Transparency, Evaluation, and Health Information Technology Workgroup

Meeting #12

March 16, 2017
<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 – 10:35</td>
<td>Patrick Roohan</td>
</tr>
<tr>
<td>2</td>
<td>Opening Remarks</td>
<td>10:35 – 10:40</td>
<td>Patrick Roohan</td>
</tr>
<tr>
<td>3</td>
<td>APC Practice Transformation Update</td>
<td>10:40 – 10:55</td>
<td>Ed McNamara</td>
</tr>
<tr>
<td>4</td>
<td>APC Practice Transformation Tracking System (PTTS) Demo</td>
<td>10:55 – 11:15</td>
<td>Jill Byron</td>
</tr>
<tr>
<td>5</td>
<td>APD Update</td>
<td>11:15 – 12:00</td>
<td>Mary Beth Conroy</td>
</tr>
<tr>
<td>6</td>
<td>Working Lunch</td>
<td>12:00 – 12:20</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>APD Presentation</td>
<td>12:20 – 12:40</td>
<td>Mary Beth Conroy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Steve Johnson (Optum)</td>
</tr>
<tr>
<td>8</td>
<td>SHIN-NY Update</td>
<td>12:40 – 1:10</td>
<td>Jim Kirkwood</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Valerie Grey (NYeC)</td>
</tr>
<tr>
<td>9</td>
<td>Health IT Integrated Quality Measurement</td>
<td>1:10 – 1:40</td>
<td>Jim Kirkwood</td>
</tr>
<tr>
<td>10</td>
<td>Discussion and Next Steps</td>
<td>1:40 – 2:00</td>
<td>Patrick Roohan</td>
</tr>
</tbody>
</table>
APC Update

Ed McNamara
What is APC?

- Statewide multi-payer approach to align care AND payment reform focused on primary care that:
  - Works to achieve triple aim goals
  - Engages practices, patients, and payers
  - Builds on evidence, experience, existing demonstrations, PCMH
  - Supports comprehensive, patient-centric primary care with coordinated care for complex patients
  - Fosters collaboration between primary care, other clinical care, and community-based services
  - Effectively utilizes HIT, including EHR, data analytics, and population health tools
  - Offers alternative payment models that support the services and infrastructure needed for advanced primary care
How is APC different from PCMH?

- Model is consistent with the principles of NCQA PCMH, but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes

Who Can Become APC?

- Internal Medicine, Family, and Pediatrics practice
# APC Capabilities: Nothing Completely New or Unfamiliar

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</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 health of 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 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>
## APC Structural Milestones

### Commitment

**Gate 1**

<table>
<thead>
<tr>
<th>Participation</th>
<th>Population health</th>
<th>Care Management/ Coord.</th>
<th>Access to care</th>
<th>HIT</th>
<th>Payment model</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. APC participation agreement</td>
<td>i. APC participation agreement</td>
<td>i. 24/7 access to a provider</td>
<td>i. Plan for achieving Gate 2 milestones within one year</td>
<td>i. Plan for achieving Gate 2 milestones within one year</td>
<td>i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year</td>
</tr>
<tr>
<td>ii. Early change plan based APC questionnaire</td>
<td>ii. Commitment to developing care plans in concert with patient preferences and goals</td>
<td>i. 24/7 access to a provider</td>
<td>i. Tools for quality measurement encompassing all core measures</td>
<td>i. 24/7 remote access to Health IT</td>
<td></td>
</tr>
<tr>
<td>iii. Designated change agent / practice leaders</td>
<td>iii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year</td>
<td>i. 24/7 access to a provider</td>
<td>i. Tools for quality measurement encompassing all core measures</td>
<td>ii. Secure electronic provider-patient messaging</td>
<td></td>
</tr>
<tr>
<td>iv. Participation in TA Entity APC orientation</td>
<td>iv. Process in place for Care Plan development</td>
<td>i. 24/7 access to a provider</td>
<td>ii. Certified technology for information exchange available in practice for</td>
<td>iii. Enhanced Quality Improvement including CDS</td>
<td></td>
</tr>
<tr>
<td>v. Commitment to achieve gate 2 milestones in 1 year</td>
<td>v. Plan to deliver CM / CC to highest-risk patients within one year</td>
<td>i. 24/7 access to a provider</td>
<td>iii. Attestation to connect to HIE in 1 year</td>
<td>iv. Certified Health IT for quality improvement, information exchange</td>
<td></td>
</tr>
</tbody>
</table>

### Readiness for care coordination

**Gate 2**

<table>
<thead>
<tr>
<th>Participation</th>
<th>Population health</th>
<th>Care Management/ Coord.</th>
<th>Access to care</th>
<th>HIT</th>
<th>Payment model</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Advanced Directive discussions with all patients</td>
<td>i. Identity and empanel highest-risk patients for CM/CC</td>
<td>i. Tools for quality measurement encompassing all core measures</td>
<td>i. 24/7 remote access to Health IT</td>
<td>i. Minimum FFS with P4P contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
<tr>
<td>ii. Process in place for Care Plan development</td>
<td>ii. Process in place for Care Plan development</td>
<td>i. Tools for quality measurement encompassing all core measures</td>
<td>ii. Secure electronic provider-patient messaging</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
<tr>
<td>iii. Plan to deliver CM / CC to highest-risk patients within one year</td>
<td>iii. Plan to deliver CM / CC to highest-risk patients within one year</td>
<td>i. Tools for quality measurement encompassing all core measures</td>
<td>iii. Enhanced Quality Improvement including CDS</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
<tr>
<td>iv. Behavioral health: Evidence-based process for screening, treatment where appropriate1, and referral</td>
<td>iv. Behavioral health: Evidence-based process for screening, treatment where appropriate1, and referral</td>
<td>i. Tools for quality measurement encompassing all core measures</td>
<td>iv. Certified Health IT for quality improvement, information exchange</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
</tbody>
</table>

