



**Department
of Health**

NYS Health Innovation Council

September 22 2015

Pre-decisional - Proprietary and Confidential

Agenda

	Timing	Topic	Lead
Introduction	10:00-10:20am	Welcome, framing of the day, and review of key programs to achieve the Triple Aim	Paul Francis/ Priscilla Almodovar/ Howard Zucker, MD, JD
Updates	10:20-10:45am	DSRIP Update	Jason Helgerson
	Workgroup updates and discussion:		
	10:45-11:25am	▪ Integrated Care	Foster Gesten, MD/ Troy Oechsner
	11:25-12:05pm	▪ Transparency, Evaluation and HIT	Patrick Roohan
	12:05-12:45pm	▪ Workforce	Wade Norwood
12:45-12:55pm	▪ Access	Joan Cleary-Miron	
Wrap up	12:55-1:00pm	Wrap up and next steps	Paul Francis/ Priscilla Almodovar/ Howard Zucker, MD, JD

Health Innovation Council: Charter

Mandate

- Frame a cohesive policy agenda to advance the **Triple Aim**
- Provide **guidance** on key **decision points** and potential **policy recommendations** developed by topical workgroups
- Consider and offer guidance to support the **consistency** of vision, mission, metrics and incentives **across key programs**

Duration

- Established 2015 to serve for 4 years

Meeting frequency

- 2015: May, September
- 2016-2020: Twice annually

Membership term

- Ongoing as appropriate

New York's participatory process

The initiatives discussed today have all engaged a wide array of external stakeholders:

- **Prevention Agenda:** Created through a collaborative effort that included leaders from healthcare, business, academia, CBOs, local health departments and multiple State agencies
- **DSRIP:** Recent learning symposium included 400 representatives from across 25 PPS'
- **SIM:** 4 External Stakeholder groups with an average of 35 external participants each (150 stakeholders); Ongoing engagement through regional stakeholder outreach

Changes in technology, behavior, business decisions and public policy all affect health care delivery

SELECT
EXAMPLES

HIT and Behavior change

- Self-management by chronically ill patients
- Shift of workforce to embrace team-based care
- PCP use of technology to enable care coordination
- Consumer use of transparency tools

Business decisions

- Investments in health information technology
- Investments in provider practice transformation
- Adoption of value-based payment
- Adoption of value-based insurance design

Public policy

- Policies to support healthy communities
- Standards for HIT interoperability, security
- Requirements for information transparency
- Common measures for quality and efficiency
- Standard role descriptions, training curricula

Innovation in support of The Triple Aim:

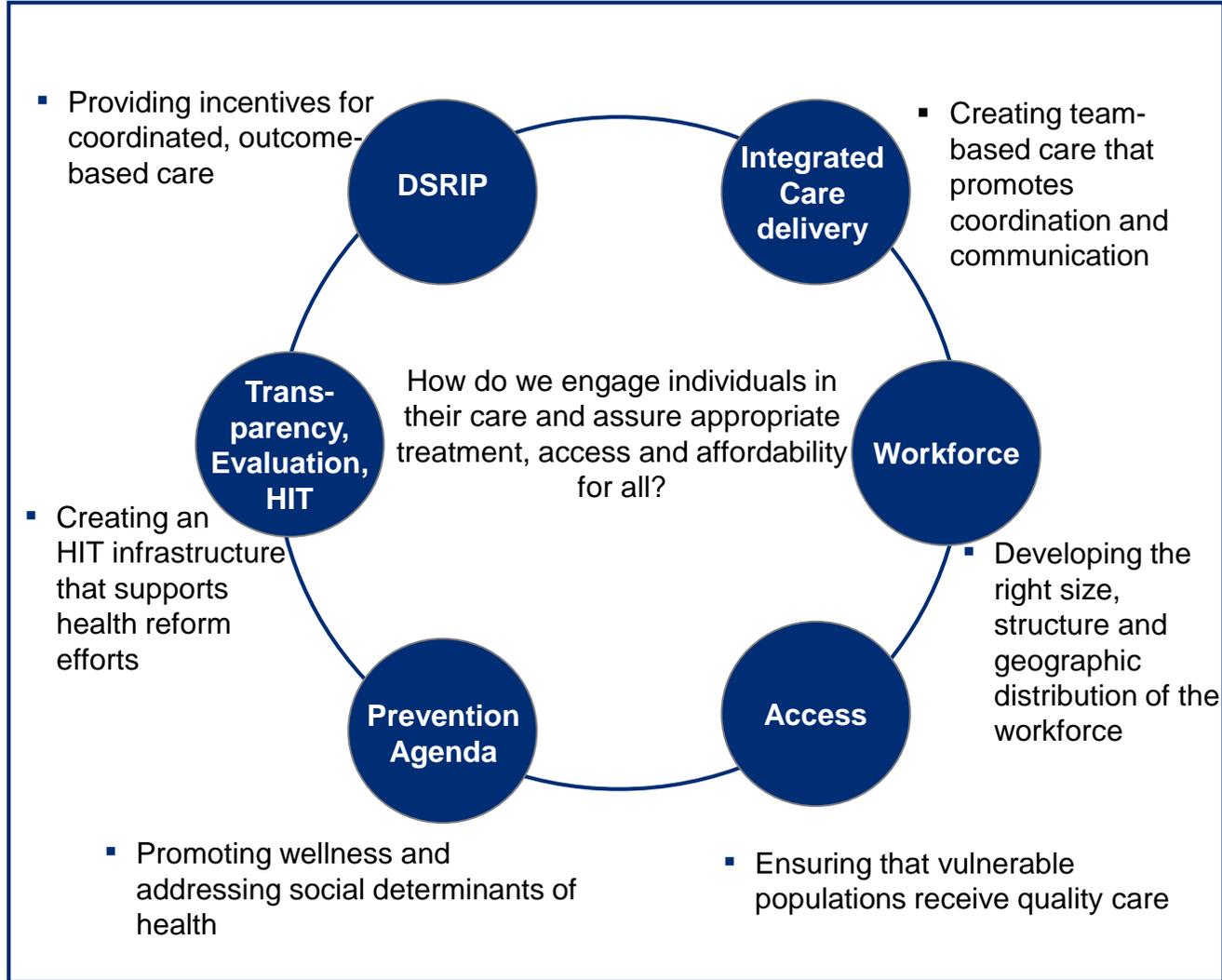
- Healthier people
- Better health and consumer experience
- Smarter spending

The SIM seeks alignment of policy initiatives that support health care innovation and reform

NOT EXHAUSTIVE

How can we ensure that the numerous initiatives in flight are able to advance the **Triple Aim**:

- **optimal health**
- **optimal care** (right care, right place, right time)
- **smarter spending**



We will discuss several emerging policy ideas today that will advance these interlocking initiatives

NOT EXHAUSTIVE

Achieving the Triple Aim ...



... requires interlocking programs and initiatives

DSRIP	<ul style="list-style-type: none"> Health Innovation through Medicaid Reform
Prevention Agenda	<ul style="list-style-type: none"> Population Health for All
Integrated care	<ul style="list-style-type: none"> Ensure all New Yorkers access to Advanced Primary Care
Workforce	<ul style="list-style-type: none"> Future care providers are well aligned with evolved care delivery systems
HIT	<ul style="list-style-type: none"> Promote access to timely actionable data for individuals, providers and payers
Access	<ul style="list-style-type: none"> Improve access to care for all New Yorkers without disparity

Emerging policy ideas

- Implementation of **value-based payment**
- Addressing Medicare alignment**
- Engage health care providers** to focus on:
 - Clinical preventive services
 - Community linkages and partnerships
 - Supporting policies and changes in the community to make them healthier
- Continue **refinement of the APC prototype**
- Explore State options to **facilitate payment innovation**
- Draft **RFP for practice transformation** technical assistance
- Develop **standard titles and competencies** for care coordinators and other emerging roles
- Build **career pathways** for direct care workers
- Amend legislation to drive **data collection**
- Continue roll-out of the **APD** and **SHIN-NY** and expand participation
- Develop a viable sustainability model
- Increase uptake of growing HIT resources and integration into provider workflows
- Ensure **alignment across HIT initiatives**
- Create the **patient portal** to give individuals convenient access to their own records
- Increase **telehealth adoption** in underserved areas
- Educate consumers** to promote health literacy

Prevention Agenda 2013-2017

Goal: Improved health status of New Yorkers and **reduction in health disparities** through increased **emphasis on prevention**

Approach



- Broad range of stakeholders collaborating at the community level to:
 - **assess** local health status and needs;
 - **identify** local health priorities; and
 - **plan, implement and evaluate** strategies for community action to improve health

Priorities

- Prevent chronic diseases
- Promote mental health and prevent substance abuse
- Promote a healthy and safe environment
- Promote healthy women, infants and children
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare associated infections

Prevention Agenda and population health through health system reform

Engage health care providers through APC model to focus attention on:

- **Delivering clinical preventive services** that will help achieve Prevention Agenda goals
- **Implementing innovative patient-centered care and strengthening community linkages** and partnerships to improve delivery of clinical services
- **Supporting policies and changes in the community** that make communities healthier and promote community-wide prevention efforts

Future priorities

- Make connections between PA, DSRIP and SIM more explicit
- Increase accountability in SIM and DSRIP for Population Health related actions aligned with the Prevention Agenda
- Create incentives to promote total population health activities by health care providers in the communities they serve, especially primary care providers
- Leverage hospital Community Benefit requirements for increased investments in population health aligned with evidence-based interventions in the Prevention Agenda

DSRIP – update

Performing Provider Systems Moving to Implementation

- The 25 Performing Provider Systems (PPS) submitted Implementation Plans to the Independent Assessor on July 31, 2015.
 - The NYS Department of Health (DOH), partner agencies, and the Independent Assessor completed reviews of the plans and identified items for PPS remediation.
 - PPS will complete their remediation efforts by September 24 and the Independent Assessor will make final determinations on the plans by September 30.
- The Implementation Plans were generally well received and indicate that PPS have defined paths for successfully implementing DSRIP.
- PPS have already begun efforts to move from planning to implementation as evidenced by the number of Organizational and Project milestones with projected completion dates of DSRIP Year 1, Quarter 2 and Quarter 3.
- PPS are scheduled to submit their second Quarterly Report in October 2015 and to receive their second DSRIP payment in January 2016.

Domain 4 Projects in DSRIP

Subdomain A. Promote Mental Health and Prevent Substance Abuse (MHSA)

- 4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities
- 4.a.ii Prevent Substance Abuse and other mental Emotional Behavioral Disorders
- 4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems

Subdomain B. Prevent Chronic Disease

- 4.b.i Promote tobacco use cessation, especially among low SES and poor mental health populations
- 4.b.ii Increase Access to High Quality Chronic Disease Preventative Care and Management
(note: this project targets chronic diseases that are not included in Subdomain 3.b)

Subdomain C. Prevent HIV and STDs

- 4.c.i Decrease HIV morbidity
- 4.c.ii Increase early access to, and retention in, HIV care
- 4.c.iii Decrease STC morbidity
- 4.c.iv Decrease HIV and STD disparities

Subdomain D. Promote Healthy Women, Infants, and Children

- 4.d.i Reduce premature births

PPS Selection of Domain 4 Projects

Domain 4 Project	Number of PPSs selecting the Project		
	New York City + Long Island	Rest of State	Total
4.a.i	0	2	2
4.a.ii	1	0	1
4.a.iii	6	7	13
4.b.i	4	7	11
4.b.ii	4	7	11
4.c.i	1	0	1
4.c.ii	7	0	7
4.c.iii	0	0	0
4.c.iv	0	0	0
4.d.i	0	2	2

PPS Regional Breakdown

Long Island

Nassau Queens Performing Provider System, LLC
Stony Brook University Hospital

New York City

Advocate Community Providers
Bronx-Lebanon Hospital Center
Lutheran Medical Center
Maimonides Medical Center
Mount Sinai Hospitals Group
Nassau Queens Performing Provider System, LLC
New York City Health and Hospitals-led PPS
St. Barnabas Hospital (dba SBH Health System)
Staten Island Performing Provider System, LLC
The New York and Presbyterian Hospital
The New York Hospital Medical Center of Queens

Rest of State

Adirondack Health Institute
Albany Medical Center Hospital
Alliance for Better Health Care, LLC (Ellis)
Central New York Care Collaborative (CNYCC aka CNY)
Finger Lakes PPS
Millennium Collaborative Care (ECMC)
Mohawk Valley PPS (Bassett)
Montefiore Hudson Valley Collaborative
Refuah Health Center
Samaritan Medical Center
Sisters of Charity Hospital aka Community Partners of WNY (Catholic Medical Partners)
Southern Tier Rural Integrated PPS (United)
Westchester Medical Center

PPS Learning Symposium

- The First Annual DSRIP PPS Learning Symposium was held September 17 – 18 in Rye Brook, NY with 400 representatives from across the 25 PPS.
- The PPS Learning Symposium was designed to:
 - Develop partnerships across PPS and mechanisms to share emerging best practices and evidence-based approaches to successfully complete project deliverables.
 - Highlight promising efforts across the state (and nationally) to transform current care delivery practices and improve care transitions.
 - Further dialogue between PPS and DOH about current key issues impacting PPS capacity to achieve DSRIP goals.
- PPS led sessions focused on DSRIP topics including patient and provider engagement, County Agency collaboration, behavioral health and clinical integration, expanding primary care capacity, and the evolving role of managed care organizations (MCOs).

