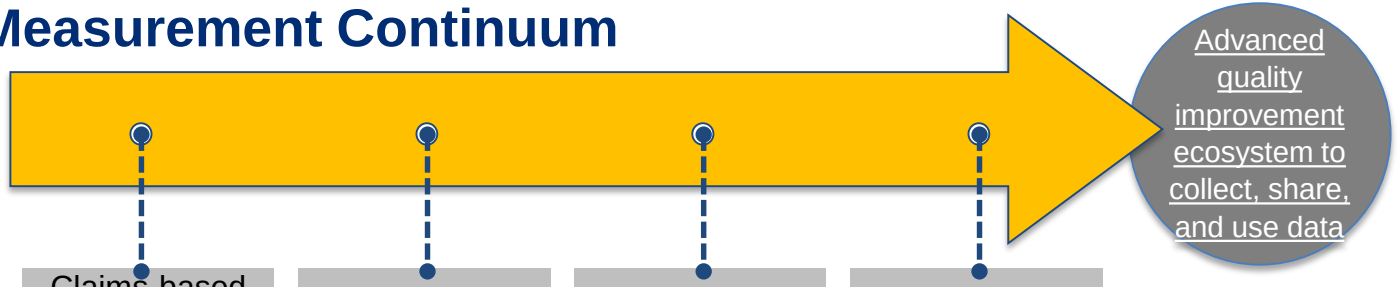
SHIN-NY Consent Activity

- NYeC Policy Committee charged with re-examining the SHIN-NY consent model in consideration of new health transformation arrangements
- Recommendations may include:
  - Consideration of an opt-out model
  - Flexibility not requiring a SHIN-NY specific consent (i.e., previous consent given)
  - Consider specific use cases, such as alerts, that may not require consent
  - Changes or reinterpretation of state law

Quality Measurement Continuum



Claims-based Quality Measurement

Claims data quality measurement and/or HEDIS data collected from surveys, chart reviews, and claims data

Self-reported

Data captured, eCQM calculated in EHR and only numerator/ denominator reported

Live automated data

Automated data acquisition from EHRs to central aggregator tool for calculation, comparison, reporting, and population level measures

Integrated data

Claims and clinical data integrated to analyze quality and address population health needs

Provider/Practice/Encounter Level Data

Patient-Centric Reporting
Provider-Centric Reporting
Practice-Centric Reporting
System-Centric Reporting
Population-level Reporting

From ONC Conference:
IT-enabled Quality Measurement (Aug 31 –Sep 1, 2016)

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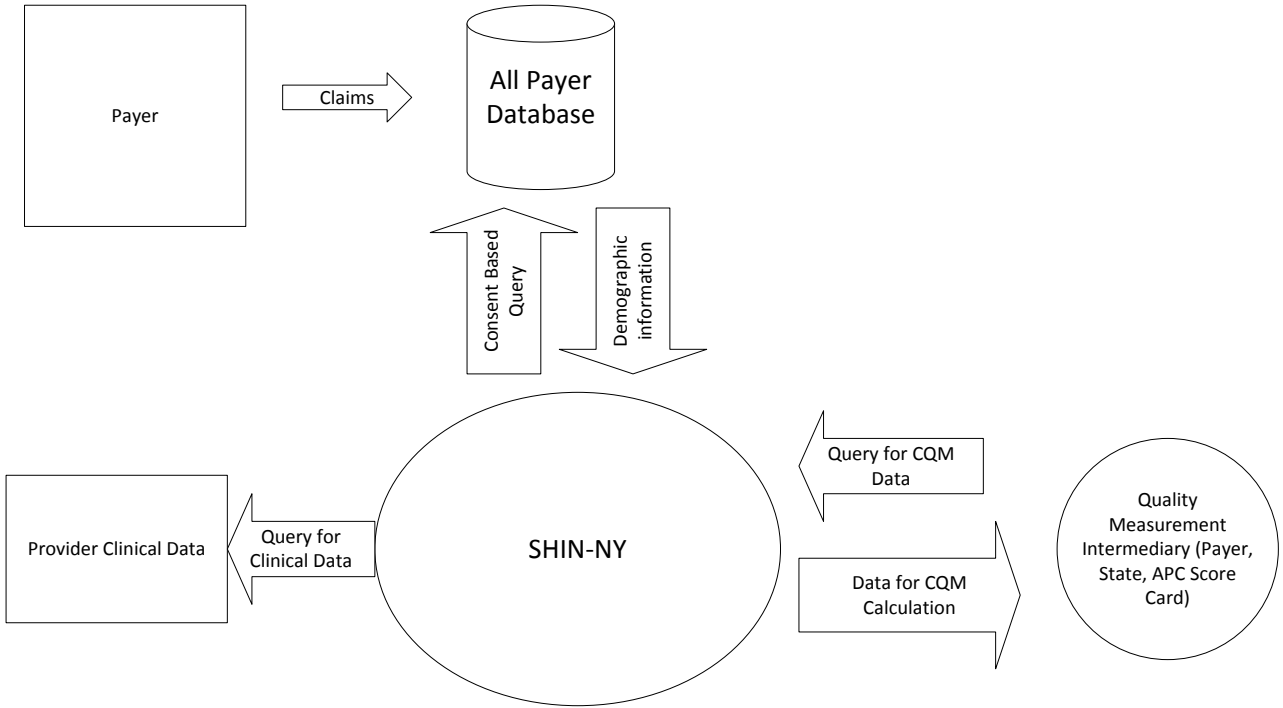
Principles and Assumptions for Data Collection