### Demonstrated APC Capabilities

**Gate 3**

<table>
<thead>
<tr>
<th>Participation</th>
<th>Population health</th>
<th>Care Management/ Coord.</th>
<th>Access to care</th>
<th>HIT</th>
<th>Payment model</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Advanced Directives shared across medical neighborhood, where feasible</td>
<td>i. Participate in local and county health collaborative Prevention Agenda activities</td>
<td>i. Tools for quality measurement encompassing all core measures</td>
<td>i. 24/7 remote access to Health IT</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
<tr>
<td>ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)</td>
<td>ii. Annual identification and reach-out to patients due for preventative or chronic care management</td>
<td>ii. Secure electronic provider-patient messaging</td>
<td>ii. Secure electronic provider-patient messaging</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
<tr>
<td>iii. Participate in local and county health collaborative Prevention Agenda activities</td>
<td>iii. Process to refer to structured health education programs</td>
<td>iii. Enhanced Quality Improvement including CDS</td>
<td>iii. Enhanced Quality Improvement including CDS</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
<tr>
<td>iv. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions</td>
<td>iv. Post-discharge follow-up process</td>
<td>iv. Certified Health IT for quality improvement, information exchange</td>
<td>iv. Certified Health IT for quality improvement, information exchange</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
<tr>
<td>v. Behavioral health: Coordinated care management for behavioral health</td>
<td>v. Behavioral health: Coordinated care management for behavioral health</td>
<td>v. Connection to local HIE QE</td>
<td>v. Connection to local HIE QE</td>
<td>i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel</td>
<td></td>
</tr>
</tbody>
</table>

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1. Gate 2BH milestones include: 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 appropriate1, and referral

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**March 16, 2017**
APC VBP Payment Goals

- Support primary care practices as they transition from FFS to VBP
- Support primary care practices as they put new services in place (advanced primary care) that are not reimbursed by FFS and which may, during the transition period, reduce revenue from FFS
- Create a viable payment replacement which rewards value using aligned metrics
Many programs: Working on Alignment

- DSRIP
- TCPI
- MACRA
- APC
- CPC+
APC Updates

Technical Assistance (TA) vendor contracts awarded

Independent Validation Agent (IVA)* to be procured

Statewide practice transformation databased--finalized

RFI for payers—released and analyzed, 1:1 meetings conducted

Practice enrollment starts now

*Independent Validation Agent (IVA) is an entity to verify the transformation work from TA vendors and practices.
TA Vendor Update

Goal is to:

- Support primary care practices to help them achieve the milestones in APC
  - TA vendor contracts awarded
  - Contracting in last stages of being finalized
  - TA vendor kickoff meeting conducted
  - Multiple TA on-boarding meetings planned
  - Future: Exchange of best practices with other transformation programs being discussed
**APC TA Vendors**

<table>
<thead>
<tr>
<th>Name of Awardee</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adirondack Health Institute</td>
<td>Capital District and Adirondacks</td>
</tr>
<tr>
<td>CDPHP</td>
<td>Capital District</td>
</tr>
<tr>
<td>HANYS</td>
<td>Capital District and Long Island</td>
</tr>
<tr>
<td>Chautauqua County Health</td>
<td>Western (Buffalo)</td>
</tr>
<tr>
<td>Solutions 4 Community Health</td>
<td>Mid-Hudson Valley and Long Island</td>
</tr>
<tr>
<td>Institute for Family Health</td>
<td>NYC</td>
</tr>
<tr>
<td>IPRO</td>
<td>NYC, Central NY (Syracuse) and Long Island</td>
</tr>
<tr>
<td>Fund for Public Health in New York</td>
<td>NYC</td>
</tr>
<tr>
<td>Finger Lakes</td>
<td>Finger Lakes (Rochester) and Central NY (Syracuse)</td>
</tr>
</tbody>
</table>
Practice Transformation Tracking System (PTTS)

Jill Byron
PTTS Goals

- Collect and organize practice site level data
- Identify practice sites participating in other federally funded transformation programs
- Assist in recruitment communication/strategies
- Monitor and report on program progress
## Defining Practice Site

| Practice/Practice Group Tax ID |
| Practice Site/Medical Home Servicing Location |
| Servicing Providers Physicians & Mid-levels Care Managers Integrated Providers |
Address Information Gaps

Practice/Practice Group
Tax ID

Practice Site/Medical Home
Servicing Location

Servicing Providers
Physicians & Mid-levels
Care Managers
Integrated Providers
Track Federal Transformation Funding

- Identify practice sites eligible for APC transformation assistance
- Prevent “double-dipping”

<table>
<thead>
<tr>
<th>Practice Site</th>
<th>APC</th>
<th>CPC+</th>
<th>DSRIP</th>
<th>TCPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Site A</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Site B</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Practice Site C</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Practice Site D</td>
<td>✔</td>
<td></td>
<td></td>
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</tbody>
</table>
Practice Site Recruitment

- NYS segmented into regions
- More than one practice transformation technical assistance (PT TA) agent assigned to region
- PTTS will indicate:
  - Engagement/enrollment status
  - PT TA
  - Competing program anticipated graduation dates
  - NCQA PCMH 2014 recognition and scoring
APC Program Progress Key Business Questions

- How many practice sites are engaged or enrolled in APC?
- How many beneficiaries enrolled in APC?
- What roles make up the APC clinical workforce?
- How many APC practice sites are participating in another federally funded program?
- How many hours of technical assistance have been provided?
Practice Site Key Business Questions

- Where is practice site’s physical/servicing location?
- What is practice site’s APC status and who is their PT TA?
- Is practice site participating in other federally funded transformation programs?
- What is practice site’s patient panel? By payer? By line of business?
- What is practice site’s clinical workforce?
- How many hours of one-on-one technical assistance has practice site received?
- What is practice site’s transformation progress?
- Is practice site NCQA PCMH 2014 Level III recognized and can they qualify for auto-credit?
- Who are the physicians and mid-levels?
- Who are the administrative contacts?
PTTS Dashboard

Subject | Record Count
--- | ---
Account Claimed | 10
Account Engaged | 6
Account Enrolled | 194
Account Released | 79
Gate Assessment | 18
Gate assessment created | 3
Practice Site Hour | 2
Site Hours | 23
TA Site Hour | 1
TA Training Session | 1

