

ANNUAL REPORT:
Implementation of the NY
State Health Innovation Plan
(SHIP)

December 2015

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Introduction

Legislation passed in 2015 requires the Commissioner of Health to prepare an annual report on the implementation of the State Health Innovation Plan (SHIP) which shall include:

- The recommendations of the workgroups established to assist the state in implementation of the SHIP;
- The Department's efforts in advancing the SHIP's goals;
- Information on the expenditures of the State Innovation Model grant.

This report provides an update on the State's SHIP and State Innovation Model activities in 2015.

New York's State Health Innovation Plan (SHIP) is the roadmap to achieve the "Triple Aim" for all New Yorkers: healthier people, better care and smarter spending. We seek to achieve this through a multi-faceted approach that has, at its heart, an advanced primary care model that integrates care with all parts of the health care system, including behavioral health and community-based providers, and aligns payment with this care model.

To achieve the aspirations of the SHIP, New York State, in coordination with Health Research Inc., applied for and was awarded a four year, \$99.9 million State Innovations Model (SIM) Testing grant from the Centers for Medicare and Medicaid Innovation (CMMI) with a start date of February 2015. The first year of the four year grant was devoted to planning; operations are to commence in 2016. As part of the planning process, the Department launched a multi-agency, multi-sector governance structure to engage stakeholders representative of payers, providers and consumers in the development of the Advanced Primary Care (APC) model and its supporting components (value based payment, common metrics, and alignment with behavioral and population health) in preparation for implementation in the later part of 2016. In addition, an existing workgroup on Health Information Technology provided guidance and input on the Statewide Health Information Network of NY (SHIN-NY) and the All Payer Data Base (APD), both key components of the SHIP, and a workgroup of workforce was convened to provide input and guidance on emerging health workforce needs in New York State.

The goals of New York's SIM grant are to:

- Promote health and well-being through development, implementation and evaluation of an advanced primary care delivery model, together with alternative payment models, that promote care coordination and management, as well as enhanced integration with behavioral and population health and with long-term care and community support.
- Support performance improvement and primary care capacity by:
 - Expanding New York's primary care workforce through innovations in professional education and training;
 - Integrating primary care with population health through Public Health Consultants (PHCs) funded to work with regional Population Health Improvement Program contractors;
 - Creation and common adoption of a core set of measures (a common scorecard) with shared quality metrics across multiple payers and providers;
 - Continuing to implement the State's All Payer Database (APD) and Statewide Health Information Network (SHIN-NY);
 - Supporting an independent evaluator, data collection, and performance monitoring; and

- Promote transparency to ensure that patients have access to information that will help them make informed choices about their health care and so that payers and providers have information that can be used to improve care and monitor expenditures and utilization.

The heart of New York's transformation work is development and implementation of the APC model, an integrated primary care delivery model which will be implemented through SIM-supported grants to regional practice transformation agents. A competitive procurement will be issued in January 2016, with initial implementation across New York anticipated to begin summer 2016. The overarching goal is for 80 percent of New York's citizens to be able to receive care in an integrated care delivery model (as defined by APC) by the end of the grant in 2019.

Background

In December 2013, the NYSDOH, in partnership with other state agencies and external stakeholders, developed New York's State Health Innovation Plan (SHIP). The SHIP is New York's roadmap to achieve the "Triple Aim" for all New Yorkers: healthier people, better care and smarter spending. New York's health care delivery transformation plan, as articulated in the SHIP, is built on five pillars and three enablers:

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

The SHIP, recognizing that a lasting health delivery system reform requires a high performing primary care system, proposes statewide implementation of an enhanced medical home model, "Advanced Primary Care" (APC). Findings in New York and nationally suggest that a care delivery system with a medical home model at its heart is likely to achieve the Triple Aim. Thus, New York requested SIM funding to support the following:

1. Transformation entities to work with practices to help them evolve to meet APC capabilities including team-based care and outcome-based payments;
2. Programs to ensure an adequate workforce consistent with an evolved primary care delivery system;
3. Development of a set of aligned quality, utilization and cost measures that are consistent across payers and providers; and
4. Population health initiatives to ensure communication and integration of clinical and community-based providers to meet CDC and Prevention Agenda goals.