- Collect once, use multiple times
- Should align with and invoke federal standards for certified EHRs
- Ensure data can be used to calculate measures at multiple population health levels
- Data elements collected should be used to support multiple quality measures
- EHR derived data will provide some, but not all, data necessary to calculate quality measures
  - Would be used in combination with claims, registry and other data

Possible Data Flow for Calculation of Quality Measures for APC



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Challenges

- Increasing SHIN-NY Data Quality and Completeness
  - Greater standardization (e.g., laboratory results)
  - Gaps in EHR functionality
  - Provider usage of EHRs

- Building out infrastructure
  - Master Provider Index
  - APD-SHIN-NY Connection

All Payer Database (APD)

- The APD will be a large repository of consolidated information that will integrate health care data across all payers and all sites of care

- The APD will:
  - Support health care finance policy, population health, and health care system comparisons and improvements
  - Serve as a key resource for consumers, providers and payers

- The APD will begin with claims and encounter data from insurance companies

Progress

- APD proposed regulations for public comment
  - Received comments in October and in the process of reviewing
- APD Guidance Document
  - Under review. Policies, data reporting formats, operational requirements
- Contract with Optum Government Solutions for data warehousing and analytic tools

Challenges

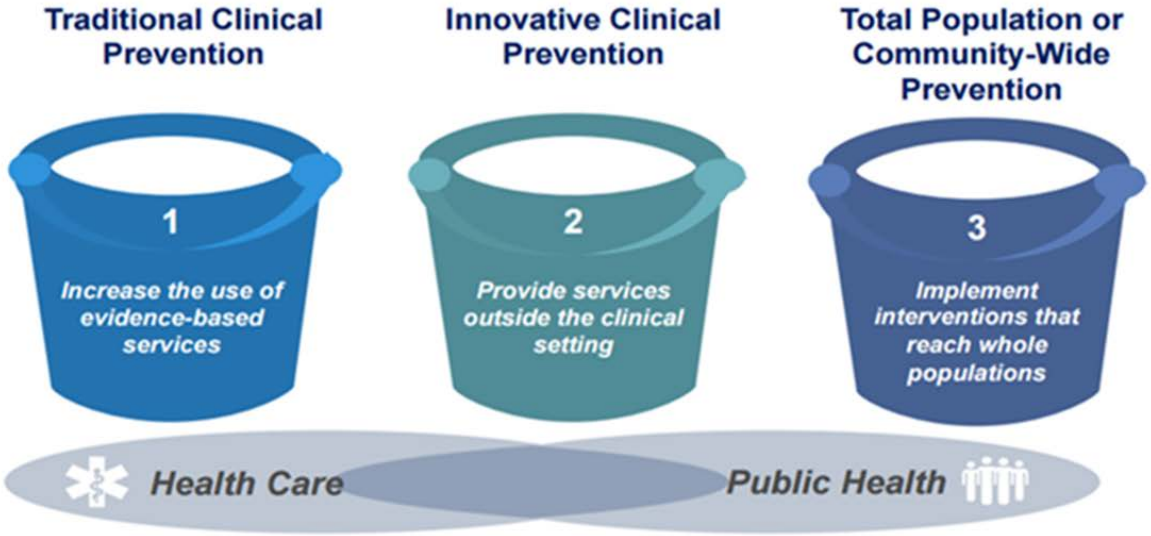
- APD data intake solution has been delayed
  - Commercial data to start in 2017
- Authority to collect self-insured data is in question. March Supreme Court Decision, Gobeille vs. Liberty Mutual – disallowed APD reporting mandate on Self-Insured Plans (ERISA pre-emption ruling)
  - Approximately 50% of commercially insured New Yorkers are in self-insured products
  - The New York State Health Insurance Plan (NYSHIP) is self-insured, and we are working with the Department of Civil Service to get their participants to submit data to the APD (1.2 million enrollees)
  - Limited dialogue on voluntary reporting has also taken place with smaller self-insured plans in western and northern NY
  - The Court suggests that states' APD interests might be served by pursuing newly created reporting rules from the US Depts. of Labor or Health and Human Services; the APCD National Council is coordinating a unified states' dialogue with USDoL

