Workforce Workgroup
Meeting # 4

February 24, 2016
Welcome and Introductions
<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
<th>Time</th>
<th>Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and Introductions</td>
<td>10:00 – 10:10</td>
<td>Patrick Coonan &amp; Wade Norwood, Co-Chairs</td>
</tr>
<tr>
<td>2</td>
<td>Subcommittee One Report Out</td>
<td>10:10 – 11:10</td>
<td>Wade Norwood</td>
</tr>
<tr>
<td>3</td>
<td>Update on New Committee Being Formed</td>
<td>11:10 – 11:20</td>
<td>Patrick Coonan</td>
</tr>
<tr>
<td>4</td>
<td>Subcommittee Report Out</td>
<td>11:20 – 12:20</td>
<td>Jean Moore</td>
</tr>
<tr>
<td>5</td>
<td>DSRIP Update</td>
<td>12:20 – 12:40</td>
<td>Peggy Chan</td>
</tr>
<tr>
<td>6</td>
<td>SIM Update</td>
<td>12:40 – 1:00</td>
<td>Hope Plavin</td>
</tr>
</tbody>
</table>
Subcommittee Report Out
Care Coordination Subcommittees of DSRIP/SHIP Workforce Workgroup

Workgroup survey found consensus on need to “develop core competencies and/or training standards for workers in care coordination titles”

Three subcommittees convened to focus on different aspects of effective care coordination

- **Subcommittee 1**: Identification of core competencies and functions and regulatory barriers that could impede effective care coordination
- **Subcommittee 2**: Identification of curricular content for educating the health workforce on core concepts in care coordination (embedded in health professions education curricula and to use for continuing education)
- **Subcommittee 3**: Identification of recommended core curriculum for training workers in care coordination titles
Subcommittee One
Subcommittee One Charge:

Advance Workgroup goals by:

• Delineating key care coordination competencies and functions;
• Maintaining a commitment to warranted variations based on patient population, clinical service lines and differing staffing patterns; and
• Identifying statutory/regulatory barriers that could impede the provision of care coordination services
Subcommittee One Membership

Chairs: Wade Norwood & Doug Lentivech

- Lloyd Sederer (OMH)
- Tim Johnson (GNYHA)
- Robin Frank (HANYS)
- Katie Gordon (HANYS)
- Gary Fitzgerald (Iroquois)
- John August (Cornell)
- Helen Schaub (1199)
- Sergio Matos (CHW of NY)
- Karen Nelson (Maimonides)
- Judith Mazza (HEALTH)
- Bill Ebenstein (CUNY)
- Nicole Haggerty (OMH)
- Melissa Harshbarger (OMH)
What Have We Done So Far?

Subcommittee Teleconference #1: Level set charge and define terms

Offline Coordination Teleconference #1: Build a common set of functions to be used by all 3 subcommittees

Subcommittee Teleconference #2: Discuss preliminary set of functions and preliminary set of licensed titles

Offline Coordination Teleconference #2: Engage relevant NYSED Board Secretaries to build a common vision
Our Operational Definitions

Title - Signifies an official position or a professional or academic qualification.

We propose using the terms “Licensed,” “Certified” and “Lay” to describe the different types of health workers that could, with varying degrees of supervision, be involved in effective care coordination.

Function – A category or group of logically associated tasks that are carried out by one or more professions, titles and/or roles (e.g., Diagnose)

Task – A defined piece of work associated with a function (e.g., Blood Test)
## Current Set of Functions

- Make appointment reminder calls to patients or oversee automated process
- Lead daily huddles
- Provide information via portal
- Review appointment history and follow up as needed
- Document preventive / chronic care services since last visit
- Verify and update missing preventive / chronic care services
- Update social history
- Verify and update demographic information (address, phone, etc.)
- Verify and update insurance information
- Verify information in referrals and test requisitions (insurance coverage, address, phone, etc.)
- Assist with visit documentation
- Assist patient in preparing questions for clinician
- Gather history during visit
- Document history
- Interpretation for patient
- Ensure Patient Compliance
- Patient education/health coaching/patient self-management
- Review clinician recommendations with patient
- Track and follow up on completion of referral visits, tests & procedures
- Set up next office visit appointment for patient
- Make appointments with specialists or for procedures for patient
- Make follow up care coordination phone calls
- Transmit documents to specialists or facilities
- Communicate with external case / disease managers
- Teach-back to ensure patient learning
- Scan documents into EHR
- Complete orders and document
- Update structured data in EHR
- Communications (contact with patients via calls/emails, route patient calls/emails to appropriate staff, review communications from facilities in re patients, track time in establishing appointments)
- Complete/document review of systems (update patient registry)
- Population Management (data reports based on patient registry, mail relevant information to patients, outreach with no-show appointments, review reports in re unfilled patient prescriptions)
Early Lessons Learned

The set of functions selected is somewhat arbitrary – we had to start with something.

