NEW YORK STATE OF OPPORTUNITY. Department of Health

Transparency, Evaluation, and Health Information Technology Workgroup

Meeting #11

September 23, 2016

NEW YORK STATE Department of Health Innovation Center

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 – 10:45	Patrick Roohan
2	Opening Remarks	10:45 – 10:55	Patrick Roohan
3	APC Practice Transformation Update	10:55 – 11:15	Ed McNamara
4	APC V1 Scorecard Update	11:15 – 11:35	Anne Schettine Paul Henfield (IPRO)
5	SIM Evaluation Update	11:35 – 11:45	Bryan Allinson
6	Online Digital Tools	11:45 – 11:55	Natalie Helbig
7	APD Update	11:55 – 12:25	Chris Nemeth
8	Working Lunch	12:25 – 12:55	
9	SHIN-NY Update	12:55 – 1:15	Jim Kirkwood Valerie Grey (NYeC)
10	Health IT Integrated Quality Measurement	1:15 – 1:45	Jim Kirkwood
11	Discussion and Next Steps	1:45 – 2:00	Patrick Roohan

APC Practice Transformation

Ed McNamara
Director of Project Management
SIM, Office of Quality and Patient Safety

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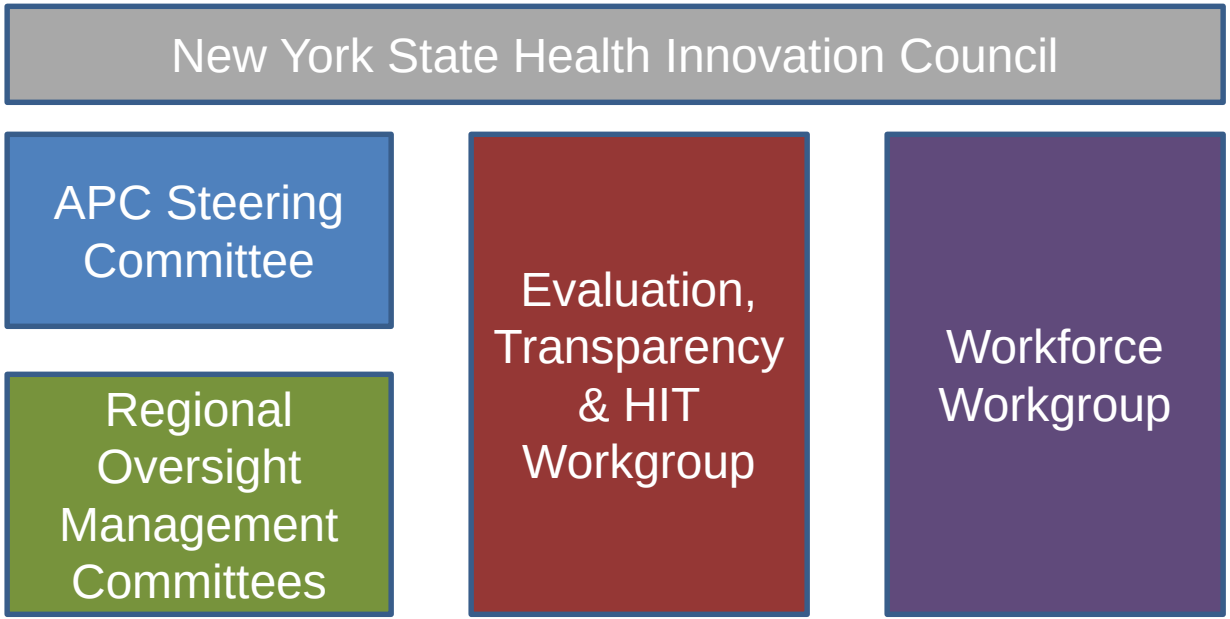
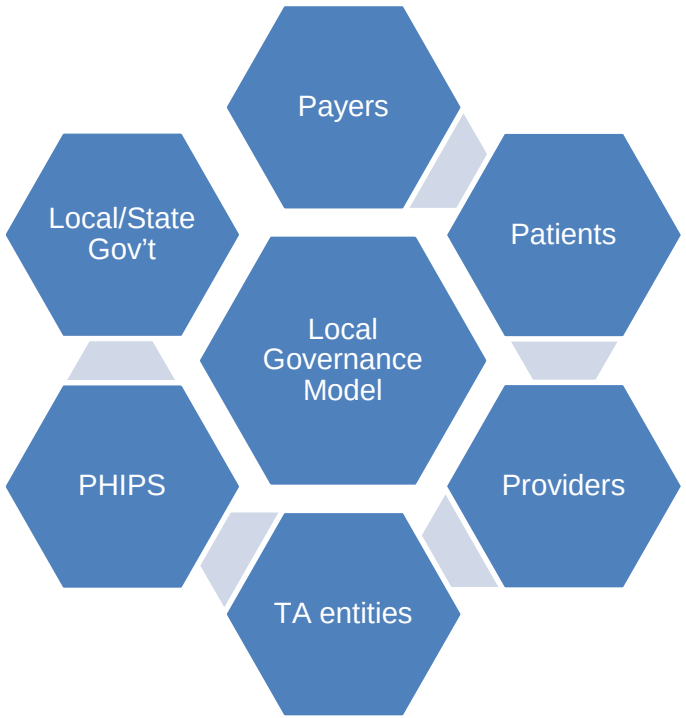
Governance