Questions and Discussion

Population Health

Sylvia Pirani
Director, Office of Public Health Practice
NYSDOH

Three Buckets of Prevention



Auerbach J., The 3 Buckets of Prevention. Journal of Public Health Management and Practice 2016.
http://journals.lww.com/jphmp/Citation/publishahead/The_3_Buckets_of_Prevention_.99695.aspx

CDC

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Practice Transformation Focuses On Bucket #1

"Practice transformation" as we use the term refers to an advanced primary care model that facilitates more integrated and coordinated care for patients coupled with payment approaches that support and reward high-value care.

The state has articulated a statewide delivery system objective that by 2020 80% of the population will receive primary care setting with the following characteristics:

- A systematic approach to primary care based prevention services, care coordination and care management for high risk patients, use of quality metrics for improvement, integration of behavioral health services and population health management

- A payment environment in which primary care is supported by alternative payment models across a critical mass of payers that recognize primary care providers for advanced services (including non-visit or procedure based interventions) and rewards them for improved performance.

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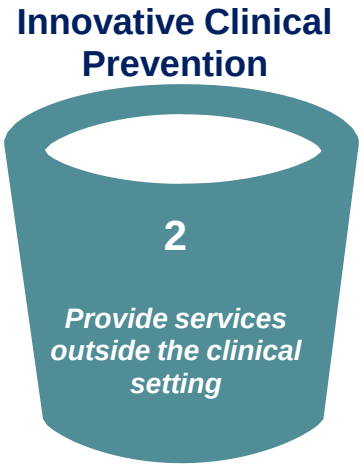
DSRIP and SIM Promote Innovative Clinical Prevention

DSRIP Domains 1-3 Projects related to cardiovascular disease, diabetes, asthma

SIM care coordination milestones



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BPHC PPS - CBO Engagement

air nyc

Asthma home-based services

- 15 years experience
- Community health workers
- Know the Bronx
- Speak the languages
- Strong track record

HEALTH PEOPLE
Community Preventive Health Institute

- Diabetes Self-Management Program (Stanford model)
- Lower Extremity Amputation Prevention Program (LEAP)
- Paid training for 20 coaches = individuals recruited from community
- Classes for 600-800 students from community **hot spots**

request for proposal

CBO-driven

- Process & Criteria
- Content & Curriculum

Community-based BH and social services targeted for funding in DY2:

- **Cultural Competency Training**
- **Critical Time Intervention**
- **Behavioral Health "Call to Action"**
- **Community Health Literacy**

Prevention Agenda 2013-2018

- Goal is improved health status of New Yorkers and reduction in health disparities through increased emphasis on prevention in five priority areas