Regulatory Relief

Regulatory Waivers

- To facilitate ongoing project implementation, regulatory waiver requests for DSRIP projects will be open and processed on a quarterly basis. Time-sensitive waivers may be submitted at any time.
- All DOH regulatory waiver determinations are posted to the DSRIP website.

Integrated Services Application

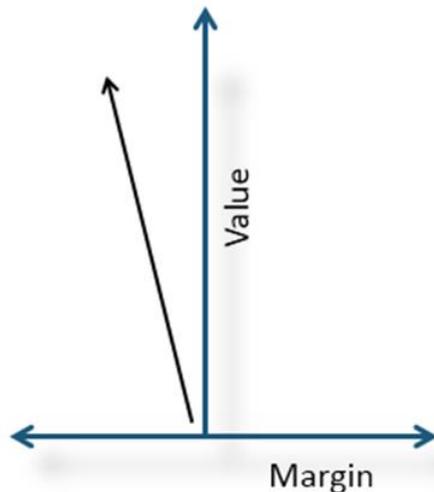
- To facilitate integration of primary care and behavioral health (mental health and/or substance use disorder) services, the DOH, the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) have established parameters for the approval of providers that want to offer services under the DSRIP Project 3.a.i Licensure Threshold. These applications are reviewed on a rolling basis.

Learning from Earlier Attempts: Value Based Payment as the Path to a Stronger System

Value Based Payment (VBP) arrangements are not intended primarily to save money for the state, but to *allow providers to increase their margins by realizing value.*

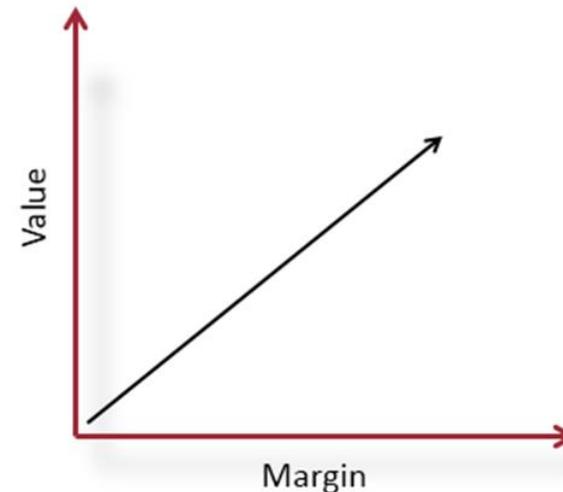
Current State

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



NYS Levels of Value Based Payments

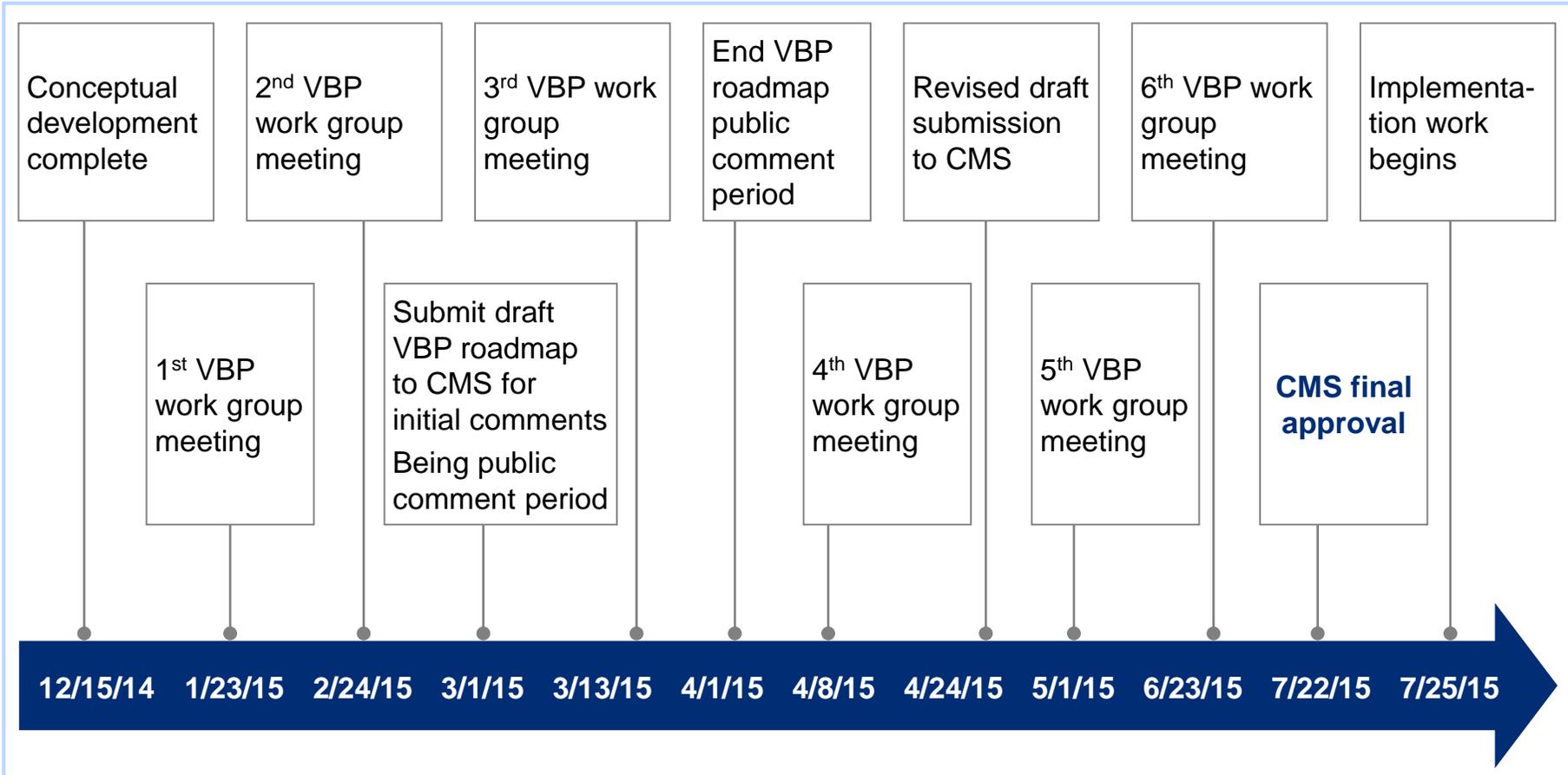
In addition to choosing what integrated services to focus on, the MCOs and PPS can choose different levels of Value Based Payments

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (for PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of $\geq 80-90\%$ of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Goal of 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher by the end of DY5.¹

¹ For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

Roadmap Development Timeline



VBP Implementation Planning: Subcommittees

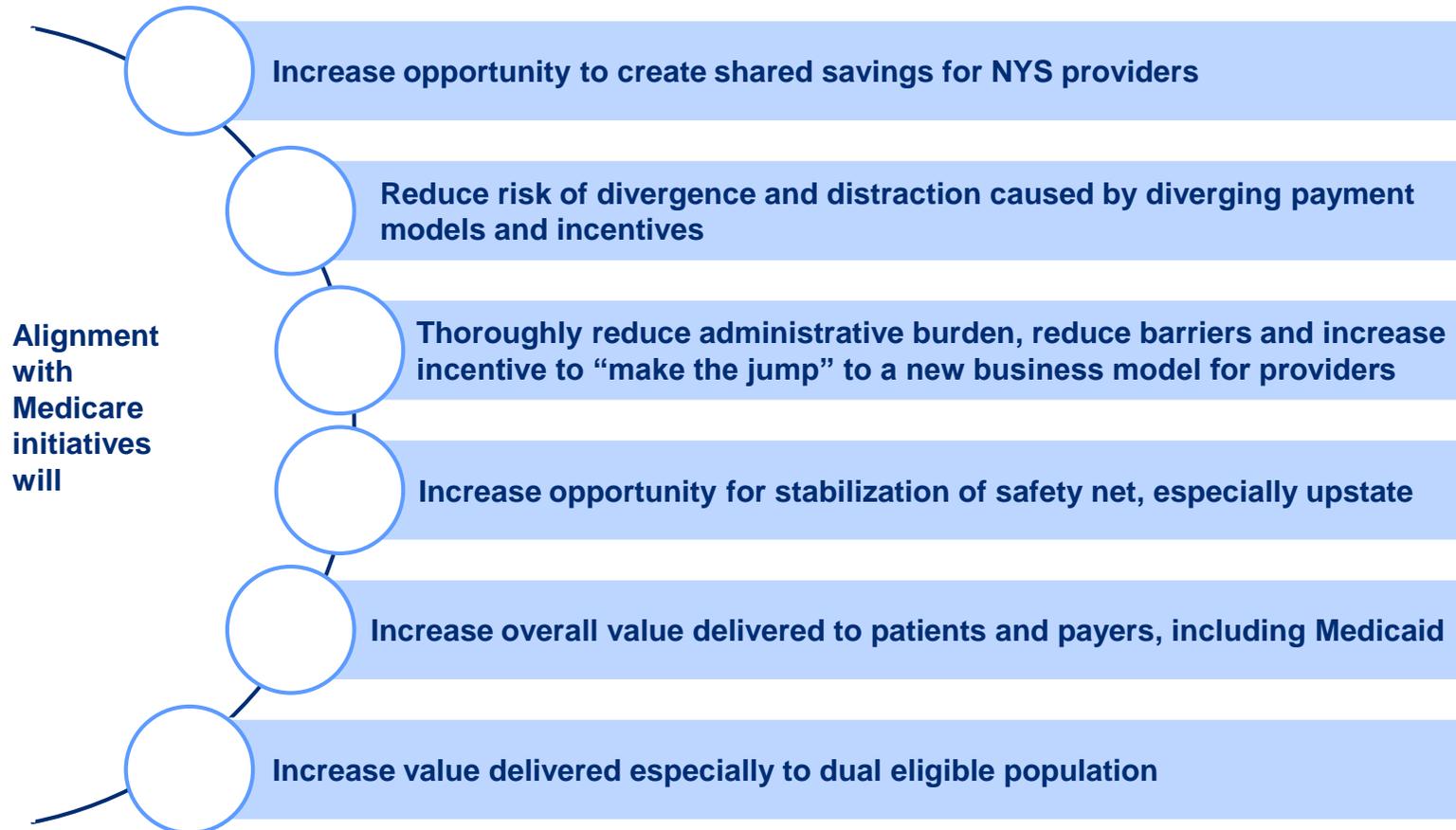
Five VBP Subcommittees were developed to focus on a number of broad policy related questions. These groups will meet between 4-6 times and plan to complete their work by January 2016. The subcommittees include the following:

Subcommittee	Co-chairs	Meetings held to date	Number of members
Technical Design I	John Ruge & Tony Fiori	2	77
Technical Design II	Denise Gonick & Lynn Richmond	2	66
Regulatory Impact	Harold Iselin & Jeff Gold	2	57
Social Determinants of Health & CBOs	Kate Breslin & Charles King	3	92
Advocacy & Engagement	Harvey Rosenthal & Trilby de Jung	2	39

VBP Implementation Planning: Clinical Advisory Groups

- Clinical Advisory Groups (CAGs) are composed of individuals with: clinical experience and knowledge focused on the specific care or condition being discussed; industry knowledge and experience; geographic diversity; and/or total care spectrum experience as it relates to the specific care or condition being discussed. The objective of the CAG is to:
 - Understand the state's visions for the Roadmap to Value Based Payment
 - Understand the HCI3 grouper and underlying logic of the bundles
 - Review clinical bundles that are relevant to NYS Medicaid
- Make recommendations to the state on:
 - Outcome measures
 - Data and other support required for providers to be successful
 - Other implementation details related to each bundle

Medicare Alignment



January of this year, CMS announced that in 2018

- 90% of FFS payments would have to be tied to quality or value (compare to Level 0)
- 50% would have to flow through Alternative Payment Models (APMs) (compare to Level 1-3)

Medicare Alignment: Proposed Approach

- NYS proposes to allow its providers and MCOs on a voluntary basis to include Medicaid beneficiaries in CMS innovative payment models. These have already been included in the Roadmap as off-menu options that would be automatically accepted as valid Level 1 or higher VBP arrangements.
- In parallel, NYS requests CMS to allow NYS providers on a voluntary basis to include Medicare FFS beneficiaries in the VBP Arrangements outlined in the NYS Payment Reform Roadmap.