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

SIM Governance Model



Regional Governance



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

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

Topics could include:

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

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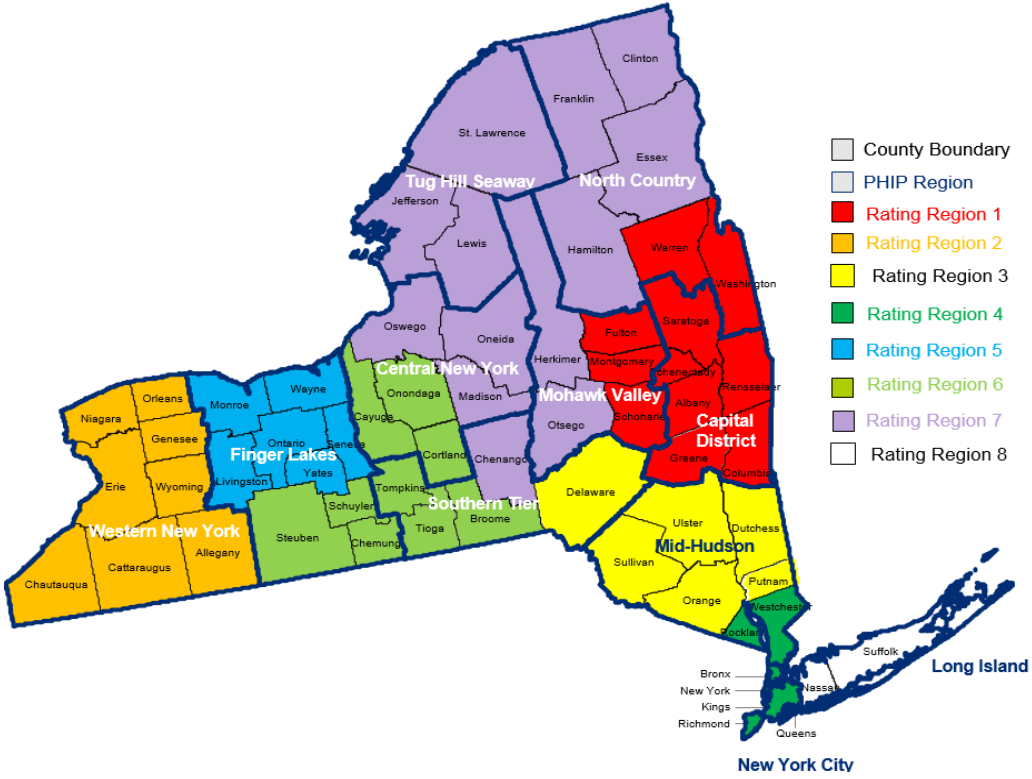
Establishing ROMC Regions



NYS Department of Financial Services (DFS) Rating Regions and Department of Health Population Health Improvement Program (PHIP) regions.