New York's plan builds on successes to date and incorporates lessons learned from an extraordinary range of initiatives, including the Aligning Forces for Quality (AF4Q) and Beacon Community initiatives in Western NY, a large number of payer-supported medical home projects, including two regional, multi-

payer medical home initiatives, and CMMI-funded Innovation initiatives, including the Finger Lakes HSA's Innovation Award. New York's Medicaid program has provided early leadership and ongoing support for the medical home model by including a major initiative to implement medical homes in physician practices across the state, in hospital teaching clinics, and, most recently, the Delivery System Reform Incentive Payment (DSRIP) program.

New York has led the nation in the adoption of the medical home model and the APC model builds on the State's strong base. As of July 2013, nearly 5,000 clinicians (25 percent of total primary care physicians) in New York were working in practices recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMHs). Federally Qualified Health Centers (FQHCs) in New York have achieved notable success, with 80 percent of FQHC networks having achieved some level of PCMH certification. Despite these successes, three-quarters of all primary care practitioners in the state work do not work in PCMH recognized practices.

New York's State Innovations Model (SIM) grant represents an opportunity to leverage investments made to date to assure broad adoption of an Advanced Primary Care (APC) model inclusive of behavioral and population health, coupled with a strong workforce and educated and engaged consumers, supportive payments, and common metrics.

Extensive stakeholder engagement resulted in development of the APC model, defined as an integrated care delivery and payment model that ties together a service delivery model with a core set of measures and aligned reimbursement in order to ensure successful outcomes and long-term sustainability (see Figure 1 below for detail). The APC model describes the following elements of care delivery that have been shown to enhance the experience for the patient and improve clinical care, while also helping a provider or practice transition from payment based on volume to payment based on value. APC defines care that:

- Is comprehensive and patient-centric;
- Promotes closer connections between primary care and other clinical care ("the medical neighborhood") and with community-based services;
- Better coordinates care for patients with complex needs;
- Improves use of health information technology (HIT), including electronic health records, data analytics, and population health tools;
- Supports a shift from encounter-based payment to alternative payment that supports the services and infrastructure needed for advanced primary care;
- Promotes multi-payer participation and alignment; and
- Assures performance measurement that is consistent and meaningful to patients, payers and clinicians.

More specifically, APC is defined in terms of the following four components:

1. **A defined set of practice capabilities:** that promote care coordination for complex patients, support robust connections with the medical neighborhood and community-based services, and an administrative infrastructure to move from fee-for service to value-driven, population-based care payment.
2. **Core measures:** Common quality, outcome and cost measures across payers and providers that ensure consistent reporting and incentives.
3. **Common milestones:** that define a practice's capabilities over time and that link to performance on core measures and with payment.
4. **Outcome-based payments:** Reimbursement structured to promote and pay for quality and

outcomes. APC reimbursement models are structured to pay for a team-based care delivery team (inclusive of physicians, care providers, care managers and others as needed) to ensure comprehensive and coordinated care delivery that incents high quality and provides opportunities for shared savings.

Figure 1: APC Capabilities

Category	Description
Patient-centered care	<ul style="list-style-type: none"> Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	<ul style="list-style-type: none"> Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/coordination	<ul style="list-style-type: none"> 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
Access to care	<ul style="list-style-type: none"> Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	<ul style="list-style-type: none"> Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	<ul style="list-style-type: none"> Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	<ul style="list-style-type: none"> Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Overarching goals of the APC model, consistent with the Triple Aim, are to support a care delivery model that results in the following by 2020:

- 80 percent of the population is cared for under primary care model that is paid for through an alternative payment model; and
- 80 percent of the population receives care within an APC setting, with a systematic focus on prevention and coordinated behavioral healthcare.

SIM Governance

External Governance Model

New York's SIM governance is modeled on New York's successful Medicaid Redesign Team (MRT) structure to include an overarching policy team supported by topic-specific workgroups. The overarching team, the Health Innovation Council comprised of internal and external stakeholders, is charged with:

- Framing a cohesive policy agenda to advance the Triple Aim
- Providing guidance on key decision points and potential policy recommendations developed by topical workgroups
- Considering and offering guidance to support the consistency of vision, mission, metrics and incentives across key programs

Reporting to the Health Innovation Council are three topic-specific workgroups as outlined below. All workgroup meeting materials are posted on the NYSDOH public website at the following link - https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm.

