### Agenda

<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>10:30 – 10:45</td>
<td>Patrick Roohan</td>
</tr>
<tr>
<td>2</td>
<td>Opening Remarks</td>
<td>10:45 – 10:55</td>
<td>Patrick Roohan</td>
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<tr>
<td>3</td>
<td>APC Practice Transformation Update</td>
<td>10:55 – 11:15</td>
<td>Ed McNamara</td>
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<tr>
<td>4</td>
<td>APC V1 Scorecard Update</td>
<td>11:15 – 11:35</td>
<td>Anne Schettine</td>
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<td>Paul Henfield (IPRO)</td>
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<td>5</td>
<td>SIM Evaluation Update</td>
<td>11:35 – 11:45</td>
<td>Bryan Allinson</td>
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<tr>
<td>6</td>
<td>Online Digital Tools</td>
<td>11:45 – 11:55</td>
<td>Natalie Helbig</td>
</tr>
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<td>7</td>
<td>APD Update</td>
<td>11:55 – 12:25</td>
<td>Chris Nemeth</td>
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<tr>
<td>8</td>
<td>Working Lunch</td>
<td>12:25 – 12:55</td>
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<tr>
<td>9</td>
<td>SHIN-NY Update</td>
<td>12:55 – 1:15</td>
<td>Jim Kirkwood</td>
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<td>Valerie Grey (NYeC)</td>
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<tr>
<td>10</td>
<td>Health IT Integrated Quality Measurement</td>
<td>1:15 – 1:45</td>
<td>Jim Kirkwood</td>
</tr>
<tr>
<td>11</td>
<td>Discussion and Next Steps</td>
<td>1:45 – 2:00</td>
<td>Patrick Roohan</td>
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</tbody>
</table>
APC Practice Transformation
Ed McNamara
Director of Project Management
SIM, Office of Quality and Patient Safety
Governance

- Proposed APC Governance Model
  - APC Steering Committee
  - Regional Oversight and Management Committees
- Consumer and patient engagement efforts
- Timeline/Next Steps
SIM Governance Model

New York State Health Innovation Council

APC Steering Committee

Evaluation, Transparency & HIT Workgroup

Regional Oversight Management Committees

Workforce Workgroup
Regional Governance

Regional Oversight and Management Committees (ROMC) will convene to:

- Resolve questions or concerns that arise in the region,
- Communicate with the Statewide Steering Committee on region-specific issues, and
- Ensure smooth implementation of the APC model within regional contexts.

Topics could include:

- Issues between TA entities and practices;
- Issues between payers and providers;
- Patient/consumer feedback;
- Best practices, lessons learned, and challenges;
- Regional linkages between clinical and community resources.
Establishing ROMC Regions

NYS Department of Financial Services (DFS) Rating Regions and Department of Health Population Health Improvement Program (PHIP) regions.
Establishing ROMC Regions (Cont’d)
One-on-One Payer Engagement Meetings

- **To date:**
  - Ongoing one-on-one meetings with commercial plans

- **Approach:**
  - Targeting regions (Capital District, Adirondacks, Hudson Valley, Finger Lakes, NYC) but will include follow-up to all plans

- **Framing:**
  - Follow up to RFI, clarify APC and answer questions
  - Better understand existing programs, determine alignment with APC
  - Identify opportunities for multi-payer efforts
  - Describing commitment for support and data requirements for quality measures
Banding

- **Band 1**: Practices already enrolled in value based contracting with payers and receiving practice transformation assistance.

- **Band 2**: Practices eligible for a payer program but are not enrolled.

- **Band 3**: Practice is not eligible for a single payer program.
Prioritizing Transformation Assistance

“Bands” of practices by participation and eligibility for commercial payer value based programs.
Consumer and Patient Engagement

- Goals:
  - Meaningful inclusion of consumer and patient voice in transformation
  - Patient perspective at statewide, regional, and practice levels

- Considerations
  - Regional governance
  - Coordination with other initiatives

- Next steps
Updates

Practice Transformation RFA Update:
- Received 19 applications from 13 bidders, for 8 DFS Regions
- Applications are currently evaluated
- Target 11/1/16 start date for contracts pending CMMI approvals

APC Milestone and Implementation Guide – V1
- 140+ pages, the Guide offers clear, practical and concise tools, forms and resources that can be used at practice level
- Input was provided by content experts, including 150+ links for easy access to resources
- Provides greater continuity of APC curriculum alignment for Statewide transformation agents and primary care practices to achieve successful outcomes
- Will be released in September
## Team-Based Care and Practice Organization
The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers and organizes and trains staff to work to The top of their license and ability to provide effective team-based care.