Activities by Entity

<table>
<thead>
<tr>
<th>Payer</th>
<th>Sum of Medicare Beneficiaries</th>
<th>Sum of Medicaid Beneficiaries</th>
<th>Sum of Commercial Beneficiaries</th>
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<tbody>
<tr>
<td>Adena</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Affinity</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anthem/BCBS</td>
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<td>0</td>
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</tr>
<tr>
<td>BCBS</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CDPHP</td>
<td>12</td>
<td>12</td>
<td>2K</td>
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<tr>
<td>Emblem</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Empire BCBS</td>
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<tr>
<td>FFS</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Medicaid</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Medicare</td>
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<td>0</td>
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<tr>
<td>Fidelis</td>
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<tr>
<td>Health First</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Independent Health</td>
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<td>444</td>
<td>6K</td>
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<td>Metropolitan</td>
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<tr>
<td>MVP Health</td>
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<td>0</td>
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<td>Care</td>
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<tr>
<td>Oscar</td>
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<tr>
<td>United</td>
<td>212</td>
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<tr>
<td>Wellcare</td>
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</table>
## Practice Site Account Detail

<table>
<thead>
<tr>
<th>Account Name</th>
<th>Access Community Health Center</th>
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<tbody>
<tr>
<td>Tax ID</td>
<td>123456789</td>
</tr>
<tr>
<td>Practice Site NPI</td>
<td>1038012345</td>
</tr>
<tr>
<td>Unique ID</td>
<td>NY000000</td>
</tr>
<tr>
<td>NCQA PCMH Project ID</td>
<td>242551</td>
</tr>
<tr>
<td>NCQA PCMH Org ID</td>
<td>171706</td>
</tr>
</tbody>
</table>

### Address Information
- **Physical Address**: 83 Maiden Lane 8th flr, New York, New York 10038-5652
- **County**: New York
- **DFS Region**: Region 4

### Transformation Agent
- **Entity**: Test T4 Agent account
- **Effective Enroll Date**: 2/1/2017
- **Effective Release Date**: None
## Practice Site Account Detail Continued

### Transformation Agent

<table>
<thead>
<tr>
<th>Transformation Agent Entity</th>
<th>Effective Enroll Date</th>
<th>Effective Release Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>test TA agent account</td>
<td>2/1/2017</td>
<td></td>
</tr>
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### Program Associations

<table>
<thead>
<tr>
<th>APC Status</th>
<th>Under Contract</th>
<th>APC Status Notes</th>
</tr>
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<tbody>
<tr>
<td>TCPI</td>
<td></td>
<td>Anticipated TCPI Graduation Date</td>
</tr>
<tr>
<td>DSRIP</td>
<td></td>
<td>Anticipated DSRIP Graduation Date</td>
</tr>
<tr>
<td>CPC+</td>
<td></td>
<td>Anticipated CPC+ Graduation Date</td>
</tr>
</tbody>
</table>

### Beneficiaries Information

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>Percent of Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>765</td>
<td>25.36%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>964</td>
<td>31.98%</td>
</tr>
<tr>
<td>Commercial</td>
<td>952</td>
<td>31.56%</td>
</tr>
<tr>
<td>Self Insured</td>
<td>333</td>
<td>11.08%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,014</td>
<td>Total Percentage: 100.00%</td>
</tr>
</tbody>
</table>

### Practice Site Clinical Workforce

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physicians</td>
<td>2.00</td>
<td>Care Managers</td>
<td>0.50</td>
</tr>
<tr>
<td>Mid Level Physician's Assistants</td>
<td>0.00</td>
<td>Integrated BH Specialists</td>
<td>0.20</td>
</tr>
<tr>
<td>Mid Level Nurse Practitioners</td>
<td>1.00</td>
<td>Integrated Specialists (Non BH)</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### Site Hours

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Support</td>
<td>2.00</td>
</tr>
<tr>
<td>On Site Coaching</td>
<td>6.00</td>
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</tbody>
</table>
# Practice Site Technical Capabilities

## Gate Status

<table>
<thead>
<tr>
<th>Gate Status</th>
<th>Gate One Completed Date</th>
<th>Gate One Completed By</th>
<th>Gate Two Completed Date</th>
<th>Gate Two Completed By</th>
<th>Gate Three Completed Date</th>
<th>Gate Three Completed By</th>
</tr>
</thead>
</table>

## Deliverable Assessment Tracking

<table>
<thead>
<tr>
<th>Gate 2</th>
<th>Deliverable</th>
<th>Milestone</th>
<th>Milestone Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliverable</td>
<td>Milestone 1 - Participation</td>
<td>Sign Gate 2 Submit Gate 2 commitment form Participation completed by APC Agreement Clinical Practice Leader and APC Business Practice Leader</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 1 - Participation</td>
<td>Attendance by one practice lead or designee as appropriate to each covered topic as required</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 1 - Participation</td>
<td>Engagement in learning activities that include sharing practice and APC-wide learning opportunities</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 2 - Patient Centered Care</td>
<td>Plan for either a patient satisfaction survey, focus group or Patient- Family Advisory Council (PFAC) that includes representative practice populations</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 2 - Patient Centered Care</td>
<td>Practice uses protocols/processes with goal of reporting Advanced Directives (AD) on all patients &gt;65 years</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 5 - Access to Care</td>
<td>Print and/or electronically provide preferred language materials to patients that meet practice community needs</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 5 - Access to Care</td>
<td>Engage interpretation services as applicable to the practice population needs, including visually or hearing impaired</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 5 - Access to Care</td>
<td>Assess need and develop plan to address population diversity and cultural needs</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 5 - Access to Care</td>
<td>Assess practice’s demands for same day appointments with goal to satisfy at least 80% of demand</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 5 - Access to Care</td>
<td>Describe policy and process for same day appointments</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 5 - Access to Care</td>
<td>Review hours of operation and scheduling patients to determine most successful method of ensuring same day appointment availability</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 5 - Access to Care</td>
<td>Improve communication capabilities by using secure communication methods (e.g. portal) or nurse call line for other non-urgent care; assures navigation to other care coordination and referral to educational resources (e.g. diabetes education tools, rainy)</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 6 - HIT</td>
<td>Attestation to connect to HIE in 1 year by establishing a participation agreement with their RHIO</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 6 - HIT</td>
<td>Develop basic Information Exchange</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Milestone 6 - HIT</td>
<td>Ability to capture, calculate and report all core measures</td>
<td></td>
</tr>
</tbody>
</table>
### NCQA PCMH Scoring