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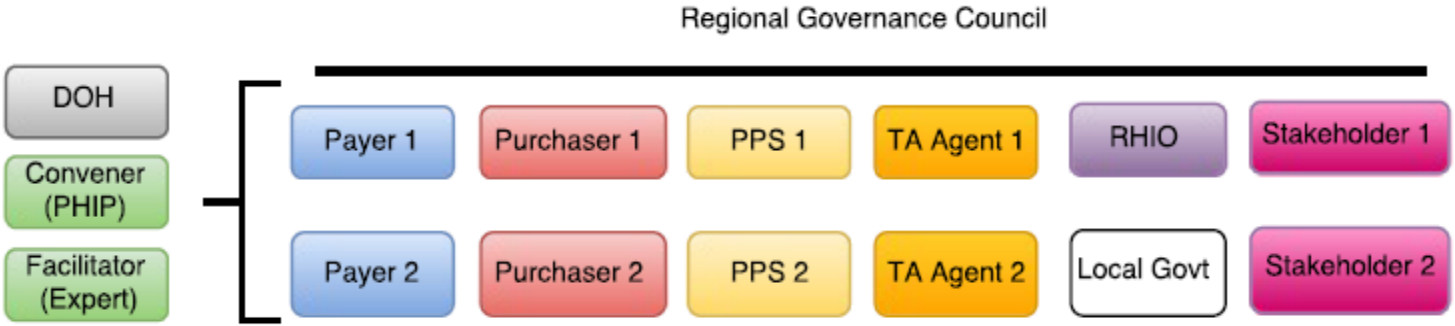
Establishing ROMC Regions (Cont'd)



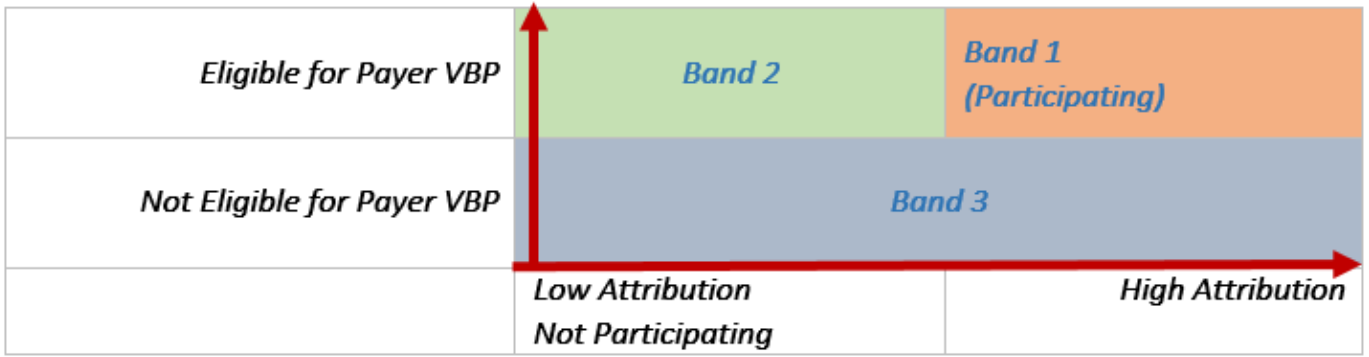
One-on-One Payer Engagement Meetings

- To date:
  - Ongoing one-on-one meetings with commercial plans
- Approach:
  - Targeting regions (Capital District, Adirondacks, Hudson Valley, Finger Lakes, NYC) but will include follow-up to all plans
- Framing:
  - Follow up to RFI, clarify APC and answer questions
  - Better understand existing programs, determine alignment with APC
  - Identify opportunities for multi-payer efforts
  - Describing commitment for support and data requirements for quality measures

Banding

- **Band 1**: Practices already enrolled in value based contracting with payers and receiving practice transformation assistance.
- **Band 2**: Practices eligible for a payer program but are not enrolled.
- **Band 3**: Practice is not eligible for a single payer program.

Prioritizing Transformation Assistance



"Bands" of practices by participation and eligibility for commercial payer value based programs.

