



INTEGRATED CARE WORKGROUP

Meeting #3

March 30, 2015

#	Topic	Time	Leader
1	Welcome and Introductions	10:00 – 10:10	Foster Gesten, MD
2	Ground Rules recap	10:10 – 10:20	Susan Stuard
3	Recap of last meeting	10:20 – 10:30	Susan Stuard
4	Context and Re-Orientation	10:30 – 10:50	Foster Gesten MD
5	A Different Paradigm	10:50 – 11:00	John Rugge, MD
6	The APC Straw-Person – Revised	11:00 – 12:00	Susan Stuard Foster Gesten, MD Marietta Angelotti, MD
	Break	12:00 – 12:15	
7	Working lunch: Straw-Person Discussion	12:15 – 1:40	All
8	Upcoming topics: (a) Population Health (b) Stakeholder Engagement (c) Payment (d) Practice Transformation RFP (e) Measurement	1:40 – 2:00	Sylvia Pirani Laurel Pickering John Powell Foster Gesten, MD

Past slides posted online:

https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm



Welcome and Introductions

Ground Rules Redux

RULES OF THE ROAD

1. Come to the meeting with a positive attitude.
2. Treat members with respect.
3. Be prompt arriving to the meeting and returning from breaks.
4. Turn cell phones off or to vibrate.
5. If you must take urgent calls, take your conversation outside.
6. Talk one at a time, waiting to be recognized by the Chairpersons.
7. Limit side conversations.
8. Stay on the topic being discussed.
9. Address any concerns about the discussion or the meeting with the Chairpersons.

Integrated Care Workgroup Charge

A. Define Advanced Primary Care (APC)

- Discuss APC model 'straw person' and refine through discussion
- Identify legislative or regulatory requirements, if any, for adoption
- Begin discussion of standardized measure set
- Adopt APC model requirements

B. Figure out how to pay for APC

- Initiate reimbursement model discussions
- Define value proposition
- Review/align payment models for freestanding and system-based practices
- Adopt APC model for implementation, including proposed payment models

C. Spread APC

- Discuss/recommend practice transformation core curriculum
- Discuss/recommend practice readiness tool and process
- Discuss/recommend RFP for practice transformation support (SIM \$)
- Convene regional meetings to discuss/refine APC, including payment model

D. Track APC

- Review initial six months of data to inform progress
- Revise and evolve delivery and payment systems as needed

Recap of Last Meeting

Meeting #2 Recap: Major Themes

- **Practice size** must be carefully considered
- Identification of **systemic deficiencies** will help define important model characteristics
- **Regulatory relief** may be necessary to assure care integration
- **Communications between primary care providers and specialists** must be addressed
- **Special populations** may require special considerations
- **Standards** must be aligned (providers and payers)
- **Health information technology** is key - resources must be made available to all
- Current **mosaic of quality measures** is frustrating

Meeting #2 Recap: Major Themes

- **There must be a compelling reason(s)** for a practice to embark on this journey.
- **Ability of primary care to deliver stated objectives** must be carefully evaluated with respect to:
 - Reducing avoidable utilization
 - Promoting improved health outcomes
- There is a need to further define:
 - Engagement of the primary care team
 - Data availability
 - Ability of providers to integrate behavioral health/population health
 - Availability of care managers and care coordinators
 - Ability to connect with specialists
 - Patient engagement
 - Payer engagement

Context and Reorientation

What are we solving for?

- Need to move from demonstration to implementation
 - CPC and MAPCP are geographically and time limited – what happens next?
 - Template for multi-payer/multi-stakeholder standards and payment approach needed
 - ‘reinventing’ for each region, program, and payer/provider is resource intensive and potentially unnecessary, confusing, inefficient
- Lack of standardization prevents:
 - Payers from knowing what they are paying for
 - Providers from knowing what is expected
- Why not just use NCQA levels or CPC?
 - Branded vs generic
 - Desire to eliminate all that is not essential (finite resources)
 - Current levels not designed to link with payment

What is the vision?

Develop a single standardized architecture that includes those elements deemed most effective in:

- Meeting overarching goals and objectives (think Triple Aim); and
- Defining a model that:
 - payers want to pay for;
 - providers think is both valuable and practical; and
 - patients/families find meaningful.

Nice vision....used how?