#### NCQA PCMH Scoring Detail

<table>
<thead>
<tr>
<th>Information</th>
<th>Standard Year</th>
<th>Level</th>
<th>Begin Recognition Date</th>
<th>End Recognition Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Org ID</td>
<td>171708</td>
<td>Recognized-Level 3</td>
<td></td>
<td></td>
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<tr>
<td>Project ID</td>
<td>242551</td>
<td></td>
<td></td>
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<tr>
<td>Recognition ID</td>
<td>181739</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Standard 1 Patient-Centered Access**
  - Received Standard Score: 8.825
  - Maximum Standard Score: 10.000

- **Standard 2 Team-Based Care**
  - Received Standard Score: 12.000
  - Maximum Standard Score: 12.000

- **Standard 3 Population Health Management**
  - Received Standard Score: 19.000
  - Maximum Standard Score: 20.000

- **Standard 4 Care Management and Support**
  - Received Standard Score: 18.250
  - Maximum Standard Score: 20.000

- **Standard 5 Care Coordination and Care Transitions**
  - Received Standard Score: 16.500
  - Maximum Standard Score: 18.000

- **Standard 6 Performance Measurement and Quality Improvement**
  - Received Standard Score: 16.250
  - Maximum Standard Score: 20.000
## NCQA PCMH Scoring Detail

### Standard 1 Patient-Centered Access

**Received Standard Score**: 8.625  
**Maximum Standard Score**: 10.000

<table>
<thead>
<tr>
<th>Standard Description</th>
<th>Points: Received Element Score</th>
<th>Points: Received Element Percent Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Max: Maximum Element Score</td>
<td>4,500</td>
<td>A</td>
</tr>
<tr>
<td>A Percent Score: Received Element Percent Score</td>
<td>100.00%</td>
<td>A Percent Score: Received Element Percent Score</td>
</tr>
<tr>
<td>A Factor 1: Providing same-day appointments for routine and urgent care (CRITICAL FACTOR)</td>
<td>Yes</td>
<td>A Factor 2: Providing routine and urgent-care appointments outside regular business hours</td>
</tr>
<tr>
<td>A Factor 3: Providing alternative types of clinical encounters</td>
<td>No</td>
<td>A Factor 4: Availability of appointments</td>
</tr>
<tr>
<td>A Factor 5: Monitoring no-show rates</td>
<td>Yes</td>
<td>A Factor 6: Acting on identified opportunities to improve access</td>
</tr>
<tr>
<td>A Max: Maximum Element Score</td>
<td>3,500</td>
<td>B Points: Received Element Score</td>
</tr>
<tr>
<td>B Percent Score: Received Element Percent Score</td>
<td>75.00%</td>
<td>B Factor Count: Total Factor Numbers</td>
</tr>
<tr>
<td>B Factor 1: Providing continuity of medical record information for care and advice when office is closed</td>
<td>Yes</td>
<td>B Factor 2: Providing timely clinical advice by telephone (CRITICAL FACTOR)</td>
</tr>
<tr>
<td>B Factor 3: Providing timely clinical advice using a secure, interactive electronic system</td>
<td>No</td>
<td>B Factor 4: Documenting clinical advice in patient records</td>
</tr>
<tr>
<td>C Max: Maximum Element Score</td>
<td>2,000</td>
<td>C Score: Received Element Score</td>
</tr>
<tr>
<td>C Percent Score: Received Element Percent Score</td>
<td>75.00%</td>
<td>C Factor Count: Total Factor Numbers</td>
</tr>
</tbody>
</table>
Potential Data Uses

- Identify the practice site attributes, workforce and capabilities that correlate with performance and health care cost
- Determine program impact
- Understand workforce readiness for value based payment
Questions
All Payer Database Update

Mary Beth Conroy
NYS All Payer Database Update

- Update on National APCD Efforts and Issues
- NYS Alignment with System Transformation
- Data Contained within APD and Project Resources
- Update on Project Deliverables
- Technical Environment and Security
- Regulation Update / Guidance Manual
- APD Advisory Group / Data Release and Review
- APD Stakeholder Meeting
- APD Presentation by Optum
National Efforts in APCD Implementation

Nationwide:
• 14 Existing
• 7 Existing (Voluntary)
• 5 In Implementation
• 16 Strong Interest
• 8 No Current Activity
On March 1, 2016, a Supreme Court decision on *Gobeille v. Liberty Mutual Insurance Co.*, ruled ERISA preempts state laws that require self-insured plans to submit claims data to APCDs.

As a result of this ruling, states cannot enforce reporting requirements against self-insured ERISA plans (ruling does not apply to fully insured).

Self-insured ERISA plans may agree to voluntarily report to state APCDs when shown incentive.

Recent legal blog post:

http://healthaffairs.org/blog/2017/03/03/all-payer-claims-databases-after-gobeille/
Federal Alternatives to SCOTUS Ruling

- An alternative was raised by the majority Court ruling that the federal Department of Labor (DOL) could collect annual, aggregated data on behalf of state APCDs to ease reporting burden.

- DOL responded with A Notice of Proposed Rulemaking in July 2016 – which is still not finalized.

- The National Academy of State Health Policy (NASHP), the APCD Council and the National Association of Health Data Organizations (NAHDO) developed a “Common Data Layout” to collect claims in a single national standard format.

- If the DOL Notice of Proposed Rulemaking is finalized, implementation will depend upon leadership in the new administration.
New York State All Payer Database (APD)

- Advancing health care transformation in an effective and accelerated manner requires data to support decision making into the challenges of access, quality, and affordability.

- The Department of Health recognizes that integrating data about the health care system into an APD that includes not only claims data, but other health-related data sources, will allow a range of stakeholders to monitor efforts to improve quality of care, population health research and reduce health care costs.