1. Integrated Care Workgroup

Goal: Promote health and well-being by supporting innovation in primary care.

Charge:

- Create a vision for Advanced Primary Care (APC) that coordinates care across specialties and care settings, improves experience and quality, and reduces costs.
- Catalyze multi-payer (including Commercial, Medicaid, and Medicare) investments in primary care practices to ensure aligned incentives and supports necessary to achieve the Triple Aim.
- Align measurement to ensure consistency and support provider and payer focus on a key set of meaningful measures.
- Provide expert guidance on practice transformation, model design elements and payment strategies.

2. Transparency, Evaluation, and HIT Workgroup

Goal: Assure implementation of health information systems necessary to support and inform transformation.

Charge: Evaluate the state's health information technology infrastructure and systems as well as other related plans and projects, including, but not limited to, the All Payer Database (APD), Statewide Health Information Network of New York (SHIN-NY) and State Planning and Research Cooperative System (SPARCS).

- Develop recommendations for the state to move toward a comprehensive health claims and clinical database to improve quality, efficiency and cost of care, and patient satisfaction.

- Design and implement/manage standardized, consistent approaches to measure cost and quality to support evaluation of the Plan's impact on system transformation and Triple Aim goals and objectives.
- Provide expert guidance on an APC scorecard for Triple Aim.

3. Workforce Workgroup

Goal: Promote a New York State health workforce that supports comprehensive, coordinated and timely access to care that encourages health and well-being. Make recommendations to the Health Innovation Council and the DSRIP Project Approval and Oversight Panel regarding workforce needs in order to support the development and promotion of integrated care delivery that will ultimately result in health improvement.

Charge: This workgroup is charged with promoting New York's health workforce to support its transition to integrated health care delivery including an Advance Primary Care practice model to assure comprehensive, coordinated and timely access to care. Emerging priority areas of focus have been identified:

- Ensure sufficient primary care workforce.
- Better distribute primary care workforce to areas of need.
- Make the most effective use of the health care workforce under the new model.
- Improve the supply and effectiveness of behavioral health workforce.
- Train workforce for team-based care.
- Shift mindsets among the health care workforce.
- Improve data collection.

The Integrated Care Workgroup is co-chaired by a state agency representative together with an external stakeholder. The Workforce Workgroup is co-chaired by two state agency representatives, as well as two external co-chairs. The Transparency, Evaluation, and HIT Workgroup is chaired by one expert state representative. External stakeholders have been selected for their expertise, vision and input.

Internal Governance

The SIM Innovation Center ("Innovation Center"), located within the New York State Department of Health, serves as the lead organization responsible for implementing the SIM and coordinating the governance process across the state. A multi-agency Health Integration Team ensures coordination across program areas within the NYSDOH and partner agencies.

The Health Integration Team reflects a novel approach to system redesign that brings together staff of the Departments of Health, Financial Services, Civil Service, Mental Health and others as needed. Representatives from these agencies participate in weekly meetings and include individuals who play critical roles in coordinating with the State's Medicaid program, DSRIP initiative, the Prevention Agenda 2013-2017, the state's population health improvement plan. The Health Integration Team membership also includes Department of Health staff who are responsible for the implementation of CDC-funded chronic disease grants, including tobacco control, diabetes, heart disease, obesity prevention and control, and cancer prevention and control. These linkages are essential for success in transforming health and health care across all of New York, including both commercial and public payers.

Progress made this year, with the support of these workgroups, follows below.

Progress in Strategic SIM Topic Areas

The implementation of the SIM cooperative agreement includes several priority issue areas that tie directly back to the pillars and enablers of the SHIP. The topic areas and the progress made in each of these strategic initiatives follows:

- Integrated Care through APC
- Health plan engagement
- APC Common Scorecard
- Health information technology
- Population health
- Workforce
- Access to Care
- Evaluation

INTEGRATED CARE THROUGH ADVANCED PRIMARY CARE

APC Design

New York's SIM initiative will invest significant federal resources (\$67M over three years) to assist primary care practices in transforming to a highly integrated, team-based care model that is inclusive of targeted care management, as well as alternative payments models that promote and incent outcome-based reimbursement.