### Part 1: Comparison - PCMH 2017 vs. APC Milestones

<table>
<thead>
<tr>
<th>PCMH 2017 Requirements (proposed categories)</th>
<th>APC Milestones</th>
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<tbody>
<tr>
<td><strong>PARTICIPATION</strong></td>
<td>Practice demonstrate readiness through either initial gating assessment or through certification.</td>
</tr>
<tr>
<td><strong>PATIENT-CENTERED CARE</strong></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><strong>ACCESS TO CARE</strong></td>
<td>Promote access as defined by affordability, availability, navigability, accessibility, of care across all patient populations.</td>
</tr>
<tr>
<td><strong>POPULATION HEALTH</strong></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><strong>CARE MANAGEMENT /CARE COORDINATION</strong></td>
<td>Manage and coordinate care across multiple providers and settings by actively tracking the highest need patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and track and optimize transitions of care. Care Management is defined as: focus on the comprehensive support of the highest risk subset of practice’s patient population. Care Coordination defined as: the practice contributes to seamless care of all patient transitions across all environments.</td>
</tr>
<tr>
<td><strong>HIT</strong></td>
<td>Use health information technology to deliver better care that is evidence-based, coordinated, and efficient.</td>
</tr>
<tr>
<td><strong>PAYMENT MODEL</strong></td>
<td>Participate in outcomes-based payment models, based on quality and cost, for over 60% of the practice’s patient panel.</td>
</tr>
</tbody>
</table>

### Part 2: Knowing and Managing Your Patients
The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

### Part 3: Patient-Centered Access and Continuity
Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

### Part 4: Care Management and Support
The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

### Part 5: Care Coordination and Care Transitions
The practice tracks tests, referrals and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.

### Part 6: Performance Measurement and Quality Improvement
The practice collects, reports and uses performance data to identify opportunities for quality improvement, sets goals and acts to improve clinical quality, efficiency, patient experience and engages the staff and patients/families/caregivers in the quality improvement activities.
CPC+

- DOH Letter to Health Plans:
  - CPC+/ APC/ Medicaid VBP roadmap broadly align
  - VBP payments to primary care practices allowing them for increase in funding and upfront investment in necessary capabilities
  - Focused on cost and quality
  - Defined but limited set of quality metrics
  - Practice transformation resources
  - CPC+ consistent with SIM/APC goals
  - CPC+ is Medicare’s contribution to APC
- Goal was to have plans apply to CPC+ to engage Medicare to have CPC+ awarded in NY State
- Payer solicitation ended June 8th, CMS will publish CPC+ regions before practice applications start July 15th
## Technical Assistance for Primary Care Practices: What Are My Options?

### Overview

**Program Description**
Federal and State programs are offering resources and technical assistance to help practices prepare for changing expectations for primary care delivered with an evolving "value-based" reimbursement environment. These programs have different features and eligibility requirements, but are aligned in providing assistance to practices interested in improving care delivery to their patients, becoming more profitable, and maintaining or improving quality and patient assessment.

### Best Options

**For Your Practice**
Depending on your professional goals, the characteristics of your practice, your business model, and payer mix, the programs below may help you achieve your goals:

- **Population Health Management**
  - State and Federal programs focus on improving care delivery to healthier populations.
  - Practices can be eligible if they meet certain criteria such as having a patient panel with a high percentage of shared medical visits.

- **Quality Improvement**
  - Programs focus on improving the quality of care delivered to patients.
  - Practices can be eligible if they meet certain criteria such as having a patient panel with a high percentage of quality measures met.

- **Population Health**
  - Programs focus on improving the health of a population of patients.
  - Practices can be eligible if they meet certain criteria such as having a patient panel with a high percentage of preventive care services provided.

### Duration

**How long will it take?**
These programs depend on your current eligibility and professional goals. The timeline for program participation can vary, depending on the specific program and the requirements.

### Value Proposition

**Financial Landscape**
Financially, value-based payments have a significant impact on practices, with the potential for increased revenue through improved patient outcomes and reduced costs.

### Approach

**APC+**
Five-year CMMI-supported primary care program implemented in 2016, expanding the scope of previous state PCMH programs to address patient-centered care.