***Developed with participation from the VBP Workgroup
To be submitted to CMS in fall 2015 for consideration***

VBP Pilots

Providers and plans have come forward to help lead VBP transition. The DOH is interested in working with early adopters of VBP to help lead the way with a pilot.

We invite the broader Medicaid community to get involved!

Integrated care – update

Integrated Care touches upon almost all aspects of the SHIP, supported by several of the other working groups

Goal	Delivering the Triple Aim – <i>Healthier people, better care and individual experience, smarter spending</i>			
Pillars	<p>Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, operational barriers; access appropriate a timely way</p>	<p>Integrate care to address patient needs seamlessly</p> <p>Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it</p>	<p>Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable individuals and providers to make better decisions at enrollment and at the point of care</p>	<p>Pay for healthcare value, not volume</p> <p>Rewards for providers who achieve high standards for quality and individual experience while controlling costs</p> <p>Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p>
Enablers	<p>Workforce strategy</p>	A	Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities	
	<p>Health information technology</p>	B	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation	
	<p>Performance measurement & evaluation</p>	C	Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation	

Objectives for the Integrated Care Workgroup

Impact the delivery of healthcare in NYS through innovation in primary care:

- **Create a vision for Advanced Primary Care (APC)** that coordinates care across specialties and care settings, improves experience and quality, and reduces costs
- **Catalyze multi-payer (including Commercial, Medicaid, and Medicare) investments in primary care practices** to make the structural changes needed to succeed
- **Align on an innovative but consistent measurement and payment system** with payers and providers that drives improvements in population health, better care, and lower costs
- **Provide and finance practice transformation technical assistance** using funds from the SIM grant

APC will catalyze improvements in the delivery of healthcare for the entire state

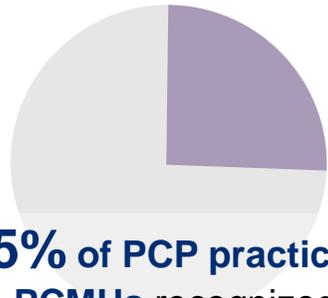
Core objectives

- 1 80% of the state's population receives primary care within an Advanced Primary Care setting, with a systematic focus on population health and integrated behavioral health care
- 2 80% of care will be paid for under a value-based financial arrangement
- 3 Individuals will receive more appropriate care for their needs

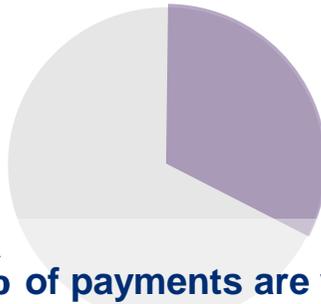
... driving aspirational outcomes

- 1 Achieve or maintain **top-quartile performance** among states for adoption of best practices and outcomes in **disease prevention and health improvement**
- 2 Achieve **high standards for quality and consumer experience**
- 3 **Generate savings** by reducing unnecessary care, shifting care to more appropriate settings, reducing avoidable hospital admissions and readmissions, and ensuring a clear link between cost and quality

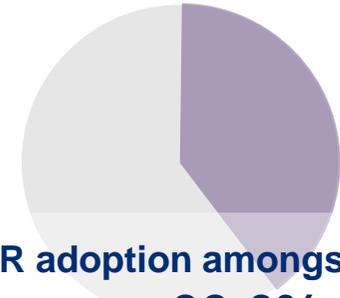
Challenges to achieving Integrated Care: by the numbers



25% of PCP practices are PCMHs recognized by NCQA

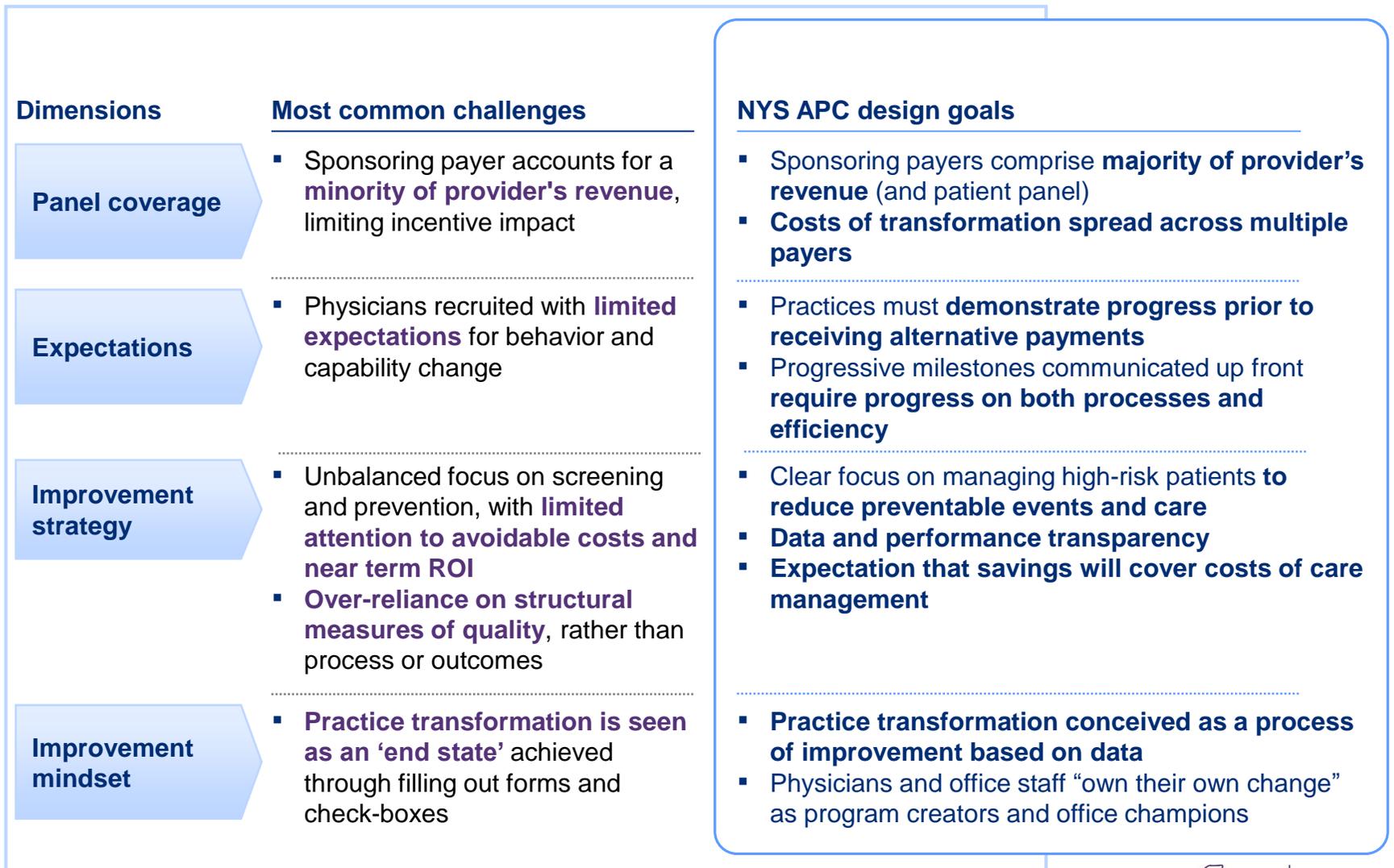


34% of payments are value-based, despite the existence of 76 value based programs among 19 payers



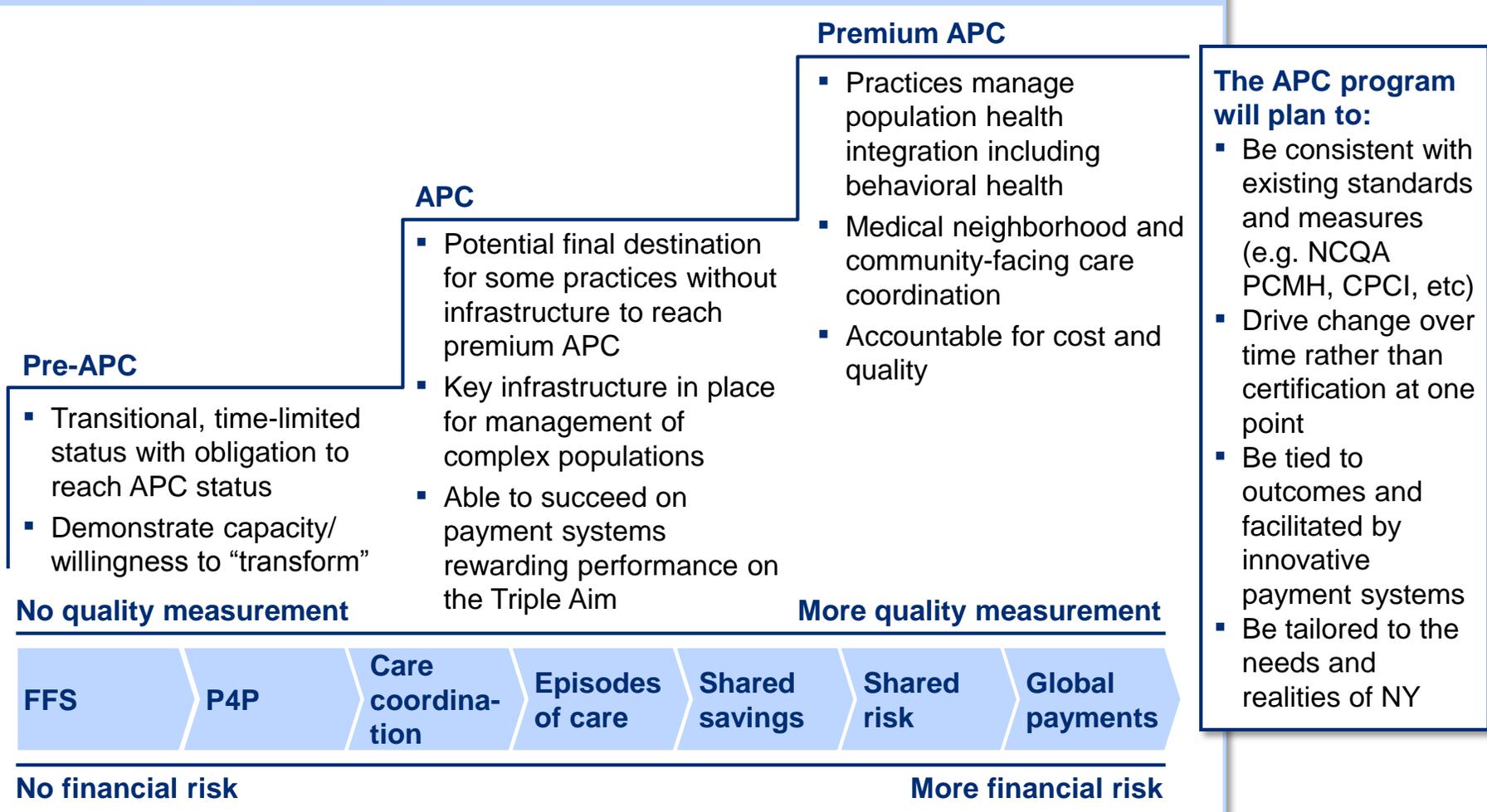
EMR adoption amongst NY physicians is **39.6%**, lower than the national average of ~48%