The difference between a function and a task is just as debatable; as a result, we stopped debating it.

We are well served by “eating the elephant one bite at a time.” We will start with the Licensed health workers but will identify barriers the impede effective care coordination by Certified and Lay workers.

This is not an easy task for the subcommittee and we expect our need for full Workgroup engagement will be around “the very not easy tasks.”
Scope of Licensed Titles

**Medicine**
- Physicians
- Physician Assistants
- Specialist Assistants

**Midwifery**

**Nursing**
- Registered Professional Nurses
- Nurse Practitioners
- Clinical Nurse Specialists
- Licensed Practical Nurses

**Social Work**
- Licensed Master Social Worker (LMSW)
- Licensed Clinical Social Worker (LCSW)
Next Steps

Report Statutory/Regulatory Barriers for Licensed Titled workers to Subcommittee

Determine Scope of Certified and Lay Titled workers for Analysis

Report Statutory/Regulatory Barriers Certified and Lay Titled workers to Subcommittee

Deliver Subcommittee report on Statutory/Regulatory Barriers for all “in-scope workers” to full Workgroup for review and refinement

Receive and, as needed, incorporate recommendations from other subcommittees with regard to workforce preparation and/or on-going development
Subcommittee Two
Subcommittee Two

Chaired by: Patrick R. Coonan, EdD, RN, NEA-BC, FACHE

Focus: Identification of curricular content for educating the health workforce in core concepts in care coordination (embedded in health professions education curricula and for continuing education of existing health care professionals).

Goal: To describe the recommended curriculum to use for educating health professions students and the existing health workforce in the core concepts of care coordination. The curriculum should be designed to provide a basic understanding of what care coordination is and the roles that health workers can play to support effective care coordination in their patient population. The initial focus will be on the following health professions: registered nurses, physicians, physician assistants and nurse practitioners. Subsequently, strategies for training other professions and occupations will be considered, including social workers, pharmacists, and medical assistants, among others.

Status: The committee will be convened to include members of the Workforce Workgroup as well as non-members from representative educational institutions and societies from across the state. Targeting a meeting in late March 2016.
Subcommittee Three
Care Coordination Subcommittees of DSRIP/SHIP Workforce Workgroup

Workgroup survey found consensus on need to “develop core competencies and/or training standards for workers in care coordination titles”

• Three subcommittees convened to focus on different aspects of effective care coordination
  o Subcommittee 1: Identification of core competencies and functions and regulatory barriers that could impede effective care coordination
  o Subcommittee 2: Identification of curricular content for educating the health workforce on core concepts in care coordination (embedded in health professions education curricula and to use for continuing education)
  o Subcommittee 3: Identification of recommended core curriculum for training workers in care coordination titles
Subcommittee Three Charge

- To review curricula used by groups across the state for training workers in care coordination titles
- To examine overlap in core content of these training programs
- To identify key curricular components to include in all basic training programs for workers in care coordination titles
Subcommittee Members

- Heather Eichen, State University of New York
- Shawna Trager, New York Alliance for Careers in Healthcare
- Sandi Vito, 1199SEIU/League Training & Upgrading Fund
- Tracey Leonard, Fort Drum Regional Health Planning Organization
- Bill Ebenstein, City University of New York
- Jean Moore, Center for Health Workforce Studies
- Carol Rodat, Paraprofessional Healthcare Institute
- Johney Barnes, Office of Mental Health
- Alexandra Blais, Home Care Association of NYS
Care Coordination Curricular Review Process

• Primary focus of curricula review:
  - CUNY Credited Course Sequence in Care Coordination and Health Coaching
  - New York Alliance for Careers in Healthcare Training
  - North Country Care Coordination Certificate Program
  - 1199SEIU Care Coordination Fundamentals

• National literature searches on care coordination training were conducted as these curricula were being developed
• The review found a great deal of consistency in content across the different training curricula
Core Curriculum Guidelines Developed

- Consists of 9 modules
- Modules include topics, learning objectives and resources
- Estimated time to complete modules is between 36-45 hours
- Considered the ‘starting point’
- Designed to be adapted to fit local circumstances
  - Could be embedded in medical assistant or home health aide training
  - Could serve as a base for care coordination training worth college credit
Summary of Modules