The APC model describes enhanced capabilities, processes, and performance of primary care providers based on lessons learned from the Comprehensive Primary Care initiative (CPCi), Multi-payer Advanced Primary Care Practice (MAPCP) program, and NCQA Patient Centered Medical Home (PCMH). Each of these initiatives is premised on primary care assuming a central role in coordination of care to achieve optimal health and well-being of their panel of patients, in collaboration with patients themselves.

Over the course of the past year, the APC model has been developed in concert with numerous external stakeholders who convened regularly as members of the Integrated Care Workgroup (ICWG). The ICWG jointly has defined the APC framework, which includes:

1. Capabilities that describe an Advanced Primary Care practice
2. Core measures that reflect a practice's impact on patient health, quality of care and experience
3. Gates that define practice capabilities and inform payers for purposes of reimbursement
4. Milestones that define specific expectations of a practice in terms of key capabilities and performance against core measures
5. A payment model that supports:
 - a. Practice Transformation, including technical support and financial assistance, to help primary care practices learn to operate in a new way
 - b. Care coordination funding to support a care plan, necessary staff, and coordination with other providers between office visits and during transitions of care
 - c. Rewards for providers for performance, relative to APC core measures

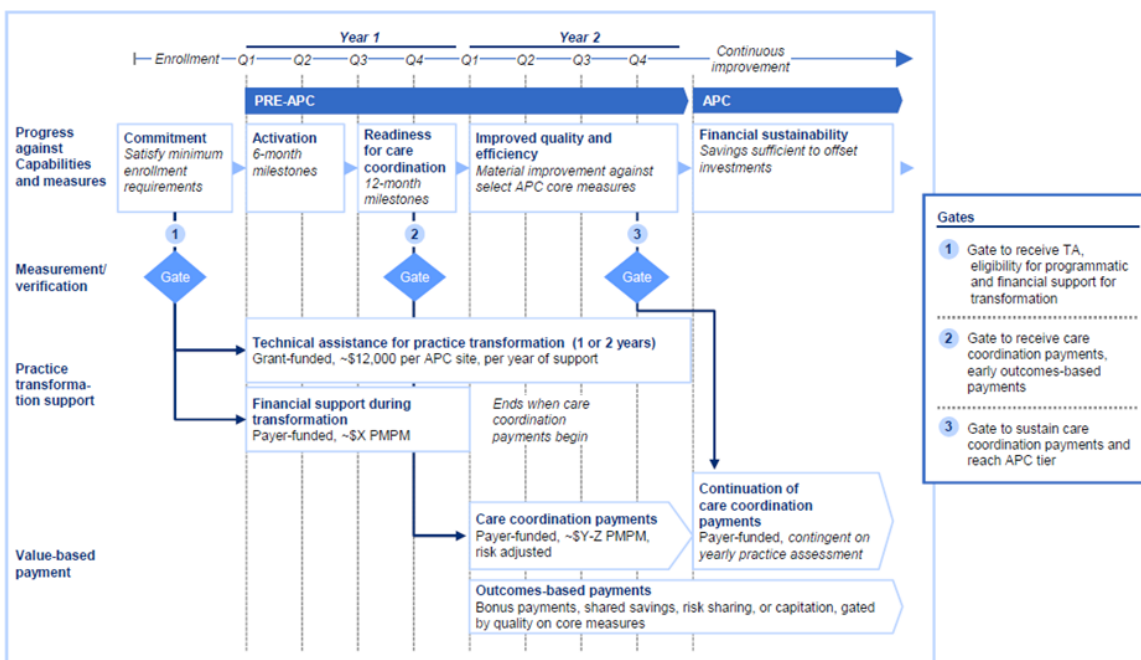
Practice Transformation to Support APC

Starting in 2016, the SIM grant award will be used to support regional practice transformation entities charged with helping practices through guidance on goal-setting, leadership, practice facilitation, workflow changes, outcome measurements, and adapting organizational tools and processes to support a team-based model of care delivery. Practice transformation support will be predicated on an initial evaluation of practice readiness. SIM funding will complement funding from two other initiatives occurring in the state – Transforming Clinical Practice Initiative (TCPI) and the DSRIP program (targeted to safety-net practices) in order to assure alignment and consistent messaging across multiple payers and providers.