NYS APC design addresses common challenges



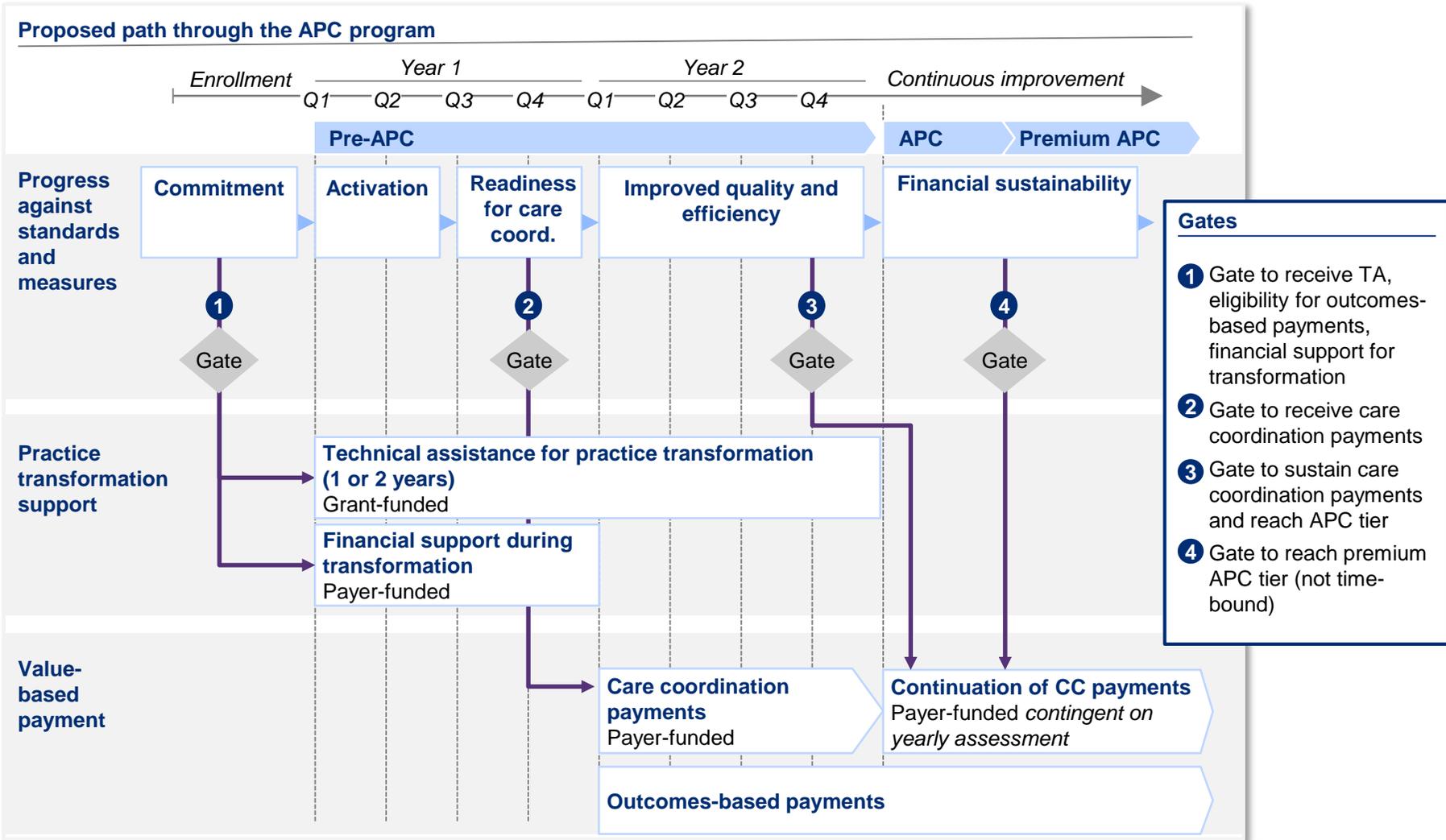
APC design: APC tiers envision progressive primary care capabilities matched with greater financial rewards for achievement

Advanced primary care components



APC design: Practices receive support for transformation– but would need to demonstrate progress to continue

PRELIMINARY



APC is designed as a program to be adapted by multiple payers, including commercial, Medicaid, and Medicare (1/3)

Commercial payers offer various VBP programs for primary care in NY

Payer

- Commercial
- Medicaid
- Medicare

- Multiple payers have participated in CPCI and MAPCP in New York
- Successful examples like CDPHP's Enhanced Primary Care program serve as a model nationwide
- Most payers have programs with performance incentives for primary care physicians, including provisions for sharing claims-based data

Steps to APC

- Align primary care strategies with APC, including payment and in-kind support
- Create provider contracts that support transformation while ensuring a clear business case
- Examine possible regulatory incentives

APC is designed as a program to be adapted by multiple payers, including commercial payers, Medicaid, and Medicare (2/3)

Payer

- Commercial
- Medicaid
- Medicare

Medicaid's DSRIP programs align with APC

- DSRIP is focused on primary care coordinating care across specialties and settings
- APC or NCQA are part of integrated delivery systems requirements (Project 2.a.ii), to be completed by 2017
- The VBP roadmap provides for a progression from payment for structural changes and reporting to payment for performance

Steps to APC

- Describe NCQA PCMH's role within APC
- Align DSRIP and APC timelines
- Adjust MCO contracts to incorporate VBP, including APC

APC is designed as a program to be adapted by multiple payers, including commercial payers, Medicaid, and Medicare (3/3)

Payer

- Commercial
- Medicaid
- Medicare

Medicare's initiatives have inspired APC plans

- CPCI initiatives have inspired APC core tenets and structure
- APC can support Medicare's target of 90% of healthcare payments being value-based by 2018

Steps to APC

- Align primary care strategies with APC in NYS, including payment and in-kind support
- Add components of APC to Medicare FFS and MA contracts

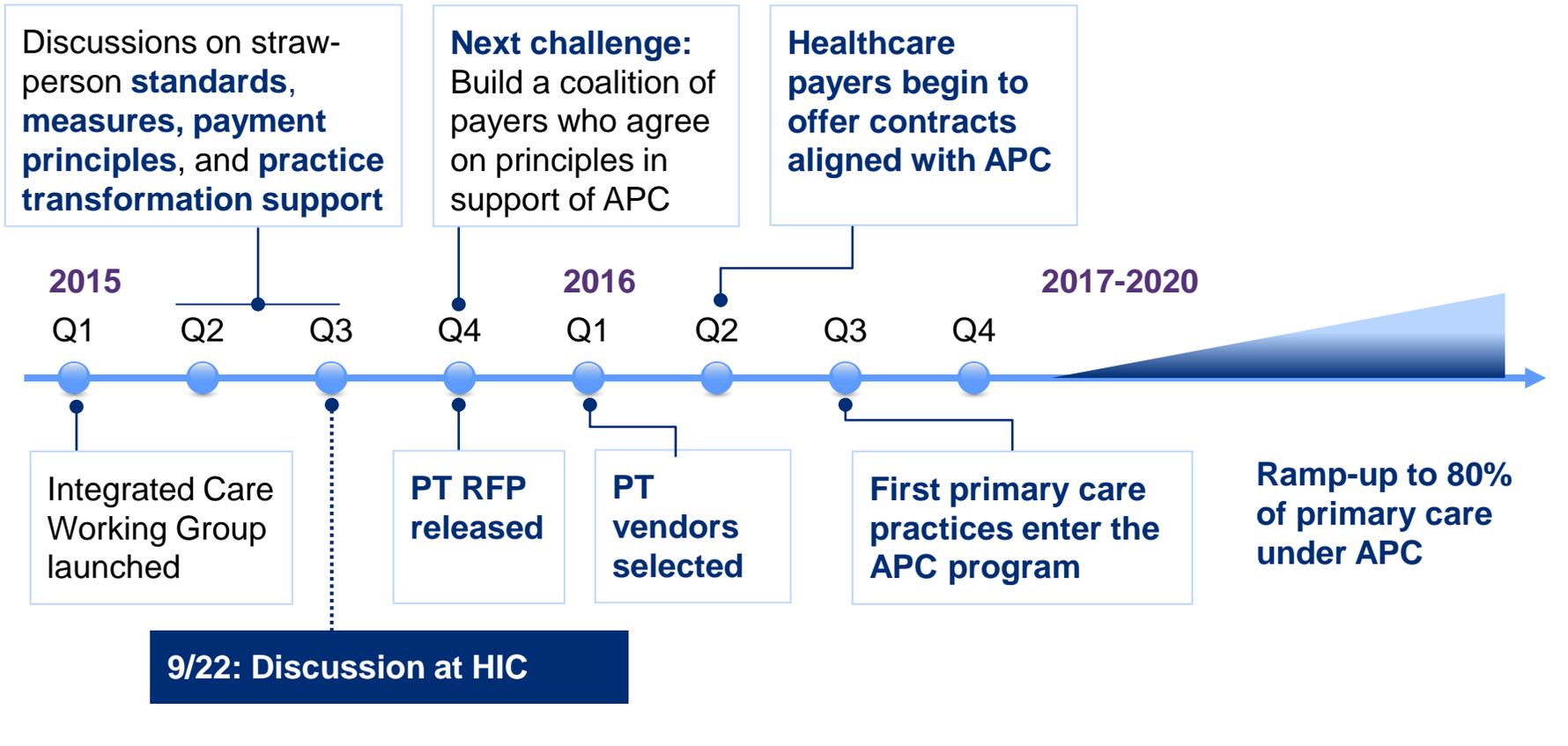
The APC program will allow for advanced / accelerated entrance for practices participating in allied programs

Practices meeting NCQA III, succeeding in value-based payments, or receiving other grant funding (e.g. TCPI, DSRIP) will have a place in APC:

- **Meeting similar criteria for other programs will be sufficient proof of meeting matching APC milestones**, though proof of any APC-specific milestones will still be necessary to pass gates
- **Advanced practices may be eligible for an accelerated program** with earlier access to CC / CM payments and stronger outcomes-based payments
- **TA support will be prioritized for practices that have not already proven advanced-practice** through other methods

Building on a strong base of progress in 2015, a continued multi-stakeholder effort is needed in coming years to achieve APC goals

New York State Advanced Primary Care Proposed Timeline



Moving toward an implementable APC model with aligned partners

Summary of recommendations

- ✓ Implement a **statewide multi-payer model for Advanced Primary Care** on which virtually all public and private payers are aligned
- ✓ Support efforts and mechanisms to **transition virtually all NYS primary care practices to APC**
- ✓ Facilitate a **consistent mechanism for measuring success** as defined by improved quality and experience and reduced costs

Ongoing work:

- ❑ Refine the APC model to ensure a win-win-win for patients, payers, and providers, with **clear and achievable business cases**
- ❑ Bring together a **critical mass of payers** and employers in NYS to support the APC transformation
- ❑ Explore options for the State to **promote an environment for payment innovation** (e.g. MLR adjustments, APC Payer scorecard, multi-payer compact)
- ❑ **Coordinate timelines and content** with programs pushing toward goals consistent with APC (e.g., DSRIP, TCPI, others)
- ❑ Ensure that investments in **practice transformation technical assistance** are used well to help practices achieve progress toward APC