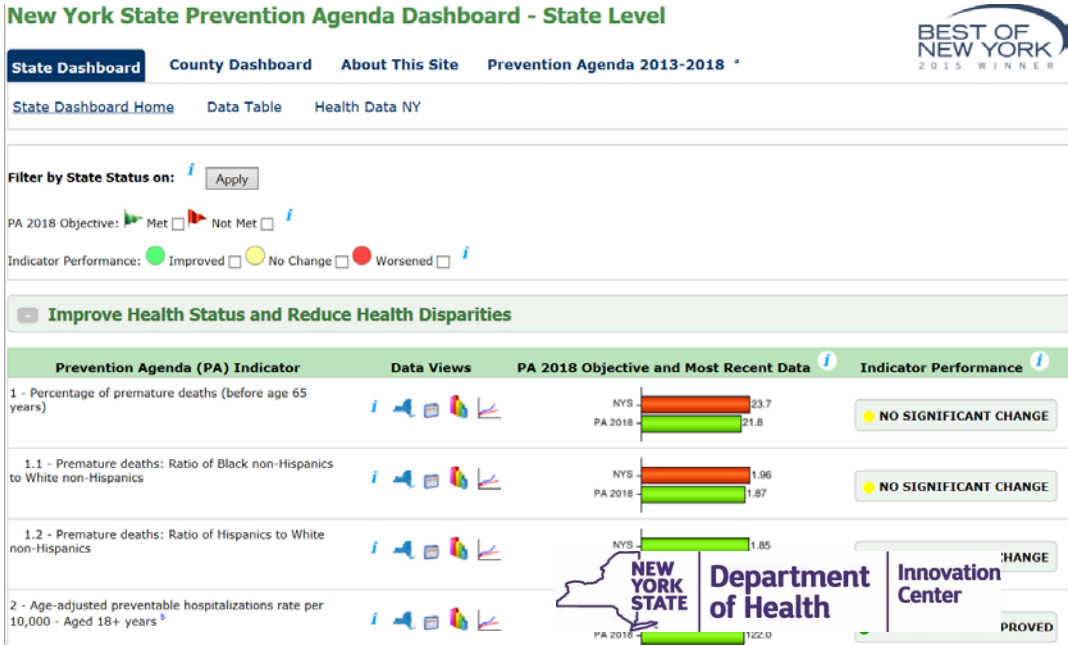
- Call to action to broad range of stakeholders to collaborate at the community level to assess local health status and needs; identify local health priorities; and plan, implement and evaluate strategies for community health improvement

Progress on Outcome Objectives

Prevention Agenda Dashboard measures progress on 96 statewide outcome indicators including reductions in health disparities.

As of October 2016:

- 24 of the objectives were met
- 19 indicators show progress (15 with significant improvement)
- 37 not met and staying the same
- 10 not met and going in wrong direction
- Of 29 objectives tracking health disparities, making progress on 6



Linking Interventions For Total Population Health (LIFT Population Health)

- RFA with total annual SIM funding of approximately $1,000,000
- Up to five awards
- Activities to be aligned locally with work being conducted by other initiatives in NYS (e.g., SIM, DSRIP, Prevention Agenda, PHIP, and other state and CDC-funded initiatives)
- Timeline
  - August 5, 2016 – RFA released
  - September 30, 2016 - Applications due
  - December 2016/January 2017 – Awards made

