NEW YORK STATE OF OPPORTUNITY. Department of Health

SHIP/DSRIP Workforce Workgroup

Meeting # 3

November 20, 2015

Welcome and Introductions

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:00 – 10:10	Patrick Coonan & Wade Norwood, Co-Chairs
2	Review Agenda and Meeting Goals	10:10 – 10:20	Co-chairs
3	Priority Areas of Focus for Workgroup 1. Development 2. Member Survey Results 3. Comments/Discussion	10:20 – 10:50	 1. Thomas Burke 2. Jean Moore 3. Co-chairs
4	Update on MRT Recommendations	10:50 – 11:05	Lisa Ullman
5	SIM Funded Rural Residency Program	11:05 – 11:20	Thomas Burke
6	Telehealth – Workforce Opportunities in NYS	11:20 – 11:35	Rae Ann Augliera
7	Sub-Workgroups on Care Coordination & Training	11:35 – 11:55	Ed McNamara & Jean Moore
8	DSRIP – Compensation and Benefits Analysis	11:55 – 12:00	Ed McNamara
9	Open Discussion and Next Steps	12:00 – 1:00	All

Priority Areas of Focus

Emerging Priority Areas of Focus

1. Ensure sufficient primary care workforce
2. Better distribute primary care workforce to areas of need
3. Making most effective use of the health care workforce under the new model
4. Improving the supply and effectiveness of behavioral health workforce
5. Train workforce for team-based care
6. Shift mindsets among the health care workforce
7. Improve data collection

Ranking of Priority Goals

Goal	Priority Ranking by Number of Respondents					Mean Score
	5 (High)	4	3	2	1 (Low)	
Goal 4: Promote the ability of New York's health workforce to function effectively in and help support emerging models of care and changes in the health care delivery system.	18	6	1	0	1	4.54
Goal 1a. Promote development of a sufficient supply of primary care providers	16	6	2	1	1	4.35
Goal 3: Enhance the effectiveness of the current workforce	14	6	0	2	1	4.30
Goal 1b. Promote development of a sufficient supply of behavioral health providers	15	6	3	1	1	4.27
Goal 2b. Address the maldistribution of providers to deliver behavioral health services	12	8	2	0	3	4.04
Goal 2a. Address the maldistribution of providers to deliver primary care	11	8	3	0	3	3.96

Member Survey Results

Goal 1: Promote development of a sufficient supply of primary care and behavioral health providers

Ranked List of Strategies to Address Goal 1

- Use pipeline programs to encourage students from underserved areas to pursue careers in behavioral health. **14**
- Use pipeline programs to encourage students from underserved areas to pursue careers in primary care. **12**
- Improve health workforce data collection in the state. **9**
- Other **10**

Member Survey Results

Goal 2: Address the maldistribution of providers to deliver primary care and behavioral health services

Ranked List of Strategies to Address Goal 2

- Use Doctors Across New York, the Primary Health Service Corps and other provider incentive programs to recruit clinicians to practice in underserved communities. **15**
- Promote use of telehealth to expand access to needed health and behavioral health services. **13**
- Improve health workforce data collection in the state. **7**
- Other. **9**

Member Survey Results

Goal 3: Enhance the effectiveness of the current workforce

Ranked List of Strategies to Address Goal 3

• Support flexibility in health professions rules to allow health workers to perform tasks for which they have been trained to do and are competent to perform. **14**

• Support flexibility in health professions rules to allow behavioral health workers to perform tasks for which they have been trained to do and are competent to perform. **12**

• Develop core competencies and/or training standards for workers in care coordination titles. **11**

• Other. **6**

Member Survey Results

Goal 4: Promote the ability of New York's health workforce to function effectively in and help support emerging models of care and changes in the health care delivery system

Ranked List of Strategies to Address Goal 4

• Identify and share information on provider 'best practices' in emerging care delivery models that have positive impacts on outcomes of care. **12**

• Train the current health workforce and health professions students in team based models of care. **12**

• Train the current health workforce and health professions students in emerging health care concepts and functions including, for example, care coordination, population health and data analytics. **10**

• Encourage inter-professional education and training, particularly among students who are likely to work in primary care practices once they complete training. **8**