- As a common 'template'
 - for regional multipayer/multiprovider initiatives to implement care/payment reform
- Enables local initiatives to focus on the logistics
 - 'how', 'who', 'when', instead of the 'what'
- Defines goals of 'transformation' for grants and other investments

Some Lessons Learned: New York State

- **Health Information Technology:** Health IT necessary and must be included in all APC stages.
- **Practice Transformation:**
 - Who should pay for what?
 - SIM resources should be used to support initial practice transformation costs
 - Payment reform should cover ongoing costs
 - Who should deliver it, and how?
 - Regional “primary care extension center” model (like TCPI/PTN)
 - Experienced, expert trainers
 - A train-the-trainer model is recommended so those experienced at practice transformation can help others
 - Those providing practice transformation support should be expected to:
 - Conduct an initial practice assessment
 - Routinely assess progress
 - Share data to encourage continuous improvement
- **Payment:** Payers must be engaged.
 - Upfront payments are critical to support transformation
 - Payment incentives must be aligned to promote desired goals and objectives

Participants: Adirondacks ACO, NYCDOHMH; Finger Lakes Health Systems Agency; Empire BCBS; SUNY Buffalo; P2 Collaborative; Chautauqua County Health Network; Taconic IPA; Hudson Headwaters Health Network; THINC; and PCIP/NYC Reach.



APC 'next gen' needs to:

- Strengthen the link between:
 - Achieving a 'standard' and
 - Achieving measurable improvement in practice performance on quality, cost, and patient experience;
- Increase practice engagement while reducing non-value added work;
- Leverage practices' investment in health information technology to help support patient care and panel management; and
- Align APC standards with other reporting requirements.

Why would physicians respond to APC?

- To generate payment for infrastructure and activities that help their patients, but are not paid for today
 - Care management and Behavioral Health
- To elevate the role of primary care providers within the delivery system
- To provide value to ACO, employer, PPS
- If 'critical mass' of payers use alternate payment models, can they ignore?
 - Medicaid PCMH incentive
- Over a third already have (PCMH or CPC or other projects/demo)

Why would payers support?

- Standardization helps reduce costs/burden of implementation across regions
- Aligns with their goals regarding care/payment reform
- Multi-payer engagement:
 - Reduces individual investment required
 - Increases likelihood of provider engagement
- DFS, Medicaid, Medicare focus on value based payments
 - Can they ignore?

NYS Payers Now: Already Engaged in Payment Reform

DFS Survey (published July 2014) found:

- **Variability.** All major insurers had value-based payment (VBP) programs. But they are independent with inconsistent progress.
- **Few Providers Impacted.** Just 15% of participating providers were in VBP.
- **Few Consumers Impacted.** Just 12% of insurers' members were in VBP.
- **Most Payments Still on FFS Basis.** Most insurers' VBP (80%) make value-based or care coordination payments *in addition to* FFS payments.
- **Pay-for-Performance (P4P) Predominates.** Almost half of VBP are "Pay-for-Performance" models.
- **Some Evidence of Savings, But Most Yet to Be Measured.**
- **Primary Care Focused – Foundation is there for APC Payment Reform.** Most of VBP models involve primary care. Specialists, hospitals, non-physician services and emergency room (ER) to a lesser degree. Lab and radiology services the least.

Source: DFS Report (<http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf>)



AND...

- APC tiers: Do we need three?
 - Role of 'pre-' as defining eligibility for transformation support?
 - Does APC and APC 'premium' really define requirements to succeed (or payer willingness to entertain) in global cap/risk arrangement?
- Who/what 'assures' that these standards are met?
 - Role of self-assessment with verification
 - Trust but verify
 - Role of data
 - Local 'faculty' (CPC)
 - Transformation organizations

The Integrated Care Workgroup

ADVANCED PRIMARY CARE
STRAW-PERSON OVERVIEW AND
DISCUSSION

Advanced Primary Care Straw-Person: Version 2.0

Lens for Discussion of APC Straw Model

- In today's discussion of the APC Straw Model, we need you to put on your consumer, provider and payer hats
 - Consumer: gut check of are these APC items meaningful to patients
 - Provider: are these APC items within “the possible” for primary care and are they worthwhile
 - Payer: are these APC items aligned to drive value in terms of quality, cost, etc.

APC Straw-Person – v 2.0 (1 of 4)