To gauge a practice's readiness for innovative payment arrangements, APC employs a set of capabilities and milestones. Practices will be provided support to achieve a core set of capabilities, be evaluated by both practice transformation entities, and be audited by a state-contracted independent third party to determine practices capabilities (gates) that will, in turn, inform payment. These gates are depicted in the following figure and are also described below:

1. Gate 1 represents initial commitment by the practice and initiation of SIM and payer-provided support.
2. Gate 2 indicates a readiness to provide, and be reimbursed for, care coordination.
3. Gate 3 represents material improvement in select APC measures and suggests a readiness for outcome-based payment (specific models in discussion).

Review: Path to APC over time for practices starting out



Engagement of Health Plans

APC development has engaged payers – including commercial health plans and employers/purchasers in self-funded arrangements – as part of the foundational developmental work through multi-payer

meetings and one-on-one consultations with payers. During these consultations, key issues have been identified and resolved, including the need for an independent third party to evaluate and deem practices ready and proficient for purposes of payment. More specifically, payer engagement will be predicated on an agreement to comply with three “gates” (see graphic above), each of which dictates a unique and evolving payment structure.

Health plans are represented in the ICWG and several participate in other SIM workgroups. A purchaser advisory council has been formed to educate self-insured employers and benefit consultants about APC and to further garner support for the model.

APC COMMON SCORECARD

A comprehensive and systemic set of indicators has been developed to allow benchmarking against national results for use by APC participating practices. The proposed measure set reflects nationally recognized measurement approaches, such as NCQA’s Healthcare Effectiveness Data Information Set (HEDIS), National Quality Forum (NQF), and Children’s Health Insurance Program Reauthorization Act, which can be used across various payers, providers and regions of the state. These indicators have been developed through extensive consultation with internal and external experts and stakeholders. The proposed core measure set is depicted in the graphic below.

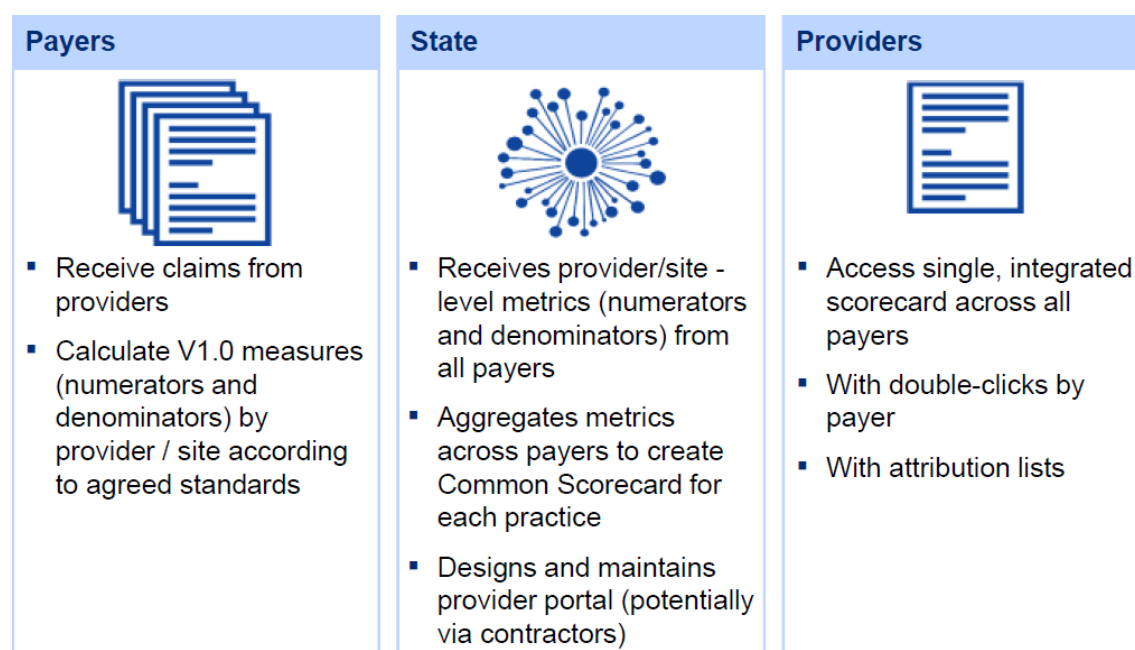
20 core measures are proposed for inclusion in the APC scorecard Claims-only is possible