• Other. **4**

MRT Workforce Work Group Update

MRT Workforce Work Group

The Medicaid Redesign Team's Workforce Flexibility and Scope of Practice Work Group (MRT Workforce Work Group) issued a report setting forth recommendations related to:

- Advisory Committee (MRT # 5501)
- Advanced Aides (MRT # 5502A)
- Advanced Home Care Aide Certification (MRT # 5502B)
- Collaborative Practice for Nurse Practitioners (MRT # 5502C)
- Practice of Dental Hygienists (MRT # 5502D)

MRT Workforce Work Group (continued)

- Supervisory Provisions for Physician Assistants (MRT # 5502E)
- Children's Dental Health Certificates (MRT # 5502F)
- Standing Orders (MRT # 5503A)
- Physician Home Visits (MRT # 5503B)
- Stackable Certifications for Direct Care Workers (MRT # 5503C)
- New York State Primary Care Service Corps (MRT # 5504)
- Exempt License Requirement for Certain Titles (MRT # 5505)
- Promote Programs such as CDPAP (MRT # 5506)

Rural Residency Program

Rural Residency Program

- Goal/Objectives – increase number of primary care physicians practicing in rural communities to support the SHIP through creation of new primary care residency programs in rural communities
- SIM – provides seed-funding to assist health care organizations to invest in the creation of residency programs that will be accredited by the end of the grant period
- Funding through a Request for Application (RFA) process – matched by organizational/community support:
  - program staff
  - costs to become accredited
  - curriculum development
  - recruitment costs
  - the development of affiliation agreements with providers

Rural Residency Program (continued)

- Organizations will develop new programs or expand existing programs in new rural communities
- Identify a potential sponsor and hospital(s) for inpatient rotations
- Include community-based ambulatory care training sites
  - Diagnostic and Treatment Centers
  - Physician Practices
  - Local Health Departments
- Focus recruitment efforts on students/residents from rural communities

New York's Telehealth Parity Law

Growth of Telehealth in Health Care Delivery

- Growing population
- Provider shortages
- Increase of older, home-bound, physically-challenged individuals coping with chronic diseases
- Lack of access to medical services in rural and geographically isolated areas
- Explosion in computer-based technology
- Consumer population at ease with computer-based/electronic transactions

(Balancing Access, Safety and Quality in a New Era of Telemedicine, Federation of State Medical Boards, 2011*)*

Benefits of Telehealth

For Providers:

- Addresses workforce maldistribution issues
- Reduces isolation experienced by providers
- Makes subspecialty decision support readily available
- Makes more effective use of limited specialist time
- Allows for better coordination of care across the health care continuum
- Can prevent unnecessary ED visits, hospital admissions, and readmissions

For Patients:

- Improved access to primary and specialty care
- Care delivery can be more patient-centered
- Reduces or eliminates geographic and socioeconomic barriers
- Diminished wait times and travel time
- Timelier care

Telehealth in New York State

- Many successful initiatives are currently in place
- Interest and momentum are building
- Implementation barriers still exist

Current Medicaid Telehealth Coverage

- Telemedicine has been covered by FFS Medicaid in specific settings and by specific provider types since September 2006
  - Coverage was expanded in February 2010, October 2011 and most recently in March 2015
  - Coverage is provided for telemedicine (live, interactive, audio-visual communication) only
  - Policy applies to Medicaid FFS; MMC plans can cover telemedicine at their option
- Home telehealth reimbursement was authorized under PHL §3614-3(c) in 2008 for certified home health agencies and long term home health care programs

Telehealth Parity Law

- New York became the 22nd state to pass telehealth reimbursement parity legislation
  - Chapter 550 of the Laws of 2014, as amended by Chapter 6 of the Laws of 2015, signed by Governor Cuomo in March 2015
  - Requires commercial insurers and the Medicaid program to provide reimbursement for services delivered via telehealth if those services would have been covered if delivered in person
  - Amends Public Health Law (PHL), Social Services Law (SSL), and Insurance Law
  - Effective January 1, 2016

Changes to Public Health Law

- Adds a new PHL Article 29-G – “Telehealth Delivery of Services”
  - Provides clear definitions to serve as a foundation for telehealth practice in New York State (PHL § 2999-cc)
  - Authorizes reimbursement under Section 367-u of SSL (PHL § 2999-dd)

Telehealth Definition

- **Telehealth** is defined as “the use of electronic information and communication technologies to deliver health care to patients at a distance, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient.”