- The goal of the APD is to serve as a comprehensive data and analytical resource for supporting decision making and research.
The APD Supports Health Care System Transformation Initiatives

**Systematic Integration of Data Technology**
- All Payer Database Claims
- SHIN-NY
- Health Assessment Data
- Public Health Data

**Applied Analysis and Analytics**
- Quality Measurement
- Cost of Care
- Care Coordination
- Clinical Decision Support

**Health Care Reform System Transformation**
- DSRIP
- SIM APC Model
- TCPI, CPC, PCMH
- MACRA / MIPS
- Value Based Care / Outcomes Based Models

Transformation Goal of The Triple Aim: Better Health, Better Care, Lower Costs
What data will the NYS APD contain and when?

APD Project Data Acquisition

Member
- Medicaid
- Medicare
- Child Health Plus
- QHP
- Essential Plan
- Commercial
  - Benefit Package – QHP
  - Benefit Package – EP
  - Benefit Package – Commercial

Public Payer
- Medicaid Encounter
- Medicaid Fee-For-Service
- Child Health Plus
- Medicaid Encounter

Private Payer
- Qualified Health Plan
- NYSofH Essential Plan
- Commercial
- Self-Funded Commercial

Provider
- National Plan and Provider Enumeration System (NPPES)
- Health Facility Information System (HFIS)
- Panel Data
- Drug Utilization

Hospital Discharge Data
- SPARCS (Article 28)

Vital Statistics
- Mortality
- Birth
- Marriages / Dissolutions

Population / Census Data
- Claritas

Clinical EHR Data
- SHIN-NY

Non-Claims Based Data
- Functional Assessment
- Public Health Registries
- Survey Data
- Social Determinants of Health

Internal Releases:
- Internal Release 1 – Spring 2017
- Internal Release 2 – Summer 2017
- Permanent Release – Late Fall 2017
- TBD Releases – Winter 2018 and Forward
March 16, 2017

APD Project Resources

- NYS DOH OQPS (Project Sponsor and Owner)
- NYS OITS (PMO, Security and Connectivity)
- NYS DOH OHIP Division of Systems
- New York State of Health Marketplace (NYSoH)
- CSRA (EIS, eMedNY, NYMMIS)
- Optum (Warehouse and Analytics)
- NYSTEC (Quality Assurance and Technical Assistance)
- CMA (MDW, OHIP Data Mart)
- Pero Group / APCD Council (Policy Support)
- Rueckert Advertising (Infographics)
APD Project Approach to Development

- Agile Project Methodology
NYS APD Design Session Topics

- APD Portal
- Security
- Type of Provider
- Member
- Disease Classification / Risk
- Quality Measurement
- Cost
- Data Modeling / Mapping
- Category of Service
- Site of Service
## Symmetry Toolkit

### Episode Treatment Groups (ETGs)
- Episode Grouper
- Clinical Resource Measurement

### Episode Risk Groups (ERGs)
- Risk Adjustment
- Predictive Modeling

### Evidence Based Medicine (EBM Connect)
- Quality Measurement
- Endorsed by AHRQ and HEDIS
- Over 650 Quality Measures
- Managed Care Plan Validation
Benefits already being realized as we develop and implement…

- **Enhanced Security**
- **Ease of Visualizations**
- **Broadened Covered Lives**
- **Full Suite of Quality Measures**
- **Master Provider Index**
- **Master Patient Index**
- **Disease and Risk Profiles with Cost**
- **National Benchmarking**
- **Advanced Analytics**
All Payer Database Key Milestones

- **Optum Warehouse and Analytics Contract Signed**
  - May 27, 2016

- **Design Sessions and Deliverable Quality Assurance and Monitoring**
  - Summer 2016 – Early Spring 2017

- **Internal Soft Launch of Interim Solution Phase I**
  - Spring 2017

- **Internal Soft Launch of Interim Solution Phase II**
  - Summer 2017

- **Permanent Warehouse and Analytics Solution Implemented**
  - Fall 2017

- **Continued additional data sources, enhancements and expansion of users**
  - Fall/Winter 2017-2018 and forward
Deliverable Approvals Since Project Initiation

- Del 9 De-Identification Method (28-Oct)
- Del 1 Project Management Plan and Schedule (31-Oct)
- Del 14 User Story Traceability Matrix (2-Nov)
- Del 18 System Security Plan (29-Dec)
- Del 19 System Vulnerability Testing (26-Jan)
- Del 21 Training Needs Analysis (31-Jan)
- Del 22 Training Plan (2-Feb)
- Del 20 Training Environment (27-Feb)
Currently Active Deliverables Through June 2017
Optum Triple Aim Analytic Services Technology Stack

Business Intelligence Tools

- **Tableau (Web/Desktop)**
  - Pre defined Reports/User Stories
  - Visual Analytics
  - Ad hoc Reporting

- **Oracle SQL Developer**
  - Ad hoc querying
  - Advanced SQL Reporting

- **SAS**
  - Advanced Statistical Analysis

- **Liferay**
  - Secured Authentication
  - Gateway to APD
  - APD Resources (Training, Documentation etc.)

---

All Payer Consolidated Data Repository

- **Oracle Exadata**
  - Relational Database Management System

- **Informatica**
  - Data Integration
  - Master Data Management
  - Geo Coding
  - Metadata Manager

---

Optum Analytics

- Symmetry
  - ETG
  - ERG
  - EBM

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Document Management

- Microsoft SharePoint
  - Document Library

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NEW YORK STATE OF OPPORTUNITY.