- Introduction to New Models of Care and Health Care Trends
- Interdisciplinary Teams
- Person-Centeredness and Communication
- Chronic Disease and Social Determinants of Health
- Cultural Competence
- Ethics and Professional Boundaries
- Quality Improvement
- Community Orientation
- Health Information Technology, Documentation and Confidentiality
Reference Materials

- List of and links to (where available) all training programs reviewed
- Resources
  - Textbooks
  - Supplemental readings
  - Documentaries/programs
  - On-line resources
Questions and comments

For discussion

1. Feedback on content?
2. What strategies could support the adoption of these guidelines?
3. What are the best approaches to update the guidelines to reflect changes in care coordination functions?
DSRIP Implementation Timeline and Key Benchmarks

Focus on Infrastructure Development

Q1|Q2|Q3|Q4

You are here

Focus on System/Clinical Development

Q1|Q2|Q3|Q4

Focus on Project Outcomes/Sustainability

Q1|Q2|Q3|Q4

PPS are currently transitioning from Planning to Implementation

DY0

DY1

DY2

DY3

DY4

DY5

- Submission/Approval of Project Plan
- PPS Project Plan Valuation
- PPS first DSRIP Payment
- PPS Submission and approval of Implementation Plan
- PPS Submission of First Quarterly Report

Domain 3: Clinical Improvement P4P Performance Measures begin

Domain 2: System Transformation P4P Performance Measures begin

Domains 2 & 3 are completely P4P
# Workforce Deliverables, Achievement Values, & Deadlines

<table>
<thead>
<tr>
<th>Milestone / Deliverable</th>
<th>AV Driving?</th>
<th>Prescribed Reporting / Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workforce Strategy Spending</strong></td>
<td>Yes</td>
<td>Baselines: DY1, Q4&lt;br&gt;Actuals: DY1, Q4 and subsequent Q2 and Q4</td>
</tr>
<tr>
<td><strong>Workforce Staff Impact Analysis (Redeployment/Retraining)</strong></td>
<td>Yes</td>
<td>Baselines: DY2, Q1&lt;br&gt;Actuals: DY2, Q2 and subsequent Q2 and Q4</td>
</tr>
<tr>
<td><strong>Workforce New Hire Analysis</strong></td>
<td>Yes</td>
<td>Baselines: DY2, Q1&lt;br&gt;Actuals: DY2, Q2 and subsequent Q2 and Q4</td>
</tr>
<tr>
<td><strong>Milestone #4: Produce a Compensation and Benefits Analysis</strong></td>
<td>Yes</td>
<td>DY1: DY2, Q1&lt;br&gt;DY3: DY3, Q4&lt;br&gt;DY5: DY5, Q4</td>
</tr>
<tr>
<td><strong>Milestone #1: Define target workforce state (in line with DSRIP program's goals)</strong></td>
<td>No</td>
<td>None – Suggested completion date of DY2, Q1</td>
</tr>
<tr>
<td><strong>Milestone #2: Create a workforce transition roadmap for achieving your defined target workforce state.</strong></td>
<td>No</td>
<td>None – Suggested completion date of DY2, Q2</td>
</tr>
<tr>
<td><strong>Milestone #3: Perform detailed gap analysis between current state assessment of workforce and projected state.</strong></td>
<td>No</td>
<td>None – Suggested completion date of DY2, Q2</td>
</tr>
<tr>
<td><strong>Milestone #5: Develop training strategy.</strong></td>
<td>No</td>
<td>None – Suggested completion date of DY2, Q2</td>
</tr>
</tbody>
</table>
Workforce Achievement Values

- Domain 1 Organizational AVs are based on the completion of Current period milestones and updates on milestones to be completed or already completed
- Each of the four Domain 1 Organizational AVs related to the Workforce section of the Quarterly Report can be earned by completing the following:

<table>
<thead>
<tr>
<th>Workforce Strategy Budget Updates</th>
<th>Workforce Impact Analysis and Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on the Workforce Strategy Budget commitment made in the Project Plan Application <em>(semi-annual Q2 &amp; Q4 reporting)</em></td>
<td>Provides details on the workforce impact and placement impact for redeployed, retrained and newly hired staff <em>(semi-annual Q2 &amp; Q4 reporting)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Hire Employment Analysis and Updates</th>
<th>Compensation &amp; Benefits Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides details on the number and types of new hires <em>(semi-annual Q2 &amp; Q4 reporting)</em></td>
<td>Captures a snapshot in time and examines workforce trends within each PPS <em>(DY2 Q1, DY3 Q4, DY5 Q4)</em></td>
</tr>
</tbody>
</table>
DSRIP PPS Workforce Budget Overview

- Each PPS submitted a Workforce Budget as part of their PPS application.
- The Workforce Budget commitments were part of the application scoring which drove the total potential PPS award.
- The Workforce Budget commitment made by each PPS is binding and is tied to Achievement Values that govern semi-annual payment amounts.
- PPSs are to expend for workforce analyses, training/retraining, redeployment, and recruitment.
- Adjustments have been made to allow PPSs more flexibility in timeframes for expenditures so long as 90% of total budget is accounted for by the end of DY4.