**CPC+**
Four-year program starting in 2020.

**DSRIP**
Four-year program starting in 2016.

**TCPI**
Four-year program starting in 2016.

### For more information on APC:

### For more information on CMS guidance on payment reform:
https://www.cms.gov/Medicare/Medicare-fee-for-service-Payment/Value-Based-Payments/MACRA-APMs-and-APMs/MACRA-APMs.html
Looking Back and Looking Forward

The ICWG has developed over 18 months:

- a consensus set of advanced primary care practice requirements
- ‘core’ quality and cost measures
- a payment approach to support practice transformation and value based payments for a statewide, multi-payer initiative

- What are the strengths and challenges of each component? Is there anything missing?
- What do you think are the top 3 considerations for achieving success as we move from development of APC to implementation?
APC Scorecard V1.0

Update

Anne Schettine, Director
Division of Quality Measurement
Office of Quality and Patient Safety
Paul Henfield, IPRO
Payer Data Source - Capabilities and Limitations

Survey Responses and follow up interviews have identified some key issues impacting the data which would be used in Version 1

<table>
<thead>
<tr>
<th>Key Decision</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Period Construct</td>
<td>Time period used for generating quality results</td>
<td>▪ 12 month rolling period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Year to date</td>
</tr>
<tr>
<td>Frequency of Data Submission</td>
<td>Interval of results</td>
<td>▪ Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Semi-annually</td>
</tr>
<tr>
<td>Audience and Purpose of Report</td>
<td>Intended users and uses of the reports</td>
<td>▪ Statewide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Focused release (i.e. practices in transformation)</td>
</tr>
<tr>
<td>Payer Engagement</td>
<td>Payer Participation in Data Submission</td>
<td>▪ Statewide</td>
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<tr>
<td></td>
<td></td>
<td>▪ Alignment with regional implementation</td>
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</tbody>
</table>
APC Scorecard Timeline - Updated

- **2016**
  - 2Q: Version 1.0 Scorecard implementation and roll out
  - 3Q: APC Scorecard content and format development
  - 4Q: Payer assessment and preparation for reporting

- **2017**
  - 1Q: Practice definition and attribution exploration work
  - 2Q: Payers deliver first metrics data files
  - 3Q: State begins baseline report production

- **2016-2017**
  - 3Q: Providers baseline Version 1.0 reports
Pilot – Data Collection

APC Scorecard Version 1 - Pilot, Phase 1 Measures

<table>
<thead>
<tr>
<th>Domains</th>
<th>NQF #/Developer</th>
<th>Measures</th>
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<tbody>
<tr>
<td>Prevention</td>
<td></td>
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<tr>
<td></td>
<td>32/HEDIS</td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>2372/HEDIS</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>33/HEDIS</td>
<td>Chlamydia Screening</td>
</tr>
<tr>
<td></td>
<td>38/HEDIS</td>
<td>Childhood Immunization Status: Combination 3</td>
</tr>
<tr>
<td></td>
<td>57/HEDIS</td>
<td>Comprehensive Diabetes Care: HbA1C Testing</td>
</tr>
<tr>
<td></td>
<td>55/HEDIS</td>
<td>Comprehensive Diabetes Care: Eye Exam</td>
</tr>
<tr>
<td></td>
<td>62/HEDIS</td>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
</tr>
<tr>
<td></td>
<td>71/HEDIS</td>
<td>Persistent Beta Blocker Treatment after Heart Attack</td>
</tr>
<tr>
<td></td>
<td>1799/HEDIS</td>
<td>Medication Management for People With Asthma</td>
</tr>
<tr>
<td>Behavioral Health/Substance Use</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>4/HEDIS</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
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<td>105/HEDIS</td>
<td>Antidepressant Medication Management</td>
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<tr>
<td>Appropriate Use</td>
<td></td>
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<tr>
<td></td>
<td>52/HEDIS</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td></td>
<td>58/HEDIS</td>
<td>Avoidance of Antibiotic Treatment in adults with acute bronchitis</td>
</tr>
</tbody>
</table>

- Planned for 4Q 2016
- Leveraging HEDIS 2016 (submitted in June 2016) with practice information attached to member level file
- Goal to determine data issues with practice aggregation across payers
APC Scorecard Production Preparation

- **Report Materials**
  - Understanding report, measure descriptions, small cell size, benchmarks