Department of Health
Data Access and De-identification

User Type
- State Agency Staff
- County & Local Policy Managers
- Health Care Researcher
- Insurance Carrier DM Staff
- Health Care Consumer
- Health Care Provider
- APD Mgmt Staff

NYS Provisioning Authority Creates NY Gov ID
- Authenticate
  - Government NY Gov ID or Equivalent
  - Personal NY Gov ID or Equivalent
  - Business NY Gov ID or Equivalent

NYS Provisioning Authority Assigns Security Role
- Data Source Security
  - Data Source Access (All)
  - No Data Source Access

- Column Level Security
  - PHI + PII Access
  - PII Access Only
  - No PHI/PII Access

Governance Managed Row/Column Control Table

| Table Name | Column Name | Data Type | Physical Encryption | Neutron Encryption | PHI/PII PN | PII PN | PHI+PII PN | Non PHI PN | Metadata 1 | Metadata 2 | Metadata 3 | Metadata 4 | Metadata 5 |
|------------|-------------|-----------|--------------------|-------------------|-----------|-------|-----------|-----------|------------|-----------|------------|----------|----------|----------|
| Table1     | Column1     | String    | Yes                | Yes               | Yes       | Yes   | Yes       | Yes       | Yes        | Yes       | Yes        | Yes       | Yes       |
| Table2     | Column2     | Integer   | No                 | No                | No        | No    | No        | No        | No         | No        | No         | No        | No        |
Regulations Adoption Process Update

- On August 4, 2016 the APD regulations were presented to the State’s Public Health and Health Planning Council (PHHPC)
- The APD regulations were posted for public comment on August 31, 2016
- The 45 day public comment period ran through October 17, 2016
- There were 9 public comments received representing multiple stakeholder groups
- The Assessment of Public Comment is being finalized
APD Guidance Manual

- Final Draft going through DOH Executive sign off process
- Contains three sections
  - Program Operations
  - Data Governance
  - Submission Specifications
- Once final, will be posted to the APD page on the DOH public website
APD Advisory Group

- The APD Advisory Group will be formed through invitation and open application.
- Consumer, multi-agency and other core stakeholder engagement and input will comprise this group’s functions.
- Comprised of representatives that have both short- and long-term vested interests in the success of the APD.
- Activities include: strategic planning functions, fiscal sustainability planning, data sharing and privacy protections, consumer utility framework and cross-agency resource coordination and communication.
Proposed APD Advisory Group Composition

- New York State Department of Health Office of Quality and Patient Safety (OQPS) (Chair);
- New York State Department of Health Office of Health Insurance Programs (OHIP) - Medicaid Program;
- New York State of Health (NYSOh) marketplace;
- New York City Department of Health and Mental Hygiene;
- New York State Department of Financial Services (DFS);
- New York State Department of Civil Service (DCS);
- New York State Office of Information Technology Services (OITS);
- Health insurers;
- Health care facilities;
- Health care practitioners;
- Purchasers of health insurance or health benefits;
- Health care consumers and advocates; and
- Health care researchers and professionals.
Data Release and Review Committee

Data Release Review Committee Functions
- Review project requests
- Ensure adherence to DOH guidelines and Federal and State laws
- Implement DUAs when required
- Implement BAAs when required
- Communicates 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
- Purchaser: 1 member
- Consumer: 1 member
- Researcher: 2 member
Save the Date: Stakeholder Meeting

- An APD stakeholder meeting will be held in Albany on April 26
- The last stakeholder meeting was in December 2015
- The draft agenda includes:
  - National Perspectives
  - An APD Project Update
  - An Optum Demonstration
  - Update on the Provider Network Data System (PNDS)
  - Facilitated Roundtable Discussions
Optum’s DW/APCD National Footprint
Optum’s Data Analytics Engagements
Single Sign-On Using NY.Gov

**What is the NY APD?**

New York’s All Payer Database (APD) contains public and private health care claims and encounter data from insurance carriers, health plans, third-party administrators, pharmacy benefit managers, Medicaid and Medicare that can be syndicated to support the management, evaluation, and analysis of the NY Health Care system.

**Links**

- Health IT Home
- All Payer Database
- The New York State Innovation Model Plan Initiative
- Key Building Blocks and Activities
- Statewide Policy Guidance

**Announcements**

- 02/27/2017: A new file for both Business and Technical Specification Documents have been loaded to NYAPD Portal for UAT testing.
- 02/23/2017: A new file for both Business and Technical Specification Documents have been loaded to NYAPD Portal for UAT testing.
- 02/15/2017: The NYAPD Interim Release 2 is scheduled to go live on June 1, 2017.

**Help Desk**

The NYAPD Help Desk will be available starting implementation of Release 2 on June 1, 2017.
Working Lunch
APD Presentation

Mary Beth Conroy
Steve Johnson (Optum)
Use Case 1 – SPARCS Inpatient APR-DRG Summary Report

Top 20 APR-DRGs by Total Discharges for all residents of Kings County that expired in the hospital, stratified by facility.
Use Case 1a – SPARCS Inpatient APR-DRG Summary Report

Top 20 APR-DRGs by Total Discharges for Statewide Medicare members, stratified by age.
Use Case 1b – SPARCS - Inpatient APR-DRG Summary Report

Top 20 APR-DRGs by Total Discharges for Statewide Commercial members, stratified by age
Use Case 2 - SPARCS - Inpatient AHRQ Prevention Quality Indicator (PQI)

Rates of preventable hospitalizations for the Heart Failure PQI for 2015

<table>
<thead>
<tr>
<th>PQI</th>
<th>PQI Description</th>
<th>18-39</th>
<th>ALOS</th>
<th>40-64</th>
<th>ALOS</th>
<th>65-74</th>
<th>ALOS</th>
<th>75+</th>
<th>ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI B</td>
<td>Heart Failure</td>
<td>955</td>
<td>5.7</td>
<td>13,600</td>
<td>5.8</td>
<td>11,417</td>
<td>6.2</td>
<td>30,254</td>
<td>6.1</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>955</td>
<td>5.7</td>
<td>13,600</td>
<td>5.8</td>
<td>11,417</td>
<td>6.2</td>
<td>30,254</td>
<td>6.1</td>
</tr>
</tbody>
</table>
Use Case 2a - SPARCS – SPARCS Inpatient AHRQ PQI report

SPARCS - Inpatient - AHRQ PQI Report
PQI Total Discharges and Average Length of Stay (ALOS) by Age Group

<table>
<thead>
<tr>
<th>Step 1: Apply Time Period</th>
<th>Step 2: Apply PQI Description</th>
</tr>
</thead>
</table>