### DSRIP Year Spending Requirement

<table>
<thead>
<tr>
<th>DSRIP Year</th>
<th>Spending Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1</td>
<td>80% of DY1 spending commitment**</td>
</tr>
<tr>
<td>DY2</td>
<td>80% of cumulative DY1 + DY2 spending commitment</td>
</tr>
<tr>
<td>DY3</td>
<td>85% of cumulative DY1 + DY2 + DY3 spending commitment</td>
</tr>
<tr>
<td>DY4</td>
<td>90% of total spending commitment</td>
</tr>
</tbody>
</table>
DSRIP Staff Impact and New Hire Analysis Overview

• PPS are required to provide details on annual staffing impact resulting from DSRIP project implementation.
  • Baselines: DY2, Q1
  • Actuals: DY2, Q2 and subsequent Q2 and Q4

<table>
<thead>
<tr>
<th>Year</th>
<th>Facility Type (defined list)</th>
<th>Job category (defined list)</th>
<th>New hires, #</th>
<th>Redeployed, #</th>
<th>Retrained, #</th>
<th>Other, #</th>
<th>Full placement (≥95% comp.), #</th>
<th>Partial placement (≥75% and &lt;95% comp.), #</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY1</td>
<td>Inpatient</td>
<td>Nurse practitioners</td>
<td>6</td>
<td>14</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Registered nurses</td>
<td>17</td>
<td>83</td>
<td>24</td>
<td>12</td>
<td>30</td>
<td>84</td>
</tr>
<tr>
<td>DY1</td>
<td>Hospital Article 28 Outpatient Clinic</td>
<td>Nurse practitioners</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Registered nurses</td>
<td>4</td>
<td>16</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

all numbers and data elements in this table are intended for illustrative purposes only

Required data elements for measuring and reporting Staff Impact

• Staff Impact reporting will be entered into a matrix of Job Titles vs. Facility Types.
• These tables will be built into MAPP for PPS reporting.
Job Titles and Facility Types

Where possible, job titles crosswalk to 2010 Standard Occupational Classification (see Appendix for full list)

For each job title, workforce impact will be reported against the most appropriate Facility Type below:

- **Physicians**
  - Primary Care
  - Other Specialties (Except Psychiatrists)

- **Physician Assistants**
  - Primary Care
  - Other Specialties

- **Nurse Practitioners**
  - Primary Care
  - Other Specialties (Except Psychiatric NPs)

- **Midwives**

- **Nursing**
  - Nurse Managers/Supervisors
  - Staff Registered Nurses
  - Other Registered Nurses (Utilization Review, Staff Development, etc.)
  - LPNs
  - Other

- **Behavioral Health (Except Social Workers providing Case/Care Management, etc.)**
  - Licensed Clinical Social Workers
  - Substance Abuse and Behavioral Disorder Counselors
  - Other Mental Health/Substance Abuse Titles Requiring Certification
  - Social and Human Service Assistants
  - Psychiatric Aides/Techs
  - Other

- **Behavioral Health (Except Social Workers providing Case/Care Management, etc.) (cont’d)**
  - Licensed Masters Social Workers
  - Social Worker Care Coordinators/Case Managers/Care Transitions
  - Other

- **Nursing Care Managers/Coordinators/Navigators/Coaches**
  - RN Care Coordinators/Case Managers/Care Transitions
  - LPN Care Coordinators/Case Managers

- **Social Worker Case Management/ Care Management**
  - Bachelor’s Social Work
  - Licensed Masters Social Workers
  - Social Worker Care Coordinators/Case Managers/Care Transition
  - Other

- **Behavioral Health (Except Social Workers providing Case/Care Management, etc.) (cont’d)**
  - Licensed Clinical Social Workers
  - Substance Abuse and Behavioral Disorder Counselors
  - Other Mental Health/Substance Abuse Titles Requiring Certification
  - Social and Human Service Assistants
  - Psychiatric Aides/Techs
  - Other