Discussion

Transparency, Evaluation, HIT – update

HIT is a critical enabler to the SHIP

Goal	Delivering the Triple Aim – Healthier people, better care and individual experience, smarter spending				
Pillars	<p>1</p> <p>Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, operational barriers access appropriate a timely way</p>	<p>2</p> <p>Integrate care to address patient needs seamlessly</p> <p>Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it</p>	<p>3</p> <p>Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable individuals and providers to make better decisions at enrollment and at the point of care</p>	<p>4</p> <p>Pay for healthcare value, not volume</p> <p>Rewards for providers who achieve high standards for quality and individual experience while controlling costs</p>	<p>5</p> <p>Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p>
Enablers	<p>Workforce strategy</p>	<p>A</p>	<p>Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities</p>		
	<p>Health information technology</p>	<p>B</p>	<p>Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</p>		
	<p>Performance measurement & evaluation</p>	<p>C</p>	<p>Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</p>		

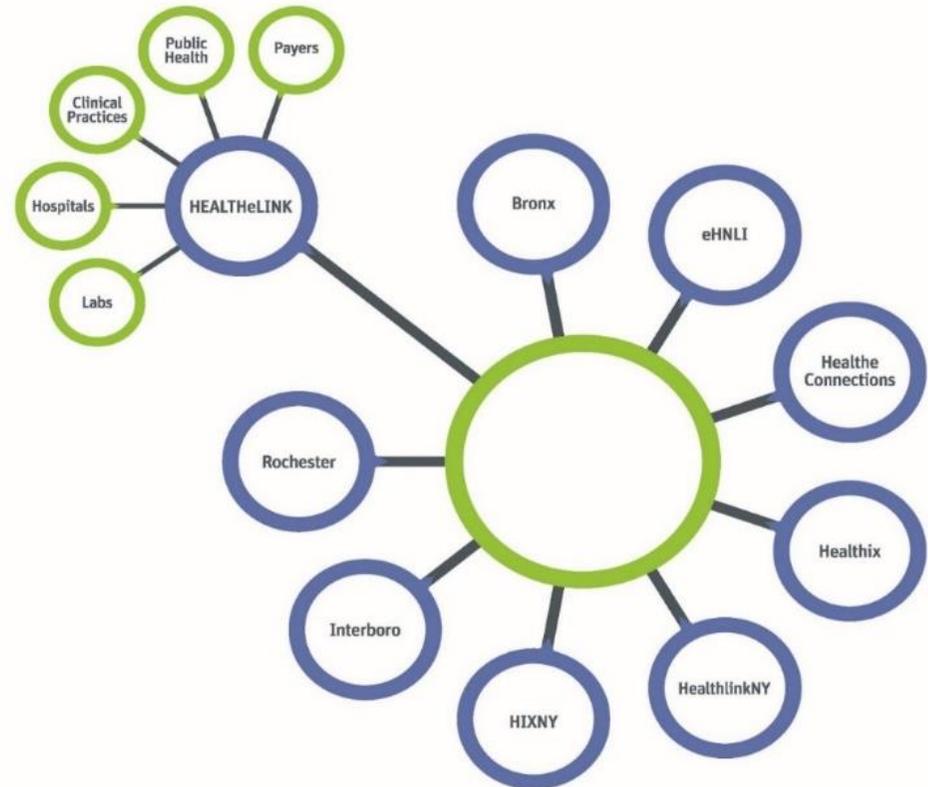
Objectives for the Transparency, Evaluation, and HIT Workgroup

Create a statewide HIT infrastructure that supports the goals of the Triple Aim through:

- Implementation of a **Statewide Health Information Network of New York (SHIN-NY)** that facilitates health information exchange to improve care coordination and reduce duplication
- Implementation of an **All-Payer Database** to increase health quality and price transparency, inform policy, enable improvements in quality and performance, and inform benchmarking and comparisons
- Development of a process for **ongoing alignment of measures and technology** to evolving health needs for the State of New York, starting with an APC scorecard

SHIN-NY: structure today

- RHIOs are connected to each other via a central bus (the green ring in the middle)
- Data from a participant of any RHIO is available to any other RHIO's participant statewide
- This system is called Statewide Patient Record Lookup (sPRL)



SHIN-NY timeline

Statewide patient lookup (connecting RHIOs to each other)

- 6 RHIOs are connected and sharing data, last 3 RHIOs by early October

Concentrated efforts on adoption

- Individual providers
- Provider systems

DSRIP – bi-weekly meetings with PPSs, SHIN-NY is the primary vehicle for HIE for DSRIP

Regulation development

- Proposed regulations will be presented to PHHPC Fall 2015
- Streamlined from the previous proposal and includes guidance document outside the regulations

APD: priority issues queried through stakeholder interviews, other states' APD experience

- **Price and Quality Transparency**
 - Create inventory of transparency tools in use by other states
 - Determine mechanisms to address concerns that price transparency may disclose proprietary information
- **Stakeholder Utility**
 - Assess ways to maximize utility of APD data for the broadest range of stakeholder groups
- **Data Release, Use and Governance**
 - Create data governance mechanisms for the collection, linkage and release of data

APD: Health foundation report findings discussed at August preview

Key findings

1. Reliable and trusted price and quality data for consumers are scarce
2. Pricing data versus charge data are required for true transparency
3. Transparency is more complex than price shopping
4. The State's vision, goals, and timeline for the APD are unclear to stakeholders
5. The New York APD is viewed as a public utility with unclear governance
6. A broad consumer strategy across state agencies will require concerted effort and coordination
7. Fiscal and programmatic sustainability will likely be challenging

All Payer Database – timeline

Data intake

- Qualified Health Plan data collection since January 2015
- Medicaid data collection began September 2015
- Commercial data collection to begin Spring 2016

Data warehousing and analytics

- Proposals received on September 2015
- Anticipated contract by February 2016

Regulation development

- Results of September 2015 HIT Workgroup meeting
- Anticipated fall 2015 public review
- Final review in Nov/Dec 2015

Measurement alignment and development

NYS has worked to align performance measurement across:

- DSRIP – core measures for pay for reporting and pay for performance
- SIM – Advanced Primary Care measures, overall health care measures
- Prevention Agenda – population measures included in SIM and DSRIP
- QARR – measures of health plan performance

Analytic alignment

- For Medicaid, standard measures for DSRIP QARR are produced for all enrollees
- Allows for analysis of: health plans, Performing Provider Systems, counties
- Potential Model for APD

Technology alignment and development

Master provider data – NY is working to align provider data needs across:

- QHPs, Medicaid managed care and Child Health Plus
- Department of Financial Services – mandated network review
- APD
- SHIN-NY
- Programmatic and regulatory functions of DOH

Master Provider Index – future

- APD (required in current procurement)
- SHIN-NY
- DSRIP/Medicaid

Critical path challenges to address

- Ensure regulations are in place for commercial payers to upload data to APD
- Keep roll-out of APD on schedule, including start of warehousing and analytics vendor selected through RFP
- Create infrastructure that feeds back data to providers and payers in a way that is both digestible and timely to help drive care improvements
- Increase uptake of HIE resources across the state, with improved incorporation into primary care provider workflows
- Manage constraints, including political, to increase health information transparency
- Develop transparency tools for individuals, payers, providers and policy makers
- Promote adoption through DSRIP PPSs and direct outreach to providers

Summary of recommendations

- ✓ Continue roll-out of two signature HIT programs: SHIN-NY and the APD
- ✓ Develop a viable sustainability model
- ✓ Expand participation in HIE
- ✓ Increase adoption of growing HIT resources within the state and integration into provider workflows
- ✓ Align HIT initiatives including Medicaid, APD, clinical data from the SHIN-NY and more

Discussion

Workforce – update

Workforce is a fundamental enabler for SHIP

Goal	Delivering the Triple Aim – <i>Healthier people, better care and patient experience, smarter spending</i>										
Pillars	<p>1</p> <p>Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, operational barriers access appropriate a timely way</p>	<p>2</p> <p>Integrate care to address patient needs seamlessly</p> <p>Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it</p>	<p>3</p> <p>Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable individuals and providers to make better decisions at enrollment and at the point of care</p>	<p>4</p> <p>Pay for healthcare value, not volume</p> <p>Rewards for providers who achieve high standards for quality and patient experience while controlling costs</p>	<p>5</p> <p>Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p>						
Enablers	<table border="1"> <tr> <td data-bbox="287 886 624 991">Workforce strategy</td> <td data-bbox="634 886 1787 991">A Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities</td> </tr> <tr> <td data-bbox="287 998 624 1131">Health information technology</td> <td data-bbox="634 998 1787 1131">B Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</td> </tr> <tr> <td data-bbox="287 1138 624 1271">Performance measurement & evaluation</td> <td data-bbox="634 1138 1787 1271">C Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</td> </tr> </table>					Workforce strategy	A Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities	Health information technology	B Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation	Performance measurement & evaluation	C Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation
Workforce strategy	A Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities										
Health information technology	B Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation										
Performance measurement & evaluation	C Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation										

A Workforce Workgroup has been established to provide external advice

Workgroup has ~40 external participants, representing all facets of the health care workforce

- Hospitals and Health Systems
- Physicians
- Graduate Medical Education
- Nurses
- Nurse Practitioners
- Direct Care Workers
- FQHCs
- Developmental Disability
- Unions/Training funds
- Mental Health and Substance Abuse
- Educational Institutions/Associations
- Community Health Workers
- Population Health
- Consumer Groups
- Home Care
- ACOs/Private Practice
- Physician Assistants
- Pharmacy

Workforce Workgroup has been actively engaged in the process

- **Two workgroup meetings** including a gallery walk and small group discussion
- **Weekly leadership meetings** to assess analysis and progress
- **Workgroup-led “peer interviews”** to gather information on the skill gap in the health care workforce
- **Workgroup Survey** to identify and prioritize key workforce issues
- **Modeling expert group** to help define assumptions around future state workforce

The Workforce team is developing recommendations to equip New York's healthcare workforce to deliver on the Triple Aim

Achieving the Triple Aim... ➤

- *Healthier people*
- *Better care and patient experience*
- *Smarter spending*

...requires changes in the healthcare delivery model (i.e., SIM/DSRIP)... ➤

- Population health focus
- Team-based, patient-centered care
- Shift in setting from inpatient to outpatient; greater focus on primary, preventative care

...with important workforce implications

- 1 What changes are needed in the **size** of the workforce?
- 2 What changes are needed in the **distribution** of the workforce?
- 3 How can the workforce of the future best be **structured** to maximize productivity and effectiveness?

To support this process, the working team has conducted analysis to build a fact base across the main dimensions

Dimensions

Findings

① What changes are needed in the **size** of the primary care workforce?

- Under the new care model, there is likely to be a **shift from acute to ambulatory settings, as well as a need for additional** care coordinators and nurses working in primary care settings

② What changes are needed in the **distribution** of the workforce?

- There is **geographical maldistribution** of the primary care and behavioral health workforce – many regions of the state are designated Health Professional Shortage Areas. This appears to be driven at least as much by non-financial as by financial factors

③ How can the workforce of the future best be **structured**?