### PQI with description along with Total # of Discharges and ALOS by Age Group

<table>
<thead>
<tr>
<th>PQI Description</th>
<th>18-39 Discharges</th>
<th>18-39 ALOS</th>
<th>40-64 Discharges</th>
<th>40-64 ALOS</th>
<th>65-74 Discharges</th>
<th>65-74 ALOS</th>
<th>75+ Discharges</th>
<th>75+ ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Short-Term Complications</td>
<td>4,127</td>
<td>3.2</td>
<td>4,319</td>
<td>3.5</td>
<td>1,015</td>
<td>5.4</td>
<td>825</td>
<td>6.2</td>
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<tr>
<td>Diabetes Long-Term Complications</td>
<td>2,073</td>
<td>3.4</td>
<td>5,764</td>
<td>3.4</td>
<td>3,546</td>
<td>7.0</td>
<td>5,999</td>
<td>7.0</td>
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<tr>
<td>Uncontrolled Diabetes</td>
<td>483</td>
<td>2.7</td>
<td>1,624</td>
<td>3.5</td>
<td>778</td>
<td>4.3</td>
<td>962</td>
<td>5.0</td>
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<tr>
<td>Grand Total</td>
<td>6,193</td>
<td>3.8</td>
<td>14,717</td>
<td>6.1</td>
<td>5,425</td>
<td>6.7</td>
<td>5,386</td>
<td>6.5</td>
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</tbody>
</table>

Rates of preventable hospitalizations for diabetes related PQIs for 2015.
Use Case 2b – SPARCS Inpatient AHRQ PQI Report

Overall PQI admissions by Year and Stratified by Gender, Age, Race and Ethnicity

Step 1: Click on PQI
Step 2: Review Stratifications by Gender, Age, Race and Ethnicity

Sample Illustration
Top 10 Diagnosis Groupings for ED visits for residents of the Capital District and Adirondack HSAs in 2015, stratified by facility.
Use Case 4 – SPARCS Emergency Department Utilization

Step 1: Select Metric
Step 2: Select Time Period
Step 3: Select Stratification

Emergency visit charges for first quarter of 2014, stratified by race.
Use Case 5 – Vital Statistics Cancer Mortality Data

Map of cancer deaths by county, stratified by age
Use Case 6 – Vital Statistics - Opioid Overdose Death Rates

Map of opioid overdose death rates by county

Step 1: Select Time Period
Step 2: Select Overdose type
Step 3: Select Color Intervals

Color Intervals related to counties on map
Use Case 7 – Provider Availability

Count of female pediatricians in each county (showing the map and table views)
Use Case 8 – Member Enrollment

<table>
<thead>
<tr>
<th>Eligibility Groups</th>
<th>Cash Safety</th>
<th>Cash SS</th>
<th>Cash Tanf</th>
<th>Ma Eligible</th>
<th>Ma Ssi</th>
<th>Non-Cash Family Health Plus</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newborn</strong></td>
<td>759</td>
<td>1.3%</td>
<td>9.8%</td>
<td>88.2%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>8,033</td>
</tr>
<tr>
<td><strong>1-2</strong></td>
<td>967</td>
<td>1.2%</td>
<td>14.4%</td>
<td>82.5%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>1,124</td>
</tr>
<tr>
<td><strong>3-5</strong></td>
<td>1,498</td>
<td>3.4%</td>
<td>3.4%</td>
<td>91.2%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>1,658</td>
</tr>
<tr>
<td><strong>6-14</strong></td>
<td>4,761</td>
<td>1.7%</td>
<td>3.7%</td>
<td>93.6%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>279,38</td>
</tr>
<tr>
<td><strong>15-19</strong></td>
<td>5,915</td>
<td>2.6%</td>
<td>2.4%</td>
<td>72.2%</td>
<td>1.4%</td>
<td>0.0%</td>
<td>167,05</td>
</tr>
<tr>
<td><strong>20-44</strong></td>
<td>23,105</td>
<td>5.4%</td>
<td>3.2%</td>
<td>88.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>259,76</td>
</tr>
<tr>
<td><strong>45-64</strong></td>
<td>17,108</td>
<td>7.2%</td>
<td>1.9%</td>
<td>74.0%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>203,20</td>
</tr>
<tr>
<td><strong>65-74</strong></td>
<td>417</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>8,265</td>
</tr>
<tr>
<td><strong>75-94</strong></td>
<td>626</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>12,519</td>
</tr>
<tr>
<td><strong>85+</strong></td>
<td>47</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>24,956</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>46,914</td>
<td>2.6%</td>
<td>3.2%</td>
<td>90.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>573,86</td>
</tr>
</tbody>
</table>

Count and percentage of Medicaid enrollees by eligibility group and age group.
Use Case 9 – Quality Adherence

Adherence rates for Diabetes care measures (based on National Standard) and further stratified by acuity group.
SHIN-NY Update

Jim Kirkwood
Valerie Grey
Hospitalization Event Notifications and Reductions in Readmissions of Medicare Fee-for-Service Beneficiaries in the Bronx, New York

Journal of the American Medical Informatics Association
October 7, 2016

An Empirical Analysis of the Financial Benefits of Health Information Exchange in Emergency Departments

Journal of the American Medical Informatics Association
June 27, 2015
Listening & Seeking Customer and Stakeholder Input

Stakeholder Focus Groups

- All Provider Types
- Health Plans
- Consumers
- Qualified Entities
- DOH Workgroups
What Are We Hearing? What Do Providers Want?