Consumer and Patient Engagement

- Goals:
  - Meaningful inclusion of consumer and patient voice in transformation
  - Patient perspective at statewide, regional, and practice levels
- Considerations
  - Regional governance
  - Coordination with other initiatives
- Next steps

Updates

Practice Transformation RFA Update:

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

APC Milestone and Implementation Guide – V1

- 140+ pages, the Guide offers clear, practical and concise tools, forms and resources that can be used at practice level
- Input was provided by content experts, including 150+ links for easy access to resources
- Provides greater continuity of APC curriculum alignment for Statewide transformation agents and primary care practices to achieve successful outcomes
- Will be released in September

PCMH 2017 vs. APC Milestones

PCMH 2017 Requirements (proposed categories)	APC Milestones
Team-Based Care and Practice Organization The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers and organizes and trains staff to work to The top of their license and ability to provide effective team-based care.	**PARTICIPATION** Practice demonstrate readiness through either initial gating assessment or through certification.
Knowing and Managing Your Patients The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.	**PATIENT-CENTERED CARE** Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Patient-Centered Access and Continuity Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.	**ACCESS TO CARE** Promote access as defined by affordability, availability, navigability, accessibility, of care across all patient populations **POPULATION HEALTH** 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 and Support The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.	**CARE MANAGEMENT /CARE COORDINATION** Manage and coordinate care across multiple providers and settings by actively tracking the highest need patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and track and optimize transitions of care. Care Management is defined as: focus on the comprehensive support of the highest risk subset of practice's patient population. Care Coordination defined as: the practice contributes to seamless care of all patient transitions across all environments
Care Coordination and Care Transitions The practice tracks tests, referrals and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.	
Performance Measurement and Quality Improvement The practice collects, reports and uses performance data to identify opportunities for quality improvement, sets goals and acts to improve clinical quality, efficiency, patient experience and engages the staff and patients/families/caregivers in the quality improvement activities.	**HIT** Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
	PAYMENT MODEL Participate in outcomes-based payment models, based on quality and cost, for over 60% of the practice's patient panel

CPC+

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

Technical Assistance for Primary Care Practices: What Are My Options?