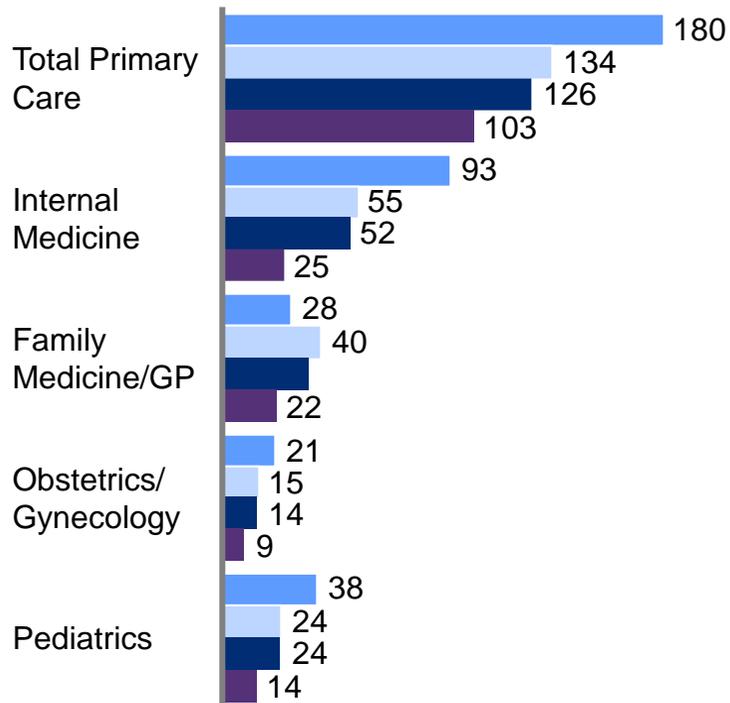
- **Structural changes are needed** to improve workforce productivity
 - Health workers do not always practice at the **top of license**
 - Care coordination and other emerging roles **lack clarity**
 - **New skills** and **mindsets (team-based care)** are needed to equip workers to deliver on the Triple Aim

Primary care physician supply per 100,000 population and Primary Care Health Professional Shortage Areas (HPSAs)

Primary care physicians

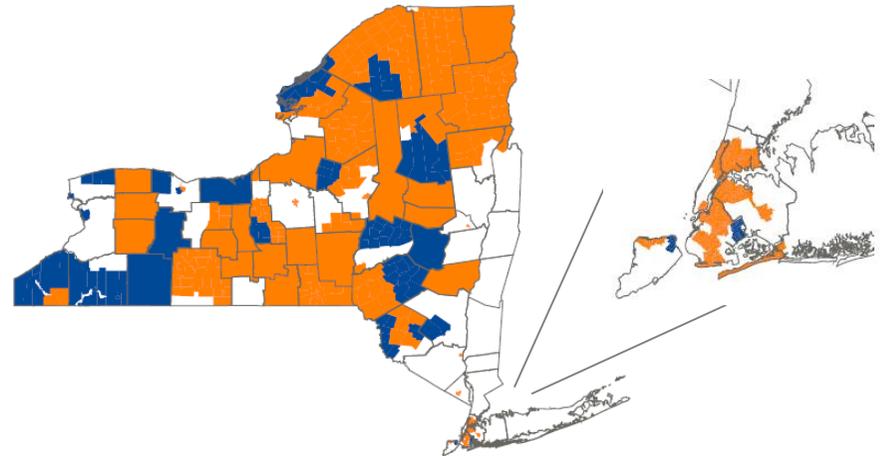
Total employees per 100,000 population, 2014/2015

NY CA
US TX

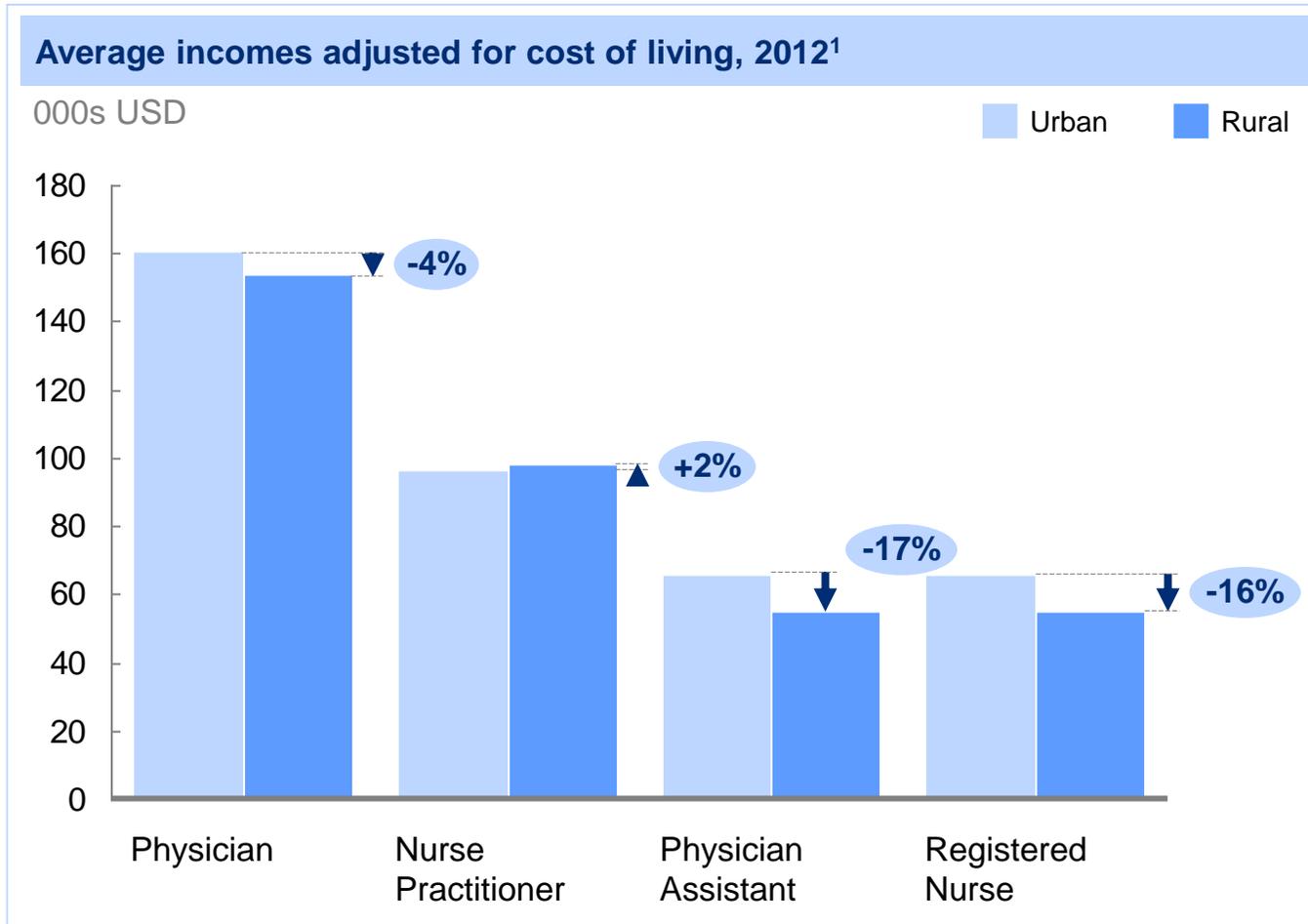


Primary Care Health Professional Shortage Areas

Geographic HPSA (<30 primary care physicians per 100,000 population)
Special Population HPSA



Health care professional incomes, adjusted by cost of living



Potential non-financial drivers:

- Lack of rural residency programs
- Tendency to practice near training location
- Longer work hours
- Lack of cultural opportunities



¹ Only 2008 data available for RNs

Source: 2008 National Sample Survey of Registered Nurses, 2012 National Sample Survey of Registered Nurse Practitioners, American Community Survey 2008-2012, salary adjusted to 2012 levels. University of Washington Center for Health Workforce Studies "Characteristics of Registered Nurses in Rural vs. Urban Areas," 2005.

Definitions of care coordinator role across different providers

Qualifications	Education	High school diploma	CASAC, Associate Degree	Bachelors' degree	RN, MSW
	Experience	1 year experience in any healthcare setting		5 years clinical experience with specific expertise in care coordination or care management	
Job description/responsibilities	Administrative Responsibilities	Booking appointments/scheduling tests		Communicating with patient caregiver/family	Coordinating insurance, maintaining EHRs
	Clinical Responsibilities	None			True clinical tasks e.g. drawing blood
	Level of patient touch	One-time engagement around single episode/visit	Ongoing patient education	Developing and coordinating care plans	Acting as patient advocate throughout health system
	Number/type of people touched	Case managing single individuals/panel		Coordinating a whole set of doctors/professionals within a practice (including recruiting, hiring, training)	
	Level of specialization	None			Specific disease or demographic specialty
	Engagement with outside orgs	Focus only on services provided by clinical organization		Engagement with non-physician professionals and outside services involved in social determinants of health	

The working team has conducted other analyses within constraints of available data

Analysis conducted

1 Size

- Behavioral health professionals per 100,000 population
- Allied health professionals per 100,000 population
- Nurse supply per 100,000 population
- Physician, NP, PA, RN employment trends over time

2 Distribution

- Distribution of Mental Health HPSAs in New York
- Literature review on non-financial considerations in health care professionals' choice of urban vs rural settings and ambulatory vs hospital settings
- Practice setting for health care workers (national)
- Choice of setting for primary care physicians entering practice in New York

3 Structure

- Percentage of time spent on top of license practice
- Skills assessment of New York primary care workforce against competencies of new care model
- Results of peer interviews of health workers in New York regarding their expectations of skills needs under new care model

- Ability to conduct workforce analysis is **constrained by available data sources**
- Need to supplement existing data with **more granular information** (e.g., PPS-collected data)

Emerging ideas in priority areas

PRELIMINARY

Areas	Emerging ideas
A Ensure sufficient primary care workforce	<ul style="list-style-type: none"> ▪ Support existing workforce training programs ▪ Assist hospital-based workers to transition into ambulatory care ▪ Build career pathways for direct care workers into primary care roles
B Better distribute primary care workforce to areas of need	<ul style="list-style-type: none"> ▪ Support existing programs supporting underserved areas (e.g. Doctors Across New York / other loan repayment programs) ▪ Launch Rural Residency and Physician Retention programs ▪ Explore ways to expand telehealth to respond to innovations
C Making most effective use of the health care workforce under the new model	<ul style="list-style-type: none"> ▪ Develop industry standard titles and minimum competency set for care coordinators and other emerging roles ▪ Embed “top of license” practice within primary care workforce
D Improving the supply and effectiveness of behavioral health workforce	<ul style="list-style-type: none"> ▪ Pursue legislative changes where appropriate to remove barriers to effective practice (e.g., extend exemption from licensure for social workers, psychologists and mental health practitioners employed in certain State-operated and funded programs)
E Train workforce for team-based care	<ul style="list-style-type: none"> ▪ Encourage completion of skills modules relating to team-based care in medical curricula and continuing medical education
F Shift mindsets among the health care workforce	<ul style="list-style-type: none"> ▪ Convene “change leaders” to act as advocates / role models for team-based care
G Improve data collection	<ul style="list-style-type: none"> ▪ Amend legislation to improve or mandate workforce data collection

Timeline of progress and next steps

New York State Workforce Proposed Timeline



Discussion

Access – update

Access is a key element of the SHIP

Goal	Delivering the Triple Aim – <i>Healthier people, better care and individual experience, smarter spending</i>				
Pillars	<p>Improve access to care for all New Yorkers, without disparity</p> <p>Elimination of financial, geographic, cultural, operational barriers access appropriate a timely way</p>	<p>Integrate care to address patient needs seamlessly</p> <p>Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it</p>	<p>Make the cost and quality of care transparent to empower decision making</p> <p>Information to enable individuals and providers to make better decisions at enrollment and at the point of care</p>	<p>Pay for healthcare value, not volume</p> <p>Rewards for providers who achieve high standards for quality and individual experience while controlling costs</p>	<p>Promote population health</p> <p>Improved screening and prevention through closer linkages between primary care, public health, and community-based supports</p>
Enablers	<p>Workforce strategy</p>	A	Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities		
	<p>Health information technology</p>	B	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation		
	<p>Performance measurement & evaluation</p>	C	Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation		

Approach for analysis and objectives of the Workgroup

Approach for analysis



Conduct analysis to better understand the patient perspective and unmet needs in terms of access to care:

- On four dimensions: **Affordability, Availability, Accessibility, and Acceptability**
- Through **eight lenses**: geographic, socio-economic, age, racial/ethnic, chronic disease, disability, sexual orientation, and gender

Objectives of Access to Care Workgroup

Inform the SHIP model by:

- Developing recommendations for consideration by the Integrated Care, HIT and Workforce Workgroups
- Developing additional recommendations to address Access issues



The Innovation Council and Workgroup have categorized issues under four broad dimensions of Access



Analysis, publications and interviews surface seven specific Access issues

Geo-graphic

- A** North Country, Tug Hill Seaway, Mohawk Valley and Southern Tier have poor access, particularly in terms of availability (primary care providers), and accessibility (distance traveled to care, e.g. ~26 miles on average in Tug Hill Seaway)
- B** The Bronx, Brooklyn and Queens have poor access across multiple dimensions, ranging from coverage to ER utilization (e.g. ~25% adults uninsured in Queens)

State-wide

- C** Linguistic barriers to care impact at least 2.3 million New Yorkers without strong English capabilities
- D** Serious health literacy barriers exist for much of the population (36% of adults nationwide have basic or below basic health literacy)