PRE APC	APC	PREMIUM APC
1. CARE MANAGEMENT FOR HIGH RISK PATIENTS a. Identify high risk patients who would benefit from care management and prepare care plans.	1. CARE MANAGEMENT FOR HIGH RISK PATIENTS a. Identify and monitor clinical and claims information to identify and provide care management (TBD) for at least 75% of those patients determined to be at highest risk. b. Document electronic medication reconciliation for patients transitioning from institutional care sites. c. Provide behavioral health assessment, depression and substance abuse screening and referrals.	1. CARE MANAGEMENT FOR HIGH RISK PATIENTS a. Assess clinical risk and provide care management services to all patients at highest risk. b. Provide behavioral health assessment, depression and substance abuse screening and referrals. c. Provide core elements of collaborative care model for depression and screening and management, including data collection and tracking. d. Integrate practice care management with Medicaid health home and health plan care managers for eligible patients. e. Document electronic medication reconciliation for patients transitioning from institutional care sites.
2. PATIENT ACCESS TO CARE a. Provision of 24/7 same day patient access to nurse or other clinician.	2. PATIENT ACCESS TO CARE a. 24/7 patient access to nurse or other clinician including reliable access to EHR after hours. b. Provide and assess performance on provision of routine and same day appointments. c. Provides at least one method of <i>asynchronous communication</i> between patient and provider with commitment to explicit response time goal.	2. PATIENT ACCESS TO CARE a. 24/7 patient access to nurse or other clinician including reliable access to EHR after hours. b. Provides “open access” for routine and urgent inclusive of same day appointments and assess performance on this access. c. Provides at least one method of asynchronous communication between patient and provider with commitment to explicit response time goal. d. Measures and reports on continuity between patient and provider, as well as between provider and provider.

APC Straw-Person – v 2.0 (2 of 4)

PRE APC	APC	PREMIUM APC
3. PATIENT EXPERIENCE a. Conduct annual patient survey and/or; b. Include patient or family member as part of practice governance structure.	3. PATIENT EXPERIENCE a. Conduct at least semi-annual patient survey and show evidence of incorporation of survey results as part of QI plan. b. Implement processes to evaluate and promote patient engagement.	3. PATIENT EXPERIENCE a. Conduct at least quarterly patient surveys to evaluate and promote patient engagement and show evidence of incorporation of survey results as part of QI efforts b. Report survey results to patients, payers or both.
4. QUALITY IMPROVEMENT a. Evaluate practice performance using a set of standardized quality metrics (HEDIS, QARR etc. that includes at least three NQF quality measures.	4. QUALITY IMPROVEMENT a. Measure and report at least six NQF measures (including at least one behavioral health); set goals for each and incorporate results as part of a formal QI process. (At least half of measures should be from EHR. b. Actively identify patient populations due for preventive or chronic care management services and communicate reminders.	4. QUALITY IMPROVEMENT a. Measure and report at least six NQF measures; set goals for each, incorporate results as part of a formal QI process and show improvement on specific measures. <ul style="list-style-type: none"> • At least half of measures should be from EHR and make use of CQM data. • Report results of at least one measure to patients, payers or both. b. Identify, more than once annually, those populations due for preventive or chronic care management services and communicate reminders.

APC Straw-Person – v 2.0 (3 of 4)

PRE APC	APC	PREMIUM APC
5. CARE COORDINATION a. System in place or in development to track referrals and follow up uncompleted referrals or reports as necessary.	5. CARE COORDINATION a. Track referrals and reports and have processes to address uncompleted referrals or reports. b. Have care compacts or collaborative agreements with at least 2 groups of high volume specialists (including behavioral health) to improve transitions in care. c. Have systems in place to identify and contact patients seen in an ED or hospital discharges.	5. CARE COORDINATION a. Track referrals and both completed and uncompleted referrals and reports. b. Have care compacts/collaborative agreements in place with at least 2 groups of high volume specialists (inclusive of behavioral health) to improve transitions in care. c. Has system in place to identify and contact patients seen in an ED or discharged from a hospital, measure the effectiveness of these efforts and implement QI efforts as needed.
6. SHARED DECISION MAKING a. Development of care plans in concert with patient preferences and goals.	6. SHARED DECISION MAKING a. Development of care plans for high risk patients that incorporate patient preferences and goals and communicate these plans in writing to the patient or caregiver. b. Documentation of advanced directives or patient declination to discuss.	6. SHARED DECISION MAKING a. Development of care plans for all patients that incorporate patient preferences and goals and communicates these plans in writing to the patient or caregiver. b. Documentation of advanced directives or patient declination to discuss.
7. LOCAL/DISTANCE LEARNING COLLABORATIVES a. Participation by PCP and/or care team in on-site or distance learning including APC education and training programs.	7. LOCAL/DISTANCE LEARNING COLLABORATIVES a. Participation by PCP and/or care team in on-site or distance learning through meetings and webinars including at least one face-to-face meeting.	7. LOCAL/DISTANCE LEARNING COLLABORATIVES a. Participation by PCP and/or care team in local or distance learning collaboratives (meetings or webinars) including at least one face-to-face meeting.