- **Psychiatrists**
  - Psychologists
  - Psychiatric Nurse Practitioners
DSRIP Compensation and Benefits Analysis Overview

- The purpose of the Compensation & Benefits Survey is to capture a *snapshot in time* and examine workforce trends within each PPS in order to:
  - Inform education and training requirements for PPSs and their partners,
  - Guide retraining for redeployed workers and employee support programs, and
  - Advance health care workforce research and policy development while demonstrating DSRIP impact.
- PPS are required to complete this analysis for DY1, DY3, and DY5 (i.e., start, mid-point, and end of DSRIP)
- A sample data grid is shown here for collecting information about all Job Titles of workers at each facility:

<table>
<thead>
<tr>
<th>Facility code</th>
<th>Facility Type (select from defined list)</th>
<th>Job category (select from defined list)</th>
<th>Individuals Employed, #</th>
<th>Vacancies/ Intend to fill, #</th>
<th>Average cash compensation rate, $</th>
<th>Benefits, as a percentage of compensation</th>
<th>CBA* Status, Y or N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A123</td>
<td>Inpatient</td>
<td>Nurse practitioners</td>
<td>88</td>
<td>4</td>
<td>$48.56</td>
<td>27%</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Registered nurses</td>
<td>1,263</td>
<td>163</td>
<td>$37.98</td>
<td>27%</td>
<td>Y</td>
</tr>
<tr>
<td>Hospital B123</td>
<td>Hospital Article 28 Outpatient Clinic</td>
<td>Nurse practitioners</td>
<td>44</td>
<td>6</td>
<td>$45.19</td>
<td>29%</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Registered nurses</td>
<td>767</td>
<td>21</td>
<td>$33.13</td>
<td>29%</td>
<td>N</td>
</tr>
</tbody>
</table>

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*CBA = Collective Bargaining Agreement*

The required set of data elements to be collected and reported by all PPS can be found in the appendix.
Example Table for Compensation and Benefits Analysis

- A sample data grid is shown here for Aggregating collected data by Job Title

<table>
<thead>
<tr>
<th>Job Title: Registered Nurse</th>
<th>Organization Category</th>
<th>Number of organizations</th>
<th>Number CBA* organizations</th>
<th>Number employees</th>
<th>Number of vacancies</th>
<th>Position vacancy rate</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; percentile average cash comp. rate, $</th>
<th>Mean average cash comp. rate, $</th>
<th>Median average cash comp. rate, $</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; percentile average cash comp. rate, $</th>
<th>Benefits, as % of average comp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All organizations</td>
<td>124</td>
<td>14</td>
<td>1797</td>
<td>107</td>
<td>5.95%</td>
<td>$30.23</td>
<td>$36.92</td>
<td>$37.31</td>
<td>$39.24</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Behavioral Health (Article 31 &amp; 32)</td>
<td>15</td>
<td>2</td>
<td>31</td>
<td>6</td>
<td>1.94%</td>
<td>$30.51</td>
<td>$28.97</td>
<td>$29.78</td>
<td>$29.58</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Article 28 Diagnostic &amp; Treatment Centers</td>
<td>33</td>
<td>2</td>
<td>423</td>
<td>10</td>
<td>2.36%</td>
<td>$29.34</td>
<td>$29.01</td>
<td>$31.20</td>
<td>$29.88</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Article 16 Clinics (OPWDD)</td>
<td>7</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>10.34%</td>
<td>$30.61</td>
<td>$30.65</td>
<td>$30.99</td>
<td>$29.93</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Home Care Agency</td>
<td>6</td>
<td>2</td>
<td>18</td>
<td>2</td>
<td>11.11%</td>
<td>$30.44</td>
<td>$31.46</td>
<td>$31.58</td>
<td>$30.39</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Hospital Article 28 Outpatient Clinics</td>
<td>19</td>
<td>2</td>
<td>79</td>
<td>29</td>
<td>36.71%</td>
<td>$31.31</td>
<td>$29.62</td>
<td>$29.73</td>
<td>$31.26</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>6</td>
<td>3</td>
<td>1057</td>
<td>51</td>
<td>4.82%</td>
<td>$28.77</td>
<td>$29.57</td>
<td>$29.45</td>
<td>$30.23</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Non-licensed CBO</td>
<td>9</td>
<td>0</td>
<td>22</td>
<td>2</td>
<td>9.09%</td>
<td>$30.52</td>
<td>$31.18</td>
<td>$28.91</td>
<td>$31.60</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Nursing Home/SNF</td>
<td>7</td>
<td>4</td>
<td>109</td>
<td>3</td>
<td>2.75%</td>
<td>$30.37</td>
<td>$30.39</td>
<td>$30.43</td>
<td>$30.06</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Private Provider Practice</td>
<td>27</td>
<td>0</td>
<td>29</td>
<td>1</td>
<td>3.45%</td>
<td>$29.72</td>
<td>$31.30</td>
<td>$31.15</td>
<td>$29.12</td>
<td>28%</td>
<td></td>
</tr>
</tbody>
</table>