- **Release Mechanism**
  - Planning in progress

- **Planning for Release to Public**
  - Guidelines for Release (time line, level of aggregation, consumer understanding of caveats and use)
  - Data maturity and completeness
  - Result requirements for comparison (i.e. risk adjustment, stratification by provider type)
SIM Evaluation Update
Bryan Allinson, Director
Innovation Center
Office of Quality and Patient Safety
Context and Scope

- Process oriented – an independent, state-procured evaluation of SIM processes
- Team with the separate, federal evaluator focused on outcomes
- The vendor will examine the SIM model overall, identifying which mechanisms lead to lower costs/better outcomes
- The scope includes the APC delivery model, value-based payments, and workforce initiatives
- Required by CMS
Online Digital Tools

Natalie Helbig, Deputy Director
Division of Information and Statistics
Office of Quality and Patient Safety
Second Round Research, Consumer Focus Groups, and Testing

- As part of a $4.6M Cycle III Price Transparency Grant
- Vendor: NY Academy of Medicine
- Will work concurrently with the development of the APD consumer-facing tools being developed
- Timeline: Summer 2016 – Winter 2017
Second Round Research, Consumer Focus Groups, and Testing

- Three phases of work:
  1) **Identifying a set of 30 products and services** (or bundle of services) that may serve as priority areas for New York State’s transparency efforts.
  2) **Understanding the information seeking and decision-making behavior.** Conducting in-depth interviews (n=18) and focus groups (n=4 groups, approximately 40 participants) with individuals who have used, or are currently considering, the health care products and services identified in phase 1.
Three phases of work (continued):

3) **Testing of products and messages.** Will conduct 6 focus groups to test multiple digital resources, including the:
   - NYS DOH health profile site;
   - A set of best practice transparency sites produced by other states or entities;
   - A set of mockups with infographics and/or tools offering alternative approaches for disseminating information on health care cost and quality, consistent with the findings from the Phase 1 and 2 research.
APD Update

Chris Nemeth, Director
All Payer Database Development Bureau
Office of Quality and Patient Safety
All Payer Database Update

I. APD Executive Kick Off with Optum
II. Optum Progress to Date
III. APD Regulations Update
IV. Draft NYS All Payer Database Guidance Manual
V. Questions?
APD Executive Kick Off with Optum

- On August 3, 2016 an Executive Kick Off meeting with Optum Government Solutions was held at the Empire State Plaza in Albany.
- Attendees included key APD partners and stakeholders from the following NYS agencies and organizations:
  - Governor’s Office
  - Division of the Budget
  - Department of Health (Executive Staff, Health Exchange, OHIP, and Budget)
  - Department of Financial Services
  - Department of Civil Service
  - Office of Information Technology Services
  - NYSTEC
  - Optum
- Copies of the Executive Kick Off Meeting materials are available upon request
Executive Kickoff Meeting Agenda

- Overview of NY’s APD solution for population health, including a description of national efforts and the data sources that will be housed in the APD
- Overview of Optum’s national APD ‘footprint’ along with an implementation timeline for New York
- NYS technology solution overview, including security provisions, data enrichment and examples of data analytics that can be applied to NYS data
- Overview of communication strategies moving forward
Optum’s Data Analytics Engagements
Optum – Progress to Date

- **Startup Planning Meetings**
  - Project Management, Data Security, Data Sources and Technical Build

- **Data Sharing**
  - Securing approvals for data sharing and providing data files for initial analytics work.

- **Data Connectivity**
  - Working with OITS to establish user connection points for both web-based system access, and APD power user VPN access
  - Commenced work with OHIP DataMart vendor to establish data exchange connectivity for interim analytics solution

- **Other**
  - Analytics Workgroups – Convened groups of data analysts/users to refine analytics tools and requirements
  - Beginning internal design sessions on provider, member, risk analysis and data mappings
APD Regulations: Public Comment Period

- On August 4, 2016, the NYS All Payer Database regulation was presented to the State’s Public Health and Health Planning Council (PHHPC*).

- The NYS APD regulation was posted for public comment in the Proposed Rule Making section of NYSDOH’s public website on August 31, 2016 and the 45 day public comment period will end on October 17, 2016.

- The regulation can be viewed by all stakeholders at the following link: http://w3.health.state.ny.us/dbspace/propregs.nsf/4ac9558781006774852569bd00512fda/9304b1b933e4feab8525801e00581b97?OpenDocument.