START

	OVERVIEW	BEST OPTIONS	DURATION	VALUE PROPOSITION
	Program Description Federal and State programs are offering resources and technical assistance to help practices prepare for changing expectations for primary care coupled with an evolving 'value-based' reimbursement environment. These 4 programs have different features and eligibility requirements but are aligned in providing assistance to practices interested in improving care delivery to their patients, become comfortable with the use of data to evaluate practice performance, and providing team based care that includes care coordination/management for complex, high need patients.	**For Your Practice** Depending on your professional goals, the characteristics of your practice, your business affiliation and payer mix, the programs below may have variable application or interest to you. Most programs do not allow any 'duplication' of funding (paying for the same assistance, at the same time) and may have eligibility or exclusion rules as applicable.	**How long will it take?** This greatly depends on current capability and professional goals. Experience with 'medical home' and 'advanced primary care' has demonstrated that many practice changes take from 1-3 years to fully implement technical assistance support duration will vary depending on practice assessments, need, goals, and the specific program chosen.	**Financial Landscape** Increasingly value based payments depend on practices being able to demonstrate high quality, improved patient access and experience of care, as well as reduction of avoidable costs. These technical assistance programs were developed to coach practices in developing the needed infrastructure and workflows that increase the likelihood of success with value based payments. Some programs and payers are also providing prospective payments to help support practice transitions.
APC	▪ Technical Assistance (TA) is provided to reach APC milestones with up to two years of support through 2019 ▪ Directed at practices with existing or planned value based contracts sufficient to support practice changes leading to non-visit based care and services	▪ Practices are eligible for TA beginning at Gate 1 if committed to implementing APC services ("Gates" are determined by level of competency) ▪ Priority is for small-medium size practices with multiple private/public payer participation ▪ Successful completion of TCPI and/or NCQA PCMH 2014 Level 3 counts as 'credit' towards APC Milestones	▪ Modular Milestone curriculum design with direct TA: practices progress through gates at own pace over time ▪ Milestone completion is assessed by technical assistance and validation vendors as practices advance ▪ Technical assistance vendors provide combination of on-site, remote, and collaborative learning and coaching	▪ APC is a multi-payer initiative that provides practice support tools to maximize payer value-based payment arrangements ▪ Participating payers, along with key stakeholders, are actively engaged in design and operation of the APC Model ▪ Payers are asked to provide some form of prospective support to practices to assist with development of practice capacity and infrastructure, in addition to offering value based payments based on performance
CPC+	▪ Five-year CMMI-directed primary care program engaging seven of the previous national CPCI regional practices/payers with potential for up to 5,000 additional practices nationally ▪ Two Tracks. Requires use of 2014 CEHRT and, at Track 2, an MOU with CMS and HIT vendor *https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus*	▪ North Hudson-Capital Region, with specific applicable counties have been selected to participate in CPC+. for more information on eligibility and enrollment: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus ▪ Eligible primary care: any existing CPCI or primary care practice not participating in other CMS-funded programs, such as FQHC's, certain MSSP ACOs and current/former MAP-CP, SIM states with Medicaid participation ▪ Recognition under the NYS APC model	▪ Eligible for overarching support from CMMI and regional learning faculty and utilization data to practices ▪ Tracks 1 and 2 require quarterly measures (eCQM) and milestone threshold reporting, with more rigor for Track 2 ▪ CPC+ practices are self-navigated, self-reporting and are provided with distance learning opportunities	▪ Ongoing Medicare, commercial performance-based incentive payments during transformation cycles for both tracks averaging $15 PBPM under Track 1 and $28 PBPM under Track 2. Commercial payers provide performance-based payments for both tracks
DSRIP	▪ Five-year program through 2020 ▪ Participants must be Medicaid providers and belong to a Performing Provider System (PPS) ▪ For primary care practices in DSRIP, the goal is to achieve NCQA PCMH 2014 Level 3 or APC *http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/*	▪ Practices work with their PPS to achieve NCQA PCMH 2014 Level 3 or APC ▪ Practices may receive support from APC or TCPI as long as the support they receive from these programs is not the same support they receive from the PPS	▪ Primary care practices participating within DSRIP are expected to be recognized as NCQA PCMH 2014 Level 3 or APC by March 31, 2018 ▪ Primary care practices already recognized as PCMH 2014 Level 3 are eligible for advanced gating in APC through 2019	▪ By the end of DSRIP (March 2020), 80-90% of managed care payments to providers are expected to be in value-based payment arrangements
TCPI	▪ PQRS-eligible, critical access hospitals, FQHCs, network providers, and FFS practices ▪ Four-year program through mid-2019. Ongoing recruitment/eligibility for TA ▪ Requires use of 2014 CEHRT *http://www.nyehealth.org/nysptn/*	▪ Practices are eligible for no-cost TA upon completion of the standard curriculum. Practices are also eligible for participation in APC/Value-Based Payments (VBP) ▪ Practices are ineligible if they are a Pioneer ACO, MAP-CP, CPC+ or other CMMI-supported program ▪ Operating in Metro NYC and Finger Lakes	▪ Practices are eligible for peer-based learning, coaching with ongoing support from TAs and national Support Alignment Networks (SANs) through a more rapid cycle-change process using LEAN and Six Sigma as hallmarks in transformation ▪ Quarterly reporting is required	▪ TCPI practices receive no-cost TA support and are eligible for quality payments through APC (VBP), MIPS or other APMs upon completion

FINISH
VALUE-BASED PAYMENTS

For more information on APC:
https://www.health.ny.gov/technology/innovation_plan_initiative/workgroup_integrated_care.htm

For more information on CMS guidance on payment reform:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

Looking Back and Looking Forward

The ICWG has developed over 18 months:

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

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

APC Scorecard V1.0 Update

Anne Schettine, Director
Division of Quality Measurement
Office of Quality and Patient Safety
Paul Henfield, IPRO