Specific populations

- E** Behavioral health access metrics are lowest in New York City and the Central Region
- F** Pediatric populations in New York City, and elderly populations in Central New York, Tug Hill Seaway, North Country and Capital regions, have particularly high rates of preventable hospitalizations (as high as 500/100,000)
- G** Numerous barriers for persons with disabilities (22.9% of the New York population): physical equipment; lack of awareness of the range of disabling conditions; clinical and non-clinical knowledge and attitudes, absence of policies and procedures

Access is closely linked to other programs supporting the Triple Aim

Efforts that support Access

- Workforce
 - Right workers in the right places
 - Workforce trained in access-related issues
- Integrated care model
 - APC improves quality of care in rural and low-income urban areas
- DSRIP

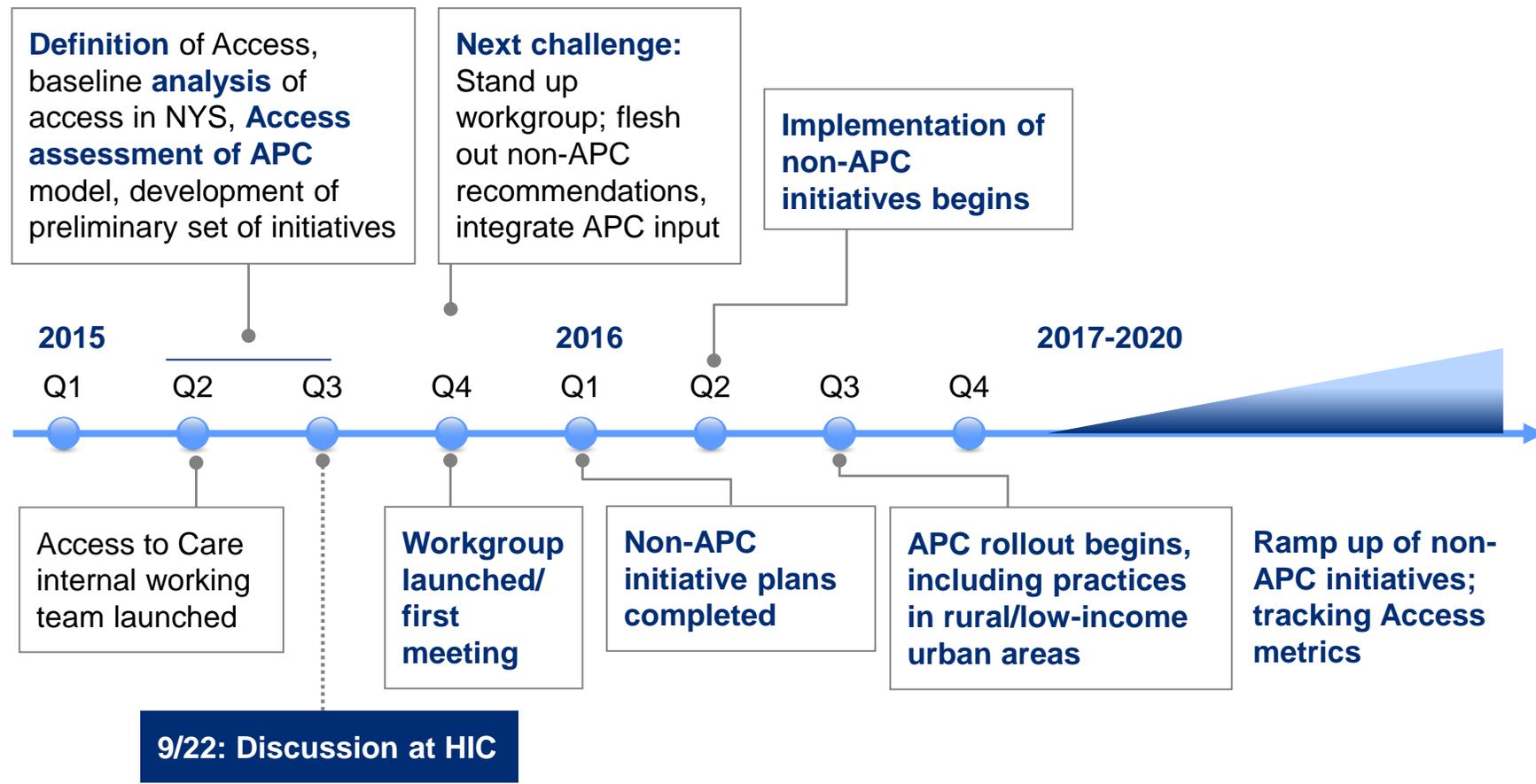
Access to Care

Efforts supported by Access

- Prevention Agenda
 - Health outcomes for specific populations improve
 - Disparities are reduced
- DSRIP
 - Hospitalizations decline among high-risk populations (e.g. low-income)

Timeline of progress and next steps

New York State Access to Care Proposed Timeline



Appendix

Goal: Ensure New York State advances the Triple Aim within 5 years

Healthier people

Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement

Better health care and consumer experience

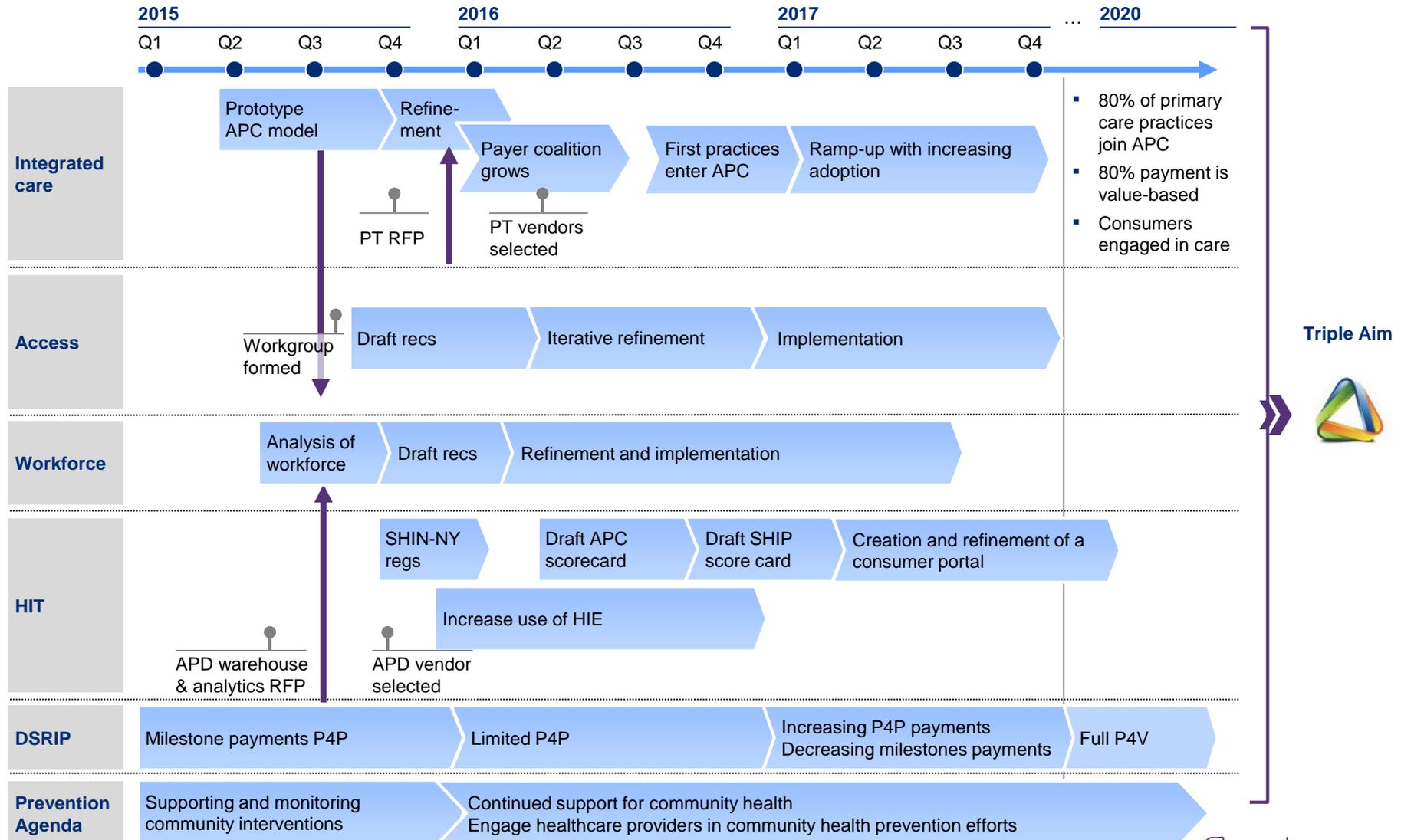
Achieve high standards for quality and patient experience, including at least 25 percent reduction in avoidable hospital admissions and readmissions

Smarter spending

Reduce unnecessary care, shift care to appropriate settings, and curb increases in unit prices for health care products and services that are not tied to quality

SHIP timeline to progress toward the Triple Aim

WIP DRAFT



DSRIP and SIM: unique but complementary

WIP DRAFT

	DSRIP	SIM
Goals	<ul style="list-style-type: none"> Integrated, value-based care through population health-based care delivery models and payment innovation 25% reduction in avoidable hospital use over 5 years 	<ul style="list-style-type: none"> Integrated, value-based care through population health-based care delivery models and payment innovation 80% of New Yorkers impacted within 5 years Achieve the Triple aim
Scope	<ul style="list-style-type: none"> All providers that qualify as safety net providers, along with conditions (PPS) of other proximate providers All Medicaid patients attributed to those coalitions 	<ul style="list-style-type: none"> All primary care practices All payers All New Yorkers
Units	<ul style="list-style-type: none"> Provider Performing Systems 	<ul style="list-style-type: none"> Primary care practices (of any size or affiliation)
Payment models	<ul style="list-style-type: none"> Provider incentive payments based on project milestones and outcomes; Value based payment 	<ul style="list-style-type: none"> Range of payment models for primary care, including P4P, shared savings, capitation, etc.

Integrated Care Appendix

Milestones related to measures progress from a focus on collection and reporting to an expectation of performance

	Commitment Gate 1	Readiness for care coordination Gate 2	Achievement of APC Gate 3	Yearly performance against core measures within APC	Achievement of Premium APC Gate 4
Objective	Ensure practices can measure, report and engage with core measures in preparation for performance improvement			Ensure practices are demonstrating material performance improvement and are on track for APC	
Proposed milestones	<ul style="list-style-type: none"> Develop a plan for collecting and reporting non-claims-based data relevant for core measures 	<ul style="list-style-type: none"> Begin measurement and reporting of all core measures QI plan: On at least one claims-based measure 	<ul style="list-style-type: none"> QI plan: on 3 prioritized core measures, incl. utilization QI plan: address health access and outcome disparities Performance expectation? 	<ul style="list-style-type: none"> Material improvement in at least 3 core measures, including at least one utilization measure (definition of “material improvement” made in contract between payer and provider) or Closure of gap to agreed-upon benchmark by at least 10% per year on 3 core measures (including at least one utilization measure) or Improvement on utilization metrics by at least 5% per year, contingent on meeting agreed-upon minimum quality standards 	<ul style="list-style-type: none"> Continued performance expectation TBD
<p>Questions for consideration:</p> <ul style="list-style-type: none"> At what point in the APC journey will it be reasonable to expect improvements on core measures? What is the required materiality / strength of performance improvement against this (sub)set of core measures? Is this best decided at a payer level? 					