*PHHPC advises the Commissioner on issues related to the preservation and improvement of public health in New York State, and has advisory and decision-making responsibilities with respect to these issues. The Council's powers and duties are set forth in section 225 of the Public Health Law.
NYS APD Guidance Manual

- A pre-decisional, working draft copy of a proposed NYS APD Guidance Manual was emailed to HIT Workgroup members on September 14.
- This draft manual contains information that supplements the draft APD regulations that are currently issued for public comment.
- We welcome comments and feedback on this manual.
NYS APD Guidance Manual: Overview

What does the APD Guidance Manual help achieve?

- While the proposed NYS APD Regulation provides the legal authority for APD creation; the APD Guidance Manual provides an implementation framework for operational aspects.
- The Guidance Manual has three components:
  1. Program Operations
  2. Data Governance
  3. Submission Specifications
1) APD Guidance Manual: Program Operations

This section of the APD Guidance Manual provides overarching background and rationale such as:

- Program Purpose: *Why is NYS pursuing an APD?*
- Legal Authority: *How can NYS pursue an APD?*
- APD Scope and Objectives: *What are the operational objectives of the APD?*
2) Guidance Manual: **Data Governance**

Two Governance Related Committees are Proposed

- **Program Governance Committee** (PGC) - responsible for overall program guidance and comprised of representatives from a variety of State entities that have both a short- and long-term APD vested interest. A newly devised Memorandum of Understanding (MOU) will assist necessary multi-agency coordination efforts.

- **Data Release Review Committee** (DRRC) - chaired by the Commissioner of Health’s designee to provide non-binding advice and opinions on applications for access to limited identifiable data. The DRRC provides comments on the merits of the application and the research protocol described therein within thirty (30) days of receipt (regularly scheduled meeting times will be posted to APD website).
2) Guidance Manual: Data Governance (cont.)

Program Governance Committee Functions:
- Interagency communications
- Cross-agency resource coordination
- Cross-agency use case coordination
- Strategic planning functions
  - Fiscal sustainability plan
  - Vendor contracting plan

Membership (7 members):
- Chair - DOH - OQPS: 2 members
- DOH - OHIP - Medicaid: 1 member
- DOH - NYSOH: 1 member
- DFS: 1 member
- DCS: 1 member
- OITS: 1 member

Data Release Review Committee Functions:
- Reviews project requests
- Ensure adherence to DOH guidelines and Federal and State laws
- Implement DUAs when required
- Implements BAAs when required
- Communication vehicle for requests and request status

Membership (13 members):
- DFS: 1 member
- DOH - OQPS: 1 member
- DOH - OHIP - Medicaid: 1 member
- Insurers: 2 members
- Health Care Facilities: 2 members
- Health Care Practitioners: 2 members
- Purchasers: 1 member
- Consumers: 1 member
- Researchers: 1 member
2) Guidance Manual: **Data Governance (cont.)**

**Further DRRC Considerations**

The following details must be described in all data release applications:

- purpose of the project and intended use of the data;
- methodologies to be employed;
- type of data and specific data elements requested (along with justification for inclusion);
- qualifications of the entity requesting the data;
- the specific privacy and security measures that will protect the data; and
- description of how the results will be used, disseminated, or published.

*Release of data currently collected by DOH and shared under **existing law, regulation, rule**, or policy shall continue under such existing law, regulation, rule, or policy. Explicit documentation of such must be included with the data release request.*
2) Guidance Manual: **Governance, Data Types and Related Access**

**Three types of APD data files: Public Use, Limited Identifiable, and Identifiable**

- Identifiable data including the following data fields **will not** be released by the APD: patient name (first, middle, last); subscriber name (first, middle, last); exact address; and any unique identifier related to any insurance entity (commercial, Medicaid, or Medicare).

- Current policy limits the release of specific identifiable data elements to requestors from internal DOH programs only. Release of limited identifiable data elements may be made to other entities, in accordance with APD data release policies and procedures.

- Any data user that violates applicable law or regulation, or any executed DUA, is subject to penalties pursuant to the provisions of applicable law including, but not limited to, Sections 12 and 12-d of the Public Health Law, and applicable sections of New York State Insurance Law and regulations.