Categories	Measures	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	✓	✓	
	2 Chlamydia Screening	✓	✓	
	3 Influenza Immunization - all ages	✓	✓	✓
	4 Childhood Immunization (status)	✓	✓	
	5 Fluoride Varnish Application	✓		
Chronic disease	6 Tobacco Use Screening and Intervention	✓	✓	
	7 Controlling High Blood Pressure	✓	✓	
	8 Diabetes A1C Poor Control	✓	✓	
	9 Medication Management for People with Asthma	✓	✓	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	✓	✓	
BH/Sub-stance abuse	11 Depression screening and management	✓	✓	
	12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓		
Patient reported	13 Record Advance Directives for 65 and older	✓	✓	✓
	14 CAHPS Access to Care, Getting Care Quickly			✓
Appropriate use	15 Use of Imaging Studies for Low Back Pain	✓		
	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
	17 Hospitalization	✓		
	18 Readmission	✓		
	19 Emergency Dept. Utilization	✓		
Cost	20 Total Cost Per Member Per Month	✓		

To promote implementation and use of the common scorecard for quality improvement, SIM funding is used to support the New York State Quality Institute. The Quality Institute is a public-private partnership created under the auspices of the United Hospital Fund as a neutral, trusted convener with the capacity to bring quality improvement experts and stakeholders from across the continuum of care together to

generate ideas, initiatives, and consensus. The Quality Institute will support and promote collaboration and organizational change necessary for alignment and adoption of quality metrics.

With an agreed upon set of common metrics, the next task is to create a mechanism for collecting and sharing this key information in advance of a fully functional APD, which is anticipated to be complete in late 2017. To ensure implementation of APC and the required metrics by Q4 2016, New York is currently engaged in conversations to secure assistance with data collection and sharing this data back with payers, providers and the State. The graphic below portrays initial thinking for the interim scorecard.



HEALTH INFORMATION TECHNOLOGY (HIT)

New York State has a substantial health IT infrastructure that includes the Statewide Health Information Network of New York (SHIN-NY), a developing All Payer Database (APD), as well as existing resources, such as SPARCS. These information systems provide benefits to many audiences and are integral to success of the APC model. Some benefits include the ability to calculate total costs of care across the practice, be able to best manage patient care through tools such as hospitalization alerts, and better track referrals and follow-up. The Transparency, Evaluation, and HIT Workgroup (HIT WG) was convened to assess and make recommendations regarding policies and initiatives that comprise the State's evolving health information technology infrastructure.

Over the past year, the HIT WG considered and provided expert input to NYSDOH to develop SHIN-NY and APD regulations. In addition, evolving initiatives to promote transparency, protect patient level data and to develop a common quality of care measure set meaningful to payers and providers alike have been discussed at length with corresponding recommendations which will be released in the Workgroup's final report.

POPULATION HEALTH

New York's SIM is predicated on an integrated care delivery model that is inclusive of and supports linkages between clinical care providers and community-based organizations in order to achieve the goals and objectives of New York State's Prevention Agenda. Population health will be promoted in several ways:

- APC practices will be charged with identifying and reporting on at least one region-specific Prevention Agenda metric and New York's core measure set includes several practice-level population health measures;
- Shortly after the release of the Practice Transformation RFP, anticipated for January 2016, NYSDOH will release an RFP to contract with entities to support the work of population health consultants (PHCs). These entities, anticipated to include one per region, will be charged with acting as the interface within the community and linking clinical care providers as they transform with community-based population health service providers. These individuals will enhance, promote, and support clinical-community integration working closely with the practice transformation entities, regional state-funded Population Health Improvement Programs (PHIPs), and Medicaid DSRIP Performing Provider Systems. The PHCs are viewed as key to achieving population health by reaching beyond clinical settings to incorporate community and public health systems.