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*CBA = Collective Bargaining Agreement

The required set of data elements to be collected and reported by all PPS can be found in the appendix.
### Examples of PPS Collaboration on Workforce

<table>
<thead>
<tr>
<th>PPS</th>
<th>Initiative</th>
<th>Impact</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maimonides Medical Center, NYU Lutheran Medical Center, St Barnabas Hospital and New York City Health and Hospital's Corporation (HHC)</td>
<td>PPSs met to discuss workforce assessment strategy and created a single workforce survey through a joint vendor contract</td>
<td>Intend to streamline data collection across overlapping partners and reduce cost through a city-wide approach on workforce current state</td>
<td>Challenges include high cost, limited on-the-ground vendor support, difficulty in identifying PPS-specific impacts, and citywide needs of New York City Health and Hospital's Corporation.</td>
</tr>
<tr>
<td>Adirondack Health Institute, Inc.</td>
<td>Partnered with SUNY, the Center for Health Workforce Studies, the Hudson Mohawk Area Health Education Center, and the Northern Area Health Education Committee for a program called RP2. RP2 is designed to address current health workforce gaps and meet future needs through the creation of regional workforce groups that include educators, employers and others</td>
<td>The initiative resulted in a regional training resource directory that will be updated by the PPS Workforce Committee. In addition, a standardized Care Management/Coordination curriculum with credentialing/certificate provision is being considered for the region. Individuals who participated in the RP2 meetings were invited to participate in AHI PPS workforce efforts by joining the Workforce Advisory Council.</td>
<td>The Workforce Advisory Council meets quarterly with meetings planned for March, June, September and December generally via webinar. In addition, AHI, SUNY, Center for Health Workforce Studies, Hudson Mohawk Area Health Education Center and Northern Area Health Education Center meet quarterly with other upstate PPS workforce representatives to share information and identify other means to collaborate.</td>
</tr>
<tr>
<td>Maimonides Medical Center, New York and Presbyterian Hospital, Bronx-Lebanon Hospital Center, St Barnabas Hospital, Advocate Community Partners and New York Health and Hospital's Corporation (HHC)</td>
<td>Participated in multi-PPS meetings to discuss workforce assessment strategy and the possibility of creating a single workforce survey to be administered by a preferred vendor(s) identified through a collaborative RFP / proposal review process.</td>
<td>Streamlined data collection across overlapping partners and reduction in cost with borough-wide (e.g., one approach in Brooklyn) approach to assessment of current workforce state.</td>
<td>Developing follow up plans to address challenges, including high cost, limited on-the-ground vendor support, difficulty in identifying PPS-specific impacts, and citywide needs of New York City Health and Hospital's Corporation (HHC) PPS and Advocate Community Partners PPS</td>
</tr>
</tbody>
</table>
Questions?

DSRIP e-mail: dsrip@health.ny.gov
SIM Update
# New York State Health Innovation Plan (SHIP)

## Delivering the Triple Aim – Healthier people, better care and individual experience, smarter spending

<table>
<thead>
<tr>
<th>Goal</th>
<th>Pillars</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to care for all New Yorkers, without disparity</td>
<td>Integrated care to address patient needs seamlessly</td>
<td>Workforce strategy</td>
</tr>
<tr>
<td>Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way</td>
<td>Integration of primary care, behavioral health, acute and post-acute care, and supportive care for those that require it</td>
<td>Health information technology</td>
</tr>
<tr>
<td>Make the cost and quality of care transparent to empower decision making</td>
<td>Information to enable individuals and providers to make better decisions at enrollment and at the point of care</td>
<td>Performance measurement &amp; evaluation</td>
</tr>
<tr>
<td>Pay for health care value, not volume</td>
<td>Rewards for providers who achieve high standards for quality and individual experience while controlling costs</td>
<td>Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</td>
</tr>
</tbody>
</table>
State Health Innovation Plan/State Innovation Model