- Table 2 in the APD Guidance Manual provides a full description of APD File Types and Data Access protocol.
3) APD Guidance Manual: Submission Specs

The Submission Specifications section of the APD Guidance Manual provides clarification on:

- Who is required to submit data
- Data submission types and transaction formats
- Timing of submissions (frequency and timing)
- Method of submissions (electronically)
- Resubmission of rejected data
- Data validation and submission compliance
- Extensions, variances or waivers
- How to receive technical assistance
Working Lunch
SHIN-NY Update
Jim Kirkwood, Director
Health Information Exchange Bureau
Office of Quality and Patient Safety
Valerie Grey, Executive Director
New York eHealth Collaborative
Significant Activities of the SHIN-NY

- Policy Committee
  - White paper on consent with possible solutions to address consent
  - Possible solutions, with recommendations by end of the year
  - Contingent upon release of 42 CFR Part 2 regulation expected soon
- In the process of implementing cross-QE alerts with 3 QEs, with more to follow
SHIN-NY Stakeholder Adoption

- Hospitals: 92%
- Public Health Department: 79%
- FQHCs: 97%
- Home Care Agencies: 79%
- Long Term Care Facilities: 48%
- Clinical Practices: 23%

Total Users: 66,787
- Physicians: 14,392
- Other Non-Clinical Care Providers: 11,536
- Clinical Care Providers: 9,588
- Other Clinical Care Providers: 8,061
- Mid-Level Providers: 5,527
Health IT Integrated Quality Measurement

Jim Kirkwood, Director
Health Information Exchange Bureau
Office of Quality and Patient Safety
Health IT-enabled Quality Measurement

(EHR + Registry + Claims + Other)
Significant Quality Measurement Activities in DOH

- QARR - managed care quality measurement system
  - Commercial HMO, Commercial PPO, NYSoh, Essential Plan, HIV SNPs

- Managed Long Term Care

- DSRIP Value Based Payment initiative

- Hospital, nursing home and home care measurement
  - Available on Health Profiles
Initiatives that collect or intend to collect EHR data for use in quality measurement

To name a few of the current ones…

- Adirondack multi-payer initiative

- Value Based Payment initiatives
  - APC Scorecard as part of SIM
  - DSRIP PPS
  - CMS MACRA with MIPS/APM

- MEIPASS (Medicaid Meaningful Use)
  - Providers must report eCQMs generated EHRs

KEY REQUIREMENT – Alignment of capability to integrate data for calculation of quality measures for various uses
Principles and Assumptions for Data Collection

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

- **Claims-based Quality Measurement**: Claims data quality measurement and/or HEDIS data collected from surveys, chart reviews, and claims data.
- **Self-reported**: Data captured, eCQM calculated in EHR and only numerator/denominator reported.
- **Live automated data**: Automated data acquisition from EHRs to central aggregator tool for calculation, comparison, reporting, and population level measures.
- **Integrated data**: Claims and clinical data integrated to analyze quality and address population health needs.

Provider/Practice/Encounter Level Data

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

From ONC Conference: *IT-enabled Quality Measurement* (Aug 31 –Sep 1, 2016)
Priority Use Cases for Clinical Quality Measure Information

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

**Major Dependencies**

- **Provider Directory** - provider/practice based calculation
  - **Data source** - provider network data system
- **Data quality**
  - **Data completeness and consistency** – address data gaps and missing data elements
  - Providers as partners in increasing data quality
- **Provider portal** - need to know how they are performing
- **Governance** - HIT Transparency and Evaluation workgroup
  - Patient/provider attribution decisions
- **Data Intermediary/Extraction**
  - Qualifications
  - Data Use policies
CQM Data Sources & Intermediaries

Data Sources
- Payers/APD
- Registries
- Claims X12
- Immunizations HL7

Data Intermediary (possibly state, payer, third party)
- Reporting Services
- Consumer Tools
- Provider Portal
- PT, Prov/Attribution
- Data Aggregation
- Data Transport and Load (Warehouse/Repository)
- Data Extraction
- Identity Management
- Security Mechanisms
- Provider Directory/Registry
- Governance
- Financing
- Policy/Legal
- Business Operations

Reporting Formats
- QRDA III/I
- Num Denom

Priority Uses
- Clinical Quality Measurement
- DSR
- Pay for Value
- Clinical action and population health measurement
- Pt Cohort Decision support & management
- Program requirements and evaluation
- Cost and quality transparency public reporting

Data Sourcing
- EHRs
- CCDA
- ADT
- Care plan

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

- Working with OHIP on Value Based Payment strategy to ensure infrastructure needs are aligned
- Identify met and unmet infrastructure needs
  - Governance
  - Provider directory
- Invoke data standards for message structure and format where possible
- Focus on QE data quality and completeness
Discussion and Next Steps

Patrick Roohan
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Next meeting: December 16, 2016 (NYC)