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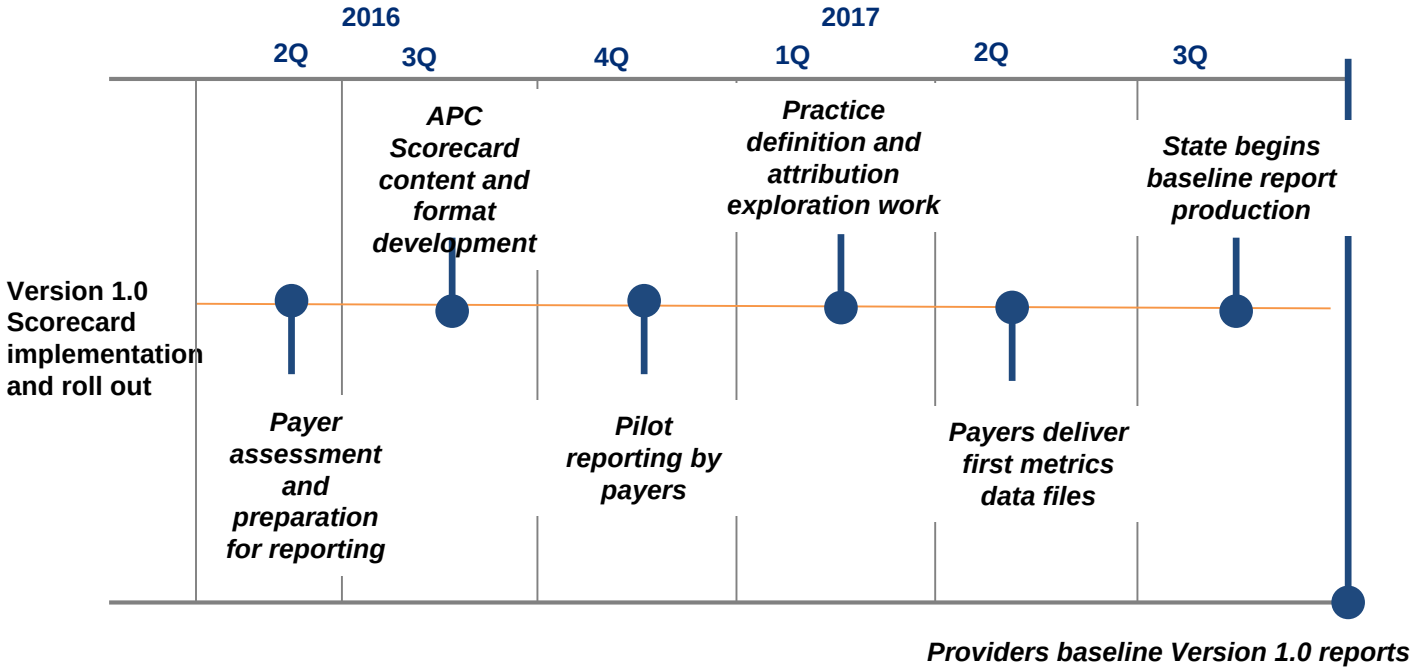
Payer Data Source - Capabilities and Limitations

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

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

APC Scorecard Timeline - Updated



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Pilot – Data Collection

APC Scorecard Version 1 - Pilot, Phase 1 Measures

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

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

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APC Scorecard Production Preparation

- Report Materials
  - Understanding report, measure descriptions, small cell size, benchmarks
- Release Mechanism
  - Planning in progress
- Planning for Release to Public
  - Guidelines for Release (time line, level of aggregation, consumer understanding of caveats and use)
  - Data maturity and completeness
  - Result requirements for comparison (i.e. risk adjustment, stratification by provider type)

SIM Evaluation Update

Bryan Allinson, Director
Innovation Center
Office of Quality and Patient Safety

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Context and Scope

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

Online Digital Tools

Natalie Helbig, Deputy Director
Division of Information and Statistics
Office of Quality and Patient Safety

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Second Round Research, Consumer Focus Groups, and Testing

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

Second Round Research, Consumer Focus Groups, and Testing

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

Second Round Research, Consumer Focus Groups, and Testing

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

APD Update

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

All Payer Database Update

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