Current draft APC core measures

PRELIMINARY

	Proposed core measure
Prevention	<ol style="list-style-type: none"> 1. Colorectal Cancer Screening* 2. Chlamydia Screening* 3. Influenza Immunization - all ages* 4. Childhood Immunization (status)* 5. Fluoride Varnish Application
Chronic Disease (Prevention and Management)	<ol style="list-style-type: none"> 6. Tobacco Use Screening and Intervention* 7. Controlling High Blood Pressure* 8. Diabetes A1C Poor Control* 9. Appropriate Medication Management for People with Asthma* 10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults*
BH / Substance Abuse	<ol style="list-style-type: none"> 11. Depression screening and management* 12. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Patient Reported	<ol style="list-style-type: none"> 13. Record Advance Directives for 65+ 14. CAHPS Access to Care, Getting Care Quickly*
Appropriate Use	<ol style="list-style-type: none"> 15. Use of Imaging Studies for Low Back Pain 16. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis 17. Avoidable Hospitalization* 18. Avoidable readmission* 19. Emergency Dept. Utilization*
Cost of Care	<ol style="list-style-type: none"> 20. Total Cost of Care

* DSRIP measures

APC Tiers – draft revised Sept 15, 2015 (1/3)

TO BE REVIEWED AND FINALIZED
ONCE MILESTONES AGREED

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
1. Patient-centered care	At least annual patient survey, or patient advisory council or patient focus group and incorporation of results/recommendations as part of QI plan.	All previous plus: <ol style="list-style-type: none"> At least semi-annual patient survey, or patient advisory council or patient focus group and show evidence of incorporation of results as part of QI plan. Conduct comprehensive health assessment for each patient inclusive of discussion of advanced directives. Develop care plans in concert with patient preferences and goals Provide culturally and linguistically appropriate care and services to promote access and quality. 	All previous plus: <ol style="list-style-type: none"> At least quarterly patient surveys or patient advisory council or focus group and show evidence of incorporation as part of QI plan. Report survey results to patients, payers or both. Include patient or family member as part of practice advisory council or governance structure. Report results of at least one standardized measure to patients.
2. Population health		<ol style="list-style-type: none"> Identify at least annually patients due for preventive or chronic care management services and communicate reminders. Evaluate health disparities in access/outcome as part of QI plan. Offer or refer patients to structured health education programs such as group classes, peer support, and self-management programs. Measure and report one prevention agenda (PA) goal consistent with local PA goals. 	All previous plus: <ol style="list-style-type: none"> Evaluate health disparities as part of QI plan and develop plan to address Identify, more than annually, patients due for preventive or chronic care management services, communicate reminders and ensure provision of appropriate follow-up care Maintain a list of community-based services that are relevant to the practice's high-risk population and establish referral and feedback mechanisms for linking patients with these services.

APC Tiers – draft revised Sept 15, 2015 (2/3)

TO BE REVIEWED AND FINALIZED
ONCE MILESTONES AGREED

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
3. Care management	<ul style="list-style-type: none"> a. Identify high risk patients who would benefit from care management (CM) b. Screening, treatment and referral where indicated for behavioral health issues. 	<p>All previous plus:</p> <ul style="list-style-type: none"> a. Provide/offer (CM) to at least 75% of high risk patients. b. Electronic medication reconciliation for patients transitioning from institutional care. c. Provide core elements of Collaborative Care model for depression screening and management, including assessment, data collection and tracking metrics over time. 	<p>All previous plus:</p> <ul style="list-style-type: none"> a. CM services offered to all high-risk patients. b. Integrate practice care management with Medicaid health home and health plan care managers as appropriate. c. Evidence-based screening, intervention, and referral to treatment, to prevent, identify, and address substance use disorders
4. Access to care	<ul style="list-style-type: none"> a. 24/7 same day patient access to nurse or other clinician via telephone and/or secure electronic messaging 	<p>All previous plus:</p> <ul style="list-style-type: none"> a. Access to EHR by the on-call clinician after hours. b. Patient access to care during non-traditional hours including at least one session/week of evening/weekend office hours. c. Synchronous and asynchronous communication such as secure electronic messaging between patient and provider with commitment to an explicit response time goal. 	<p>All previous</p>
5. Quality improvement	<ul style="list-style-type: none"> a. Evaluate practice performance using a set of at least 3 standardized quality (HEDIS, QARR, MU CQMs, etc.). 	<p>All previous plus:</p> <ul style="list-style-type: none"> a. Measure and report at least six standardized measures (including behavioral health and patient experience) b. Incorporate results as part of a formal QI process. c. At least half of measures should be from EHR. 	<p>All previous plus:</p> <ul style="list-style-type: none"> a. At least half of measures make use of CQM data.

APC Tiers – draft revised Sept 15, 2015 (3/3)

TO BE REVIEWED AND FINALIZED
ONCE MILESTONES AGREED

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
6. Care coordination	<p>a. System in place to track high risk referrals</p>	<p>a. Track referrals and reports of referral visit to PCP and have processes to address uncompleted referrals or reports.</p> <p>b. Have care compacts or collaborative agreements with specialists (including behavioral health) to improve transitions in care.</p> <p>c. Have systems in place to identify and contact patients seen in an ED or hospital discharges.</p>	<p>All previous plus:</p> <p>a. Measure the effectiveness of care transitions processes in contacting and following up with patients and implement QI efforts as needed.</p>
7. Health Information Technology	<p>Practice able to meet one of the following:</p> <p>a. Attest to Meaningful Use Stage 1 within one year</p> <p>b. Signed contract with an EHR vendor</p> <p>c. IT and data utilization capabilities including:</p> <ul style="list-style-type: none"> • Tool to enable population health tracking and quality reporting over time • Access to and use of reports (clinical or claim-based) that identify high risk patients • Ability to electronically document and share a care plan, with all members of the practice. 	<p>All previous plus:</p> <p>a. Meaningful Use Stage 1</p> <p>b. Connected to local RHIO or has plans to connect with six months.</p>	<p>All previous</p> <p>a. Meets all MU Stage 2 and Stage 3 requirements.</p> <p>b. Connected to local RHIOs and uses data for patient care activities.</p>

Example: Meeting NCQA criteria is one way that practices can make progress toward APC milestones

APC Domains	NCQA Criteria	Current APC milestones
Care coordination	<ul style="list-style-type: none"> 5. Track and coordinate care 4. Track and manage care 	<ul style="list-style-type: none"> Care coordination / management: Track and manage referrals and care transitions; Provide CM to high-risk patients and link to behavioral health
Patient centered care	<ul style="list-style-type: none"> 1. Enhance Access and Continuity 2. Team-based care (including CLAS²) 	<ul style="list-style-type: none"> Access: 24/7 access by phone, after-hours access Patient-centered care: Patient surveys, data reporting, culturally and linguistically appropriate care
QI / Population health	<ul style="list-style-type: none"> 3. Population Health management 6. Measure and Improve performance 	<ul style="list-style-type: none"> Population health: identify patients with chronic and preventive health needs, develop plan to address health disparities, link to community resources Quality Improvement: measure and report quality measures and engage in formal QI plan
Information technology	<ul style="list-style-type: none"> In other criteria: 6 (EHR technology), 4 (Use electronic prescribing) 	<ul style="list-style-type: none"> Health Information Technology: Achieve meaningful-use standards and connect to local RHIOs
Value-based payment		<ul style="list-style-type: none"> Payment model: Negotiates alternative payment models

1 Based on on NYS SHIP, December 2013

2 CLAS: Culturally and Linguistically Appropriate Services

Source: NYS SIM documents, NCQA's Standards and Guidelines for PCMH 2014

Case example: A primary care provider's experience of SHIP initiatives

Current state

- Over two decades in practice, Dr. G has seen a **growth in administrative tasks and a decrease in time with patients** driven by FFS
- Despite great efforts to become **NCQA PCMH certified, practice workflows have not significantly changed**
- Despite interest in **new payment programs**, she is concerned they are:
 - **Temporary**
 - Based on a **small proportion of her panel**
 - **Different** from each other

NYS SHIP initiatives

APC will drive consistency in primary care transformation and associated payments

Through **DSRIP** Medicaid will support her transformation and integration within a performing provider system

Workforce initiatives will ensure that members of her team can help her care for the whole patient while helping keep her work at top-of-license

Prevention Agenda will connect her to community resources and efforts to ensure a healthy community

Future state

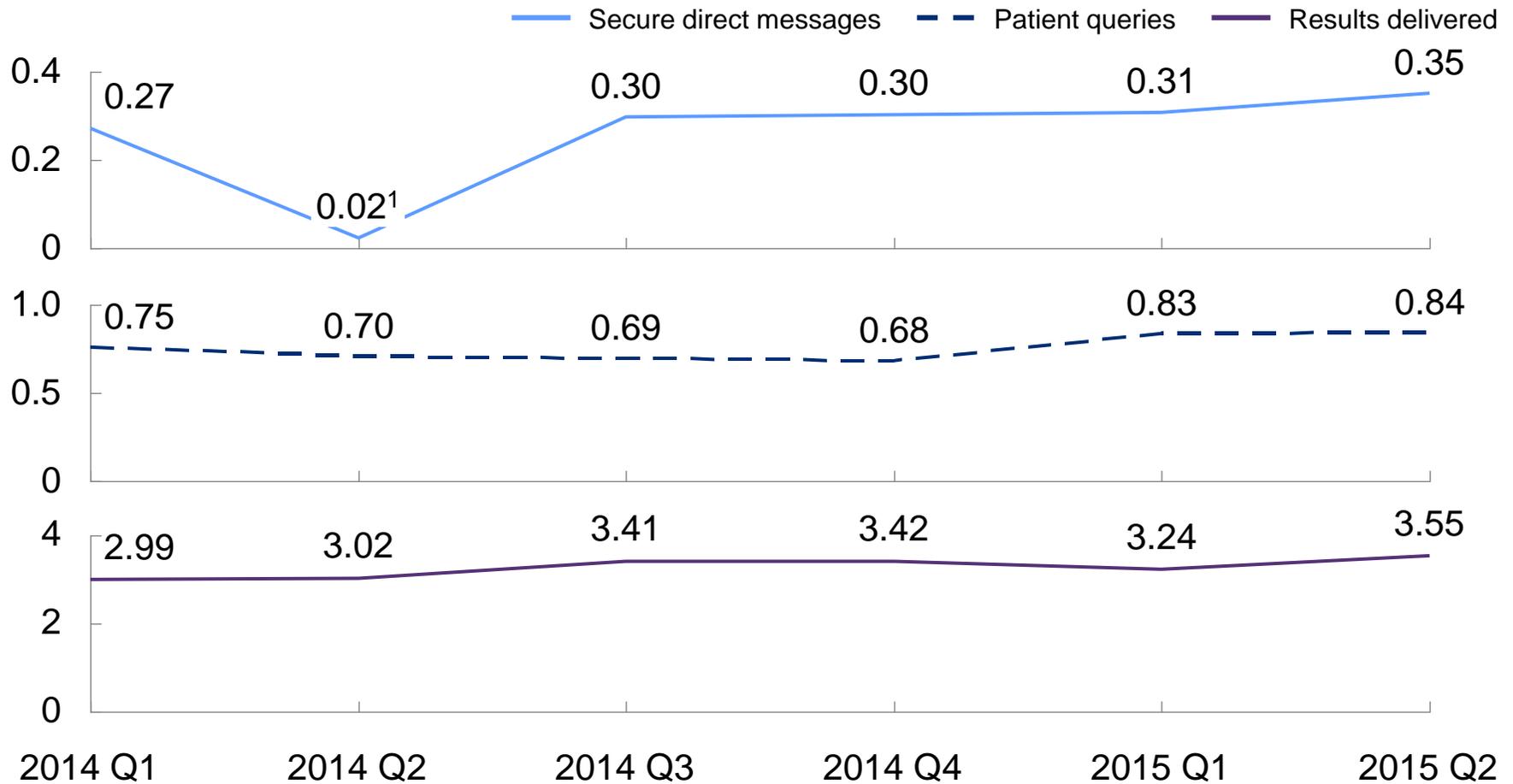
- Dr. G will lead a **team of care providers practicing at top-of-license to provide coordinated whole-patient care**
- **Measurement and payment models will be more consistent** across her patient panel, allowing her team to focus on key improvement areas
- Her patients will benefit from **improved care, experience, and outcomes**, and will be better involved in care decisions



Transparency, Evaluation and HIT Appendix

Statewide patient lookup: growth in information sharing across RHIOs

Number of transactions between RHIOs, Q1 2014 – Q2 2015, Millions



¹ Q2 2014 had a reporting issue for direct messaging

Nb – ‘Secure direct messages’ are provider-to-provider messages, ‘results delivered’ are results sent to providers automatically