- Speedy relevant information
- Better quality & complete data
- "Search-ability"
- Finish the basics
- Info that goes across borders
- Simplicity & ease of use (SSO)
- Alignment & Standardization
- Easy reporting
- EHR integration
- Output that matters
- Highest privacy & security
- Consent policy changes
- Help educating patients
Game Plan & Target Timelines

**ORIENTATION & LISTENING TOUR**
9/16 - 11/16

**LONG-TERM VISION**
12/16 - 3/17

**MULTI-YEAR ROADMAP**
12/16 - 7/17

**YEAR 1**

- IMPLEMENTATION OF TO BE DETERMINED PRIORITIES
- NYEC GOVERNANCE CHANGES THROUGH SEPTEMBER
- NYEC/RHIO CONTRACTING THROUGH OCTOBER 2017

STAKEHOLDER ENGAGEMENT THROUGHOUT
Multi-Year Roadmap

Long-Term Vision

What’s In It
• Mission
• Vision
• Guiding Principles
• Long-Term Objectives

Operational Plan

What’s In It
• Strategies
• Action Plan
• Metrics & Measurement
• Budgeting
Future Considerations & Trends

- Data Quality Assurance
- Patient Engagement & Customer Needs
- Quality Reporting
- All Payer Database
- Social Determinants of Health
- Population Health
Some Planning Assumptions

- Pressure on government funding

- Need to supplement with other funding and work toward sustainability

- Current “network of network” approach will be retained but will likely change

- Better integration and alignment with State and Federal health reform initiatives

- Stakeholders will demand improvements

- NYS will set clearer (fundable) priorities

- More competition to create tools for providers and plans

- Roles and responsibilities will shift and change, sometimes significantly
Vision & Mission

SHIN-NY
Our mission is to improve healthcare through the exchange of health information whenever and wherever needed

Shared Vision
Our vision is a dramatically transformed healthcare system where health information exchange is universally used as a tool to make lives better

NYeC
Our mission is to improve healthcare by collaboratively leading, connecting, and integrating health information exchange across the State
Proposed Guiding Principles
Passionate Beliefs

• Patient-centered
• Public benefit
• Support reform initiatives
• Stakeholder inclusive
• Consensus building
• Customer-focused
• Regional markets
• Statewide good transcends individual interests

• Operational excellence
• Trust, security and transparency
• Efficiency--value engineering
• Leverage private investment
• Highest quality, integrated data
• Leading technology
• Standardization
• Influence & alignment with federal standards

Strong advocacy and using all levers at federal, state and local level to promote robust SHIN-NY
SHIN-NY Long-Term Objectives

**Reach maximum potential**
- Adoption close to 100%
- Full data contribution by all (CCDA)
- Highest data quality
- Info shared for 95% of patients
- Enhance functionality/customer satisfaction
- Highest level security & system reliability
- Effective, efficient, affordable

**Integration & accessibility**
- Data standardized and normalized
- Data both pulled and pushed
- Useful tools for VBC (including care plans)
- Clinical & other useful data can be integrated
  - Claims
  - Registries
  - Social determinants
  - Consumer reported
- Data used for quality reporting
- Integrated with APD
- Data available to patients/consumers

**Work toward sustainability**
- Because the SHIN-NY is of high-value, and used by virtually everyone, users will enthusiastically support via user fees or other mechanisms
NYeC Long-Term Objectives

Connect HIE & Ensure Access to Statewide Data

- Successfully connect QEs to facility data sharing (sPRL)
- Create master provider index
- Ensure access to statewide data (“wire once”)
- Ensure technical standards & system performance

Lead SHIN-NY Efforts*

- Provide thought leadership & collaboration
- Recommend policy, governance, operations, functionality
- Contract for SHIN-NY enterprise including QE core services
- Ensure oversight, performance & consistent measurement
- Achieve maximum SHIN-NY potential
- Create self-sustainability options when maximum potential reached

Advocacy & Education

- Advocate on behalf of SHIN-NY for funding & policy
- Promote best practices & learning systems
- Support federal efforts for interoperability
- Present united voice & force with EHR vendors
- Help providers transform, use EHRs, and connect to the SHIN-NY

*in partnership with New York State
Next Steps . . .

• Continue stakeholder engagement on Operational Plan
• Develop recommendations and priorities
• Goal of Operational Plan is for completion by July
• Then ... on to QE performance-based contracting
• And implementation and execution of the Roadmap
nyehealth.org

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40 Worth Street, 5th Floor  New York, New York  10013
80 South Swan Street, 29th Floor  Albany, New York  12210
HIT Enabled Quality Measurement

Jim Kirkwood
CQM Data Sources & Intermediaries

Data Sources
- Payers/APD
- Registries

Data Intermediary
(possibly state, payer, third party)

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
- Immunizations HL7
- Claims X12

Functions
- Data Sourcing
  - Cleansing
  - Calculation
  - Consistent formatting
  - Reporting

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

- **Business need**
  - Generate quality measures using QE-sourced data for multiple State initiatives
  - Generate hybrid HEDIS measures without chart abstraction to populate the APC scorecard, enable health plans to establish baselines for VBP contracts, allow VBP contractors to identify improvement areas among their providers or facilities, and allow providers to manage outcomes

- **Approach**
  - Design and implement a pilot project to complement claims data with clinical data in order to enrich quality measurement (and potentially reduce burden of chart review)

- **Objectives**
  - Assess feasibility of QEs providing the desired data elements identified by OQPS
  - Identify the most effective data flow
  - Test a method of transport for the data from QEs to State OR QEs to Plans
  - Validate data received
  - Explore issues related to consent and privacy
  - Explore issues related to provider-patient attribution, provider aggregation across payers, etc.

- **Assumptions**
  - Partners may include QEs, VBP Contractors, Health Plans
  - Focus on a subset of measures/data elements (APC Scorecard V 1 measures or a subset thereof)
Current SHIN-NY Activities Related to Quality Measurement

- Clinical/Claims integration project
- SHIN-NY Data Quality Assessment
  - Understanding processes for onboarding participants and approaches to increase data quality
  - Adherence to interoperability standards
    - Message format, vocabulary standards, exchange protocols
- Setting standards for data contribution to the SHIN-NY: Common Clinical Dataset
Next Steps

- VBP Pilots
  - Assess infrastructure needed
- SIM
  - Document current state data flow
- Further assess data needs to refine use case
  - List of data elements mapped to measures and to C-CDA standards
    - Understand context for each data element (structure, temporality, etc.)
    - (excel spreadsheet)
  - Assess feasibility of meeting data needs
    - Data Quality Assessment
- Identifying State use cases
  - population health measurement
- Identify policy issues
- Propose future-state data flow
Sharing APD Data with the SHIN-NY

1. Demographic Update on Patient X
2. Query for Patient X
3. Query for Patient X
4. Response (Claims)
5. Response (Clinical + Claims)
Discussion and Next Steps

Patrick Roohan
Director
Office of Quality and Patient Safety

Next meeting: June 6, 2017 (NYC)