Advanced Primary Care

- Goal is a multipayer approach to aligned care/payment reform focused on primary care that:
  - Achieves (works to achieve) triple aim goals
  - Engages practices, patients, and payers
  - Builds on evidence, experience, existing demonstrations, PCMH
  - Is sustainable
    - Not ‘just’ a grant program
  - Is supported by HIT/HIE, workforce, access
  - Is statewide
  - Combines care and payment reform
Progress: Thanks to our Integrated Care Workgroup and Stakeholder Inputs

- Broad consensus on practice capabilities (and approach to measure/determine)
- Finite set of shared ‘core’ measures (currently ~20)
  - Non-FFS payments depend on measures/performance

Approach to aligned payment support
- technical support to practices
- care management support from payers
- value/outcome based payments
## APC Capabilities

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Patient-centered care</td>
<td>▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population</td>
</tr>
<tr>
<td>Population Health</td>
<td>▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment</td>
</tr>
<tr>
<td>Care management/coordination</td>
<td>▪ Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care</td>
</tr>
<tr>
<td>Access to care</td>
<td>▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations</td>
</tr>
<tr>
<td>HIT</td>
<td>▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient</td>
</tr>
<tr>
<td>Payment model</td>
<td>▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice’s patient panel</td>
</tr>
<tr>
<td>Quality and performance</td>
<td>▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel</td>
</tr>
</tbody>
</table>
Updated path to APC over time for practices starting out

Year 1
- **Commitment**
  - Satisfy minimum enrollment requirements
- **Activation**
  - 6-month milestones
- **Readiness**
  - for care coordination
  - 12-month milestones

Year 2
- **Improved quality and efficiency**
  - Material improvement against select APC core measures
- **Financial sustainability**
  - Savings sufficient to offset investments

**Continuous improvement**

---

**Gates**
1. Gate to receive TA, eligibility for programmatic and financial support for transformation
2. Gate to receive care coordination payments, early outcomes-based payments
3. Gate to sustain care coordination payments and reach APC tier

**Technical assistance for practice transformation (1 or 2 years)**
- Grant-funded, ~$12,000 per APC site, per year of support

**Financial support during transformation**
- Payer-funded, ~$X PMPM

**Care coordination payments**
- Payer-funded, ~$Y-Z PMPM, risk adjusted

**Outcomes-based payments**
- Bonus payments, shared savings, risk sharing, or capitation, gated by quality on core measures

---

**Progress against Capabilities and measures**

**Measurement/verification**

**Practice transformation support**

**Value-based payment**
APC structural milestones

**What a practice achieves on its own, before any TA or multi-payer financial support**

**Commitment**

Gate 1

- Participation agreement
- Early change plan based APC questionnaire
- Designated change agent/practice leaders
- Participation in TA Entity Orientation
- Commitment to achieve gate 2 milestones in 1 year

**Patient-centered care**

i. Process for Advanced Directive discussions with all patients

**Population health**

i. Commitment to developing care plans in concert with patient preferences and goals
ii. Behavioral health: Self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year

**Care Management/Coord.**

i. Identify and empanel highest-risk patients for CM/CC
ii. Process in place for Care Plan development
iii. Plan to deliver CM/CC to highest-risk patients within one year
iv. Behavioral health: Evidence-based process for screening, treatment where appropriate, and referral

**Access to care**

i. 24/7 access to a provider
ii. Same-day appointments
iii. Culturally and linguistically appropriate services
iv. At least 1 session weekly during non-traditional hours

**HIT**

i. Plan for achieving Gate 2 milestones within one year
ii. Tools for quality measurement encompassing all core measures
iii. Certified technology for information exchange available in practice for
iv. Attestation to connect to HIE in 1 year
v. Minimum FFS with P4P2 contracts with APC-participating payers representing 60% of panel within 1 year

**Payment model**

i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year
i. Minimum FFS with P4P2 contracts with APC-participating payers representing 60% of panel
i. Minimum FFS + gainsharing3 contracts with APC-participating payers representing 60% of panel

**Readiness for care coordination**

Gate 2

What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet

Prior milestones, plus...

- Participation in TA Entity activities and learning (if electing support)

**Demonstrated APC Capabilities**

Gate 3

What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination

Prior milestones, plus...