APC Straw-Person – v 2.0 (4 of 4)

PRE APC	APC	PREMIUM APC
8. HEALTH INFORMATION TECHNOLOGY	8. HEALTH INFORMATION TECHNOLOGY	8. HEALTH INFORMATION TECHNOLOGY
<ul style="list-style-type: none"> a. Willing to attest to Meaningful Use Stage 1 within one year. b. Signed contract with EHR vendor. 	<ul style="list-style-type: none"> a. Meaningful Use Stage 1. b. Connected to local RHIO or has plans to connect with six months. c. ePrescribing 	<ul style="list-style-type: none"> a. Meets all MU Stage 2 requirements. b. Working towards MU Stage 3. c. Connected to local RHIOs and uses data for patient care activities. d. ePrescribing
9. PARTICIPATION AGREEMENT	9. PARTICIPATION AGREEMENT	9. PARTICIPATION AGREEMENT
<ul style="list-style-type: none"> a. Completion of a standardized self-assessment tool and on-site audit to evaluate readiness for/interest in change. b. Commits to meeting APC standards within 1-2 years. c. Sponsorship for education and training support is available. d. Up-to-date board certification. 	<ul style="list-style-type: none"> a. Uses standardized self-assessment tool and on site audit to evaluate current capacities and readiness for change. b. Proof of transformation sponsorship. c. Up to date board certification. 	<ul style="list-style-type: none"> a. Uses standardized self-assessment tool and on site audit to evaluate current capacities and readiness for change.
10. PAYMENT MODEL	10. PAYMENT MODEL	10. PAYMENT MODEL
<ul style="list-style-type: none"> a. Interested/able to participate in alternative payment model(s). 	<ul style="list-style-type: none"> a. Negotiates alternative payment model (s) with interested payers. 	<ul style="list-style-type: none"> a. Negotiates alternative payment model(s) beyond FFS with interested payers with goal to impact at least 50% of covered lives in the practice.

Discussion

NEXT STEPS

Upcoming Topics

OVERVIEW OF NEXT TOPICS

Incorporating Population Health into Primary Care Transformation

SIM and APC will support Population Health By:

- Focusing on clinical preventive services that impact Prevention Agenda goals, such as:
 - Implementing evidence-based clinical guidelines for prevention and treatment of children and adults who are overweight and obese
 - Promoting guideline concordant tobacco treatment for persons with mental illness
 - Adopting Million Heart Strategies to increase hypertension control
- Strengthening linkages between clinical care, public health and community based organizations, such as:
 - Collaboration among all three sectors to retain persons with HIV/STD/Hep C in care
 - Public Health home visits to assess triggers and medication compliance for asthma patients
 - Incorporating fall risk screening for older adults and linking them to evidence based community based falls preventions programs such as Tai Chi, Moving for Better Balance, Stepping On.

Northeast Business Group on Health: Engaging Commercial Health Plans and Employers to Pay for APC

- Statewide webinar to present SIM initiative and APC Model
- Baseline survey of current APC payment activity
- Convene 8 regions; present APC Model
- Work with existing Collaboratives
- Discover current plan activity reimbursing for APC
- Reconcile actual and expected reimbursement strategy
- Feedback to “SIM Central”
- Back to regions; more reconciliation

Payment

- Value Based Payment (VBP) being discussed in different contexts:
 - Commercial payers: SIM, APC
 - Medicaid: DSRIP
 - Medicare
- Need to coordinate across payers
 - Defining VBP
 - Overall goals: increasing percentage of VBP coverage
 - Tracking progress towards goals: Catalyst for Payment Reform (CPR) survey

Resources

- **Two types of resources required:**
 - Investments in practice transformation support
 - One of the targets for SIM funding; more will be required
 - Payments to support/reward operations as an APC - transitional and ongoing operating costs of Infrastructure to meet standards
 - *For first 2-3 years, while gaining traction*
 - *Thereafter could dial-down, move to shared savings*
- **Principles**
 - Must align with movement from volume to value
 - Improved outcomes and reduced costs
 - Requires ‘critical mass’ of payers and alignment
 - May be different payment methods
 - Many payers have developed their own models, no “one true cross”
 - Payment may vary, depending on practice’s status
 - Freestanding practice, paid directly, or
 - Part of larger system, with ACO-like (e.g., shared savings) payment in place

Practice Transformation RFP

- Clear articulation of the ‘what’ (standards or desired practice capacities)
- Approach to prioritizing the ‘who’ is eligible (which practices?)
 - Avoiding duplication (of payment or efforts)
 - Prioritizing need coupled with likelihood of ‘success’
 - Defining how to assess ‘likelihood’
 - Defining ‘sponsorship’ functions
 - Role of payer alignment and support
- Approach to defining “by whom” and “how”
 - Who does the “practice transformation”?
 - What’s the curriculum (common, statewide?)
 - What and how should they get paid?

Measurement

- Measures for:
 - Success
 - Payment
 - Evaluation
 - Quality improvement
 - Public reporting
- The Crowded Measurement Field
 - PQRS
 - ACO
 - QARR/HEDIS
 - DSRIP/PPS
 - Private Payers
 - Meaningful Use CQMs