While population health does not have its own SIM workgroup, a number of population health representatives serve on the other SIM workgroups to ensure integration of population health within other areas of focus.

WORKFORCE

New York's robust health care workforce faces future challenges including regional variation in workforce supply, primary care workforce shortages, hospital downsizing, and an aging workforce. The State and the Workforce Workgroup have initiated and will continue to examine New York's educational and training institutions and their ability to adequately equip the State's workforce in the networked, team-based, value-driven, primary care focused model of the future. New York proposes several initiatives to support the new APC model including the following:

1. Identification of clinical and non-clinical gaps and needs specific to primary care, behavioral health, oral health, pharmacy and other areas needed to support the APC model and development of recommendations through a workgroup inclusive of leaders in education and health care.
2. Identification of mechanisms to increase the number of primary care residencies throughout New York, particularly in primary care Health Professional Shortage Areas.
3. Identification of opportunities to increase the number of active nurse practitioners and physician assistants working in primary care.
4. Development of tools to increase retention of physicians trained in New York. Currently, the State retains only 45 percent of all residents trained in New York. New York will work with regional provider networks, including teaching institutions, insurers, community health centers, and hospitals, to establish community incentives that aim to recruit and train nurses and residents, promote a diverse provider workforce, and address issues of cultural competency and health disparities.

As health care evolves and moves to incorporate innovative care delivery models, a primary goal of the SIM grant remains to ensure a dependable supply of competently trained professionals. Moreover, having the ideal size workforce deployed to deliver care most efficiently is of paramount concern to policy makers.

The Workforce Workgroup is comprised of stakeholders ranging from educational institutions and health systems, to small provider groups to union and trade associations. The workgroup has been assembled to address workforce issues that span across not only SIM, but also the Delivery System Reform Incentive Payment program (DSRIP). A Compensation and Benefits Workgroup was convened to identify common data reporting elements for compensation and benefits that would allow aggregation of data to regional levels for collaborative planning and analyses. It will support guidance being developed for PPS distribution that specifies data elements and other clarifications including additional data fields for emerging titles.

Next year, the workgroup will continue to drive change and monitor the state of the workforce by developing a core set of competencies that define care management across a broad and encompassing cross section, as well as developing curricula for pedagogical training and retraining of workers as the shift to new models of care reallocates resources away from acute care settings. NYSDOH, together with HRI, will issue two procurements in 2016, one to support rural residency programs, the other to support physician retention in New York State.

- The Rural Residency procurement is intended to provide funding to support the development and accreditation of innovative, rural-based graduate medical education (GME) models. These GME models will help alleviate regional and primary care workforce shortages and prepare physicians to deliver quality services in the networked, team-based, value-driven, primary care focused model of the future. The funded GME models will create new opportunities for medical school graduates to train in rural and under-served areas of the state and foster community and provider collaborations that will help develop strategies to ensure that the new physicians continue to practice in rural communities. Successful implementation and replication of the programs will result in increased access to health care services for New Yorkers who are geographically isolated, economically or medically vulnerable.
- The Physician Retention initiative will test model(s) to increase the retention and recruitment of physicians to work in medically underserved regions within the State, particularly targeting physicians who are completing their residency training in New York. Physicians and medical residents will be given the opportunity to visit communities in New York State and learn about health care facilities and resources, talk to local practicing physicians and health care administrators, and learn about social, recreational, educational, and cultural activities available in the various communities in the State.

ACCESS TO CARE

Under SIM, New York seeks to bring together key stakeholders, evaluate access from four key perspectives and develop a set of policy recommendations intended to eliminate barriers in accessing care, including those that are financial, geographic, social, and cultural in nature. While access to care was envisioned as having its own topical workgroup, discussions are underway to determine if a subset of another workgroup would be more feasible in order to avoid duplication of efforts and ensure better integration of access issues across the other existing workgroups. Key measures of access will be

incorporated as part of the APC core measure set. Additional areas of inquiry include the potential for telehealth as a mechanism for expanding access and unique challenges and policy opportunities associated with access for unique populations such as persons with disabilities.