Telehealth Definition

- Telehealth is limited to:
  - Telemedicine
  - Store-and-forward
  - Remote patient monitoring
- Telehealth excludes audio-only, fax-only, and email-only transmissions

Telemedicine Definition

- **Telemedicine** is defined as “the use of synchronous two-way electronic audio visual communications to deliver clinical health care services which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site.”
  - Distant site – location of the telehealth provider
  - Originating site – location of the patient

Store-and-Forward Definition

- **Store-and-forward** is defined as “asynchronous, electronic transmission of a patient’s health information in the form of patient-specific digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site.”

Remote Patient Monitoring (RPM) Definition

- **Remote patient monitoring** is defined as “the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a person at an originating site that is transmitted to a telehealth provider at a distant site for use in treatment and management of medical conditions that require frequent monitoring.”

Telehealth Provider Definition

- Providers eligible for reimbursement include:
  - Physician
  - Physician Assistant
  - Dentist
  - Nurse Practitioner
  - Podiatrist
  - Optometrist
  - Psychologist
  - Social Worker
  - Speech Pathologist
  - Audiologist
  - Midwife
  - Certified Diabetes Educator
  - Certified Asthma Educator
  - Genetic Counselor
  - Hospital
  - Home Care
  - Hospice
  - Registered Nurse, only when receiving data by means of RPM
  - Any other provider as determined by the Commissioner pursuant to regulation

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Distant Site Definition

- **Distant site** is defined as “a site at which a telehealth provider is located while delivering health care services by means of telehealth.”

Originating Site Definition

- **Originating site** is defined as “a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth.”
- Eligible originating sites include:
  - PHL Article 28 facilities
  - PHL Article 40 facilities
  - Mental hygiene facilities
  - Private physician’s offices
  - Patient’s place of residence when a patient is receiving services by means of remote patient monitoring

Changes to Social Services Law

- Sections 367-u of Social Services Law was amended to read:
  - “Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the deliver of health care services through telehealth as defined in subdivision four of §2999-cc of the Public Health Law. Such services shall meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title.”

Changes to Insurance Law

- Adds new Insurance Law § 3217-h, § 4306-g, § 4406-g – “Telehealth Delivery of Services” provisions:
  - “An insurer shall not exclude from coverage a service that is otherwise covered under a policy… because the service is delivered via telehealth…”
  - “…An insurer may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy.”

Changes to Insurance Law

- **Telehealth** definition:
  - “The use of electronic and information and communication technologies by a health care provider to deliver health care services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located.”

	Current Medicaid Policy (as of March 2015)	Parity Law also includes (Effective January 2016)
Eligible modalities	Telemedicine (live, interactive audio-visual communication) Home telehealth (as authorized under PHL §3614-3(c)	Remote patient monitoring (RPM) Store-and-forward
Eligible "hub" sites (distant site/ location of consulting practitioner)	• Article 28 Hospitals • Article 28 Diagnostic & Treatment Centers (D&TCs) • Article 28 Facilities Providing Dental Services • Federally Qualified Health Centers (FQHCs) that have "opted into" APGs • Office of Mental Health facilities • Practitioner Offices	• Article 36 Home Care Services Agencies • Article 40 Hospices
Eligible "spoke" sites (originating site/ location of patient)	• Article 28 Hospitals • Article 28 Diagnostic & Treatment Centers (D&TCs) • Article 28 Facilities Providing Dental Services • Federally Qualified Health Centers (FQHCs) • Non-FQHC School Based Health Centers (SBHCs) • Office of Mental Health facilities • Practitioner Offices	• Article 40 Hospices • A patient's place of residence, when receiving remote patient monitoring services
Eligible "hub" site practitioners	• Physician Specialists (including Psychiatrists) • Certified Diabetes Educators (CDEs) • Certified Asthma Educators (CAEs or A-ECs) • Genetic Counselors Psychiatric Nurses Practitioners • Clinical Psychologists • Dentists • Licensed Clinical Social Workers (LCSWs) and Licensed Master Social Workers (LMSWs) employed by an Article 28 clinic (current coverage policy applies)	• Physicians • Physician Assistants • Nurse Practitioners • Podiatrists • Optometrists • Speech Language Pathologists • Audiologists • Midwives • Other providers as determined by the Commissioner • Registered nurse (for use of RPM only)