LIFT Population Health Projects

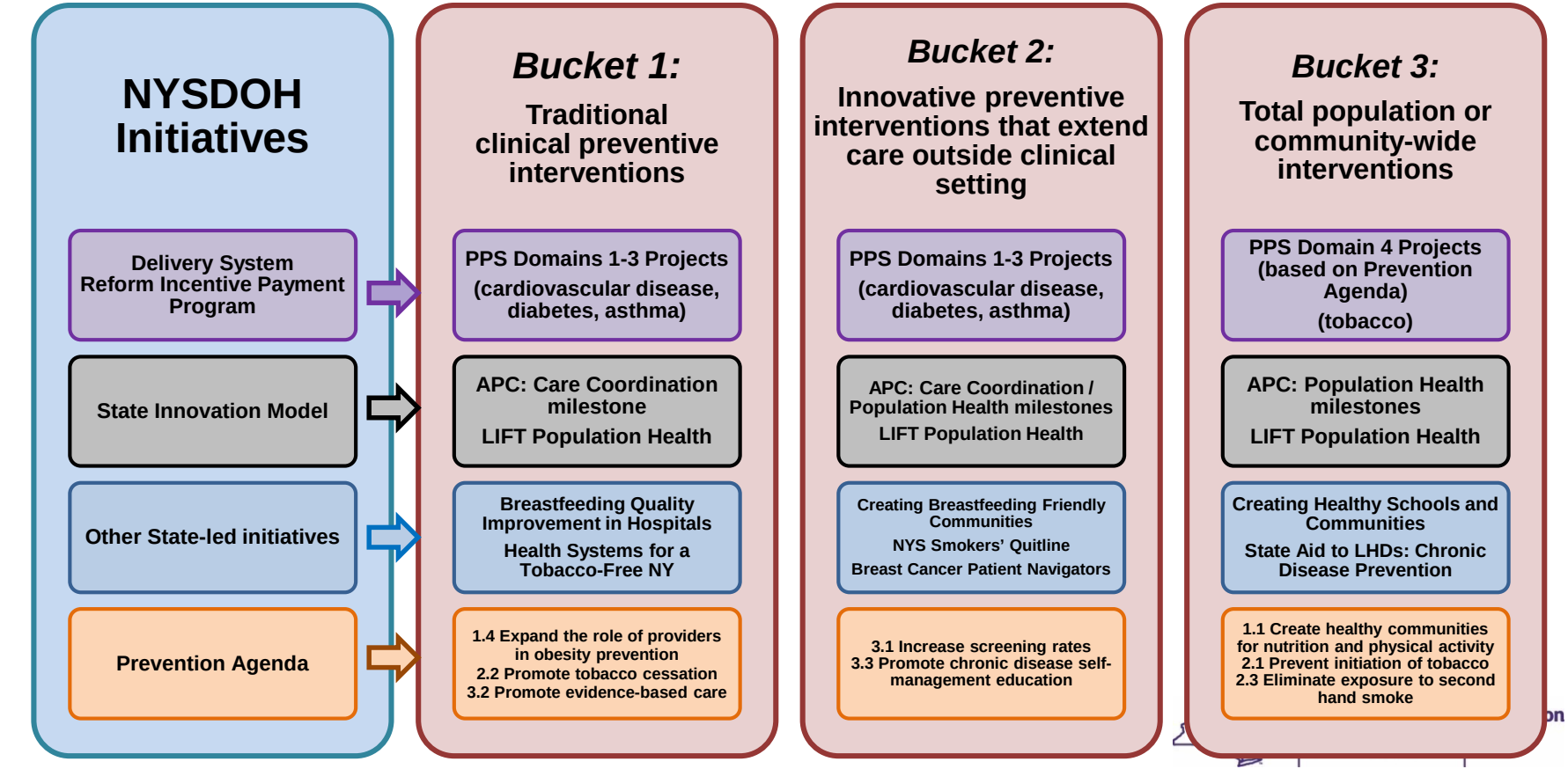
Communities will focus on one of the five issues related to the Prevent Chronic Disease priority area of the New York State Prevention Agenda 2013-18:

- Prevent and Control Obesity and Diabetes
- Prevent and Reduce Tobacco Use
- Prevent Cardiovascular Disease and Control High Blood Pressure
- Reduce and Control Asthma
- Prevent and Detect Cancer

Awardees will develop portfolio of interventions across three categories or “buckets”

- Traditional Clinical Prevention (10% of effort)
- Innovative Clinical Prevention (30% of effort)
- Total Population or Community-Wide Prevention (60% of effort)

Alignment of NYSDOH Prevention Activities* Across DOH Initiatives by Bucket of Prevention



* The list of activities is not comprehensive, but illustrative, with a focus on chronic disease prevention. October 2016.

Advanced Primary Care (APC): Prevention and Population Health Milestones

- Identification and outreach to patients due for preventive or chronic care management
- Process to refer patients to self-management programs and community-based resources
- Participate in at least two Prevention Agenda activities annually in conjunction with county health department

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Questions and Discussion

Final Comments and Closing