Issues identified under access that will continue to be explored throughout 2016 include:

- Is my health care affordable (coverage, premiums, co-pays, cost transparency)?
- Are services available when and where I need them (quantity and distribution of primary, behavioral, and specialty services; social services; convenient hours)?
- Can I access the facilities that are available (timeliness for appointments and wait times; transportation; disability access, including physical access and accommodation of clinical and non-clinical needs)?
- Do I find the services acceptable/understandable (culturally and/or linguistically appropriate; individual awareness of the spectrum of available providers; self-directed health care)?

EVALUATION

The Innovation Center will use traditional project management tools to ensure efficiency, goal attainment and course correction as needed. To ensure continuous improvement and impact of the SIM initiative, resources will be used to fund an external evaluation contractor to evaluate the NYSDOH's implementation of its goals under SIM. The SIM-funded evaluation is intended to address the following components:

1. How the proposed model improves population health, health care delivery and reduces costs;
2. How the proposed model leverages state regulatory and policy levers;
3. Methods used to identify providers, provider organizations, and payers participating in the model and to evaluate payer and provider-specific success and challenges;
4. Identification of all data sources to be used and their relation to proposed outcome measures;
5. Outline a process for use of NYSDOH data given the multiple available data sets available; and
6. Identification of gaps in available measures and proposals for how best to address identified gaps.

This evaluator is anticipated to begin the evaluation process of SIM in NYS next year. In addition, CMMI conducts its own evaluation of SIM states so that together a comprehensive picture of the success of internal operations and in meeting external objectives.

Expenditures

The initial SIM grant award period began on February 1, 2015 and continues through January 31, 2016. One of the initial activities central to ensuring implementation of the SIM initiative is staffing of the Innovation Center. At the time of this report, several new staff have been hired as dedicated members of the Innovation Center. Certain areas of the SIM implementation were determined to be achieved through the use of contractors, listed below with a brief synopsis of their scopes of work.

The following is a breakdown of the categorical expenses in CY2015 (as of 12/7/15):

Category	Award to Date Expenses
Salaries	\$377,246.38
Fringe Benefits	\$165,472.14
Equipment	\$15,469.50
Supplies	\$16,095.72
Travel	\$10,225.18
Services	\$13,727.84
Contractors	\$335,384.69
Miscellaneous	\$3,658.26
Indirect Costs	\$125,042.37

The following is a listing of contractors in 2015, including a brief synopsis of their respective scopes of work:

Contractor	Awardee	Scope of Work
Management Contractor	McKinsey and Company, Inc.	The Management Consultant subcontractor supported the Innovation Center Director and Executive agency staff to facilitate project implementation and discussions with the Team and workgroups. This consultant offered strategic guidance, guided workgroups to commit to recommendations, aligned direction across the multiple workstreams and workgroups, and supported completion of activities within timeline.
SHIN-NY Consultant	Kuvop, LLC	The contractor supported the Innovation Center by providing advice on how best to structure health information exchange activities in New York State in order to support goals of integrated care delivery and the health information exchange.
Measure Standardization Contractor	United Hospital Fund - Quality Institute	The contractor worked closely with Innovation Center to develop standardized measures and ways for practices to collect data.
Value-Based Insurance Design Contractor	The Value-Based Insurance Design Center/University of Michigan	The contractor served in an advisory role with NYSDOH and the Department of Civil Service as it considered developing a value based insurance design benefit for state employees.

Employer and Self-Insured Engagement Contractor	The Northeast Business Group on Health	The contractor supported the Innovation Center, Department of Financial Services, and workgroups to create a common agenda and plan of action to improve care, reform payment, and align measures and benchmarks with employers, purchasers, and payers statewide.
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Conclusion

Year one of the SIM cooperative agreement focused on the following:

- An inventory and identification of workforce goals, objectives and ongoing initiatives
- Continued work to develop the SHIN-NY and APD
- Identification of key access concerns
- Significant work to design the APC model

Extensive stakeholder engagement will continue to inform the SHIP and the SIM and will guide implementation of key initiative components in subsequent years. In year two of the grant (2/1/16-1/31/17), we will focus on the strategic implementation of the APC model across New York including release of the Practice Transformation request for proposals to support practices in evolving to APC. This year provided a strong foundation for operationalizing SIM. The Innovation Center will continue to engage stakeholders throughout the process to ensure support for this initiative and to promote alignment with other transformation efforts across the State.