Implementation

- Regulations related to the Telehealth Parity Law are under development
- The Department of Health website will be updated with information, resources, and FAQs related to telehealth reimbursement and other telehealth implementation issues
- Questions from providers can be directed to telehealth@health.ny.gov

Care Coordination

Detailed Steps for Care Coordination

Category	Activities
A Patient registry/ Member identification	1. Select data feeds 2. Data warehousing (structured database) 3. Data hosting (server capacity) 4. Select data feed and methodology 5. Perform data analysis 6. Identify individuals for enrollment in programs
B Enrollment	1. Define enrollment protocol template/script and skill requirements 2. Contact patients (house call center) 3. Input enrolled patients into system
C Risk stratification/ Assessment	1. Define assessment template/script and skill requirements 2. Schedule assessment with individual patients 3. Perform assessments in person 4. Perform assessments telephonically 5. Submit assessment output into system
D Care Plan development	1. Select relevant care planning template 2. Gather clinical input on proposed care plan 3. Share proposed care plan with patient, finalize, and enter into system
E Guidance	1. Assemble directory of service providers 2. Schedule appointments as per care plan
F Care delivery	1. Track care plan completion 2. Adjust care plan as needed

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DSRIP Workforce Update

Compensation & Benefits Survey

- Compensation & Benefits workgroup convened to identify common data reporting element for compensation and benefits that would allow aggregation of data to regional level for collaborative planning and analyses
- Guidance being developed for PPS distribution that specifies data elements and other clarifications
- Guidance also includes additional data fields for emerging titles category of non-licensed care coordinators to survey educational requirements
- Due date for review of completion of surveys and workforce strategy roadmap reviewed by PPS Governance has been shifted to DY2 Q1 (April-June 2015)

Compensation & Benefits Survey

- The following are required data elements for measuring and reporting Compensation & Benefits:
  - Number employees
  - Number vacancies / intend to fill
  - Compensation rate (mean, median, 25th & 75th percentile)
  - Benefits as a percentage of compensation
  - Collective Bargaining Agreement (CBA) status
  - For only the “Non-licensed Care Coordination” category:
    - Specify any minimum degree requirement
- For each Job Title, PPSs will report in aggregate across all organizations as well as for each Facility Type

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Workforce Transformation

Workforce Transformation

Current state

- **Siloed care delivery model**: Inconsistent collaboration across different professional types; physicians are individually accountable for patients
- **Inconsistent care coordination**: small percentage of patients with chronic conditions receive care coordination; poor execution of coordination/communication between different patient caregivers
- **Frequent use of high-cost, acute care settings**: Many individuals use acute care settings as primary source of care and may not see PCP regularly

Future state

- **Team-based care delivery model**: physician leads multi-disciplinary team jointly accountable for patients
- **Appropriate care coordination**: patients with complex chronic conditions have dedicated care coordination; patients with minor conditions receive necessary coordination; care coordinators facilitate all necessary communication between all patient caregivers
- **Reduced ER usage**: PCPs act as primary source of care; improved primary care and management of complex chronic conditions reduces ER usage

Implications

- More engagement with the primary care system, fewer encounters with high-resource acute care settings
- Physicians tailor the amount of time and resources spent per patient to patient need; shift in tasks from physicians to other care team members
- More care coordinators required; some burden of care shifts from other care professionals to care coordinators

Workforce Transformation Tools

- Better leverage available workforce development resources including:
  - Doctors Across NY Loan Repayment and Practice Support
  - DSRIP WF Training Funding
  - Primary Health Services Corps
  - Health Workforce Retraining Initiative
  - Right Health Professionals in the Right Places
- Identify and highlight best practices in strategies to transition from acute care to ambulatory care
- Identify core competencies and core curriculum in care coordination

Closing

Next Steps