- Advanced Directives shared across medical neighborhood, where feasible
- Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)
- Participate in Prevention Agenda
- Annual identification and outreach to patients due for preventative or chronic care management
- Process to refer to self-management programs
- Integrate high-risk patient data from other sources (including payers)
- Care plans developed in concert with patient preferences and goals
- CM delivered to highest-risk patients
- Referral tracking system in place
- Care compacts or collaborative agreements for timely consultations with medical specialists and institutions
- Post-discharge follow-up process
- Behavioral health: Coordinated care management for behavioral health

**Technical specifications can be found in pre-read**

1 Uncomplicated, non-psychotic depression
2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework
3 Equivalent to Category 3 in the APM framework
### 11 measures are proposed for inclusion in our V1.0 scorecard (target launch July 2016)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Measures</th>
<th>Claims</th>
<th>EHR</th>
<th>Survey</th>
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</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
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<tr>
<td></td>
<td>1  Colorectal Cancer Screening</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td></td>
<td>2  Chlamydia Screening</td>
<td>✔️</td>
<td>✔️</td>
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<td>3  Influenza Immunization - all ages</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
<td>4  Childhood Immunization (status)</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
<td>5  Fluoride Varnish Application</td>
<td>✔️</td>
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<td><strong>Chronic disease</strong></td>
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<td></td>
<td>6  Tobacco Use Screening and Intervention</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
<td>7  Controlling High Blood Pressure</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
<td>8  Diabetes A1C Poor Control</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
<td>9  Medication Management for People with Asthma</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
<td>10 Weight Assessment and Counseling for nutrition and physical activity</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td></td>
<td>for children and adolescents and adults</td>
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<tr>
<td><strong>BH / Substance abuse</strong></td>
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<td></td>
<td>11 Depression screening and management</td>
<td>✔️</td>
<td>✔️</td>
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<td></td>
<td>12 Initiation and Engagement of Alcohol and Other Drug Dependence</td>
<td>✔️</td>
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<tr>
<td></td>
<td>Treatment</td>
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<tr>
<td><strong>Patient reported</strong></td>
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<td></td>
<td>13 Record Advance Directives for 65 and older</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td></td>
<td>14 CAHPS Access to Care, Getting Care Quickly</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
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<tr>
<td><strong>Appropriate use</strong></td>
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<td></td>
<td>15 Use of Imaging Studies for Low Back Pain</td>
<td>✔️</td>
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<tr>
<td></td>
<td>16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>✔️</td>
<td></td>
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<tr>
<td></td>
<td>17 Avoidable Hospitalization</td>
<td>✔️</td>
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<tr>
<td></td>
<td>18 Avoidable readmission</td>
<td>✔️</td>
<td></td>
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<tr>
<td><strong>Cost</strong></td>
<td></td>
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<tr>
<td></td>
<td>19 Total Cost Per Member Per Month</td>
<td>✔️</td>
<td></td>
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</tr>
</tbody>
</table>

Claims-only is possible
Overview of 2016 major events leading to full Jan 2017 implementation

### New York State Advanced Primary Care Timeline: MAJOR EVENTS

<table>
<thead>
<tr>
<th>Payers (public &amp; private)</th>
<th>Providers</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>February: Release APC Information Request</td>
<td>Q1 2016: Outreach and education for practices</td>
<td>Q4 2015-Q2 2016: Payers/providers work with State to operationalize scorecard</td>
</tr>
<tr>
<td>May: Rate review submissions</td>
<td>Q2 2016: Informational self-assessment available</td>
<td>December: V1 baseline scorecards available</td>
</tr>
<tr>
<td>Q3-4: Practices begin self-assessments, gating; TA and payer contracting</td>
<td>Q3-4: TA entities begin gating assessments &amp; OE begins reviews</td>
<td>Q4 2017: V2 Scorecards</td>
</tr>
<tr>
<td>Q1 2017: First APC-contract payments</td>
<td>Q1 2017: TA entities begin delivering TA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2015</th>
<th>2016</th>
<th>2017-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
</tbody>
</table>
Questions and Discussion

For additional information on SIM, SHIP, and APC:

• SHIP/SIM website: https://www.health.ny.gov/technology/innovation_plan_initiative/
• APC materials -- under Integrated Care Workgroup:
  https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm
• SIM inbox: sim@health.ny.gov
DSRIP Appendices
Appendix: Full List of Job Titles

- Where possible, job titles crosswalk to 2010 Standard Occupational Classification
Appendix: Required Data Collection Elements for Compensation & Benefits Analysis

- 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)
    - Note: *The PPS should collect average compensation rate for each job title at a given facility, and then the PPS’s aggregate reporting over all facilities should provide the mean, median, 25th & 75th percentile of these average compensation rates*
  - Benefits as a percentage of compensation
  - Collective Bargaining Agreement (CBA) status
  - For only the “Non-licensed Care Coordination” category:
    - Is there a degree requirement?
    - If yes, what is/are the minimum degree requirement(s)?
  - For each Job Title, PPSs will report in aggregate across all organizations as well as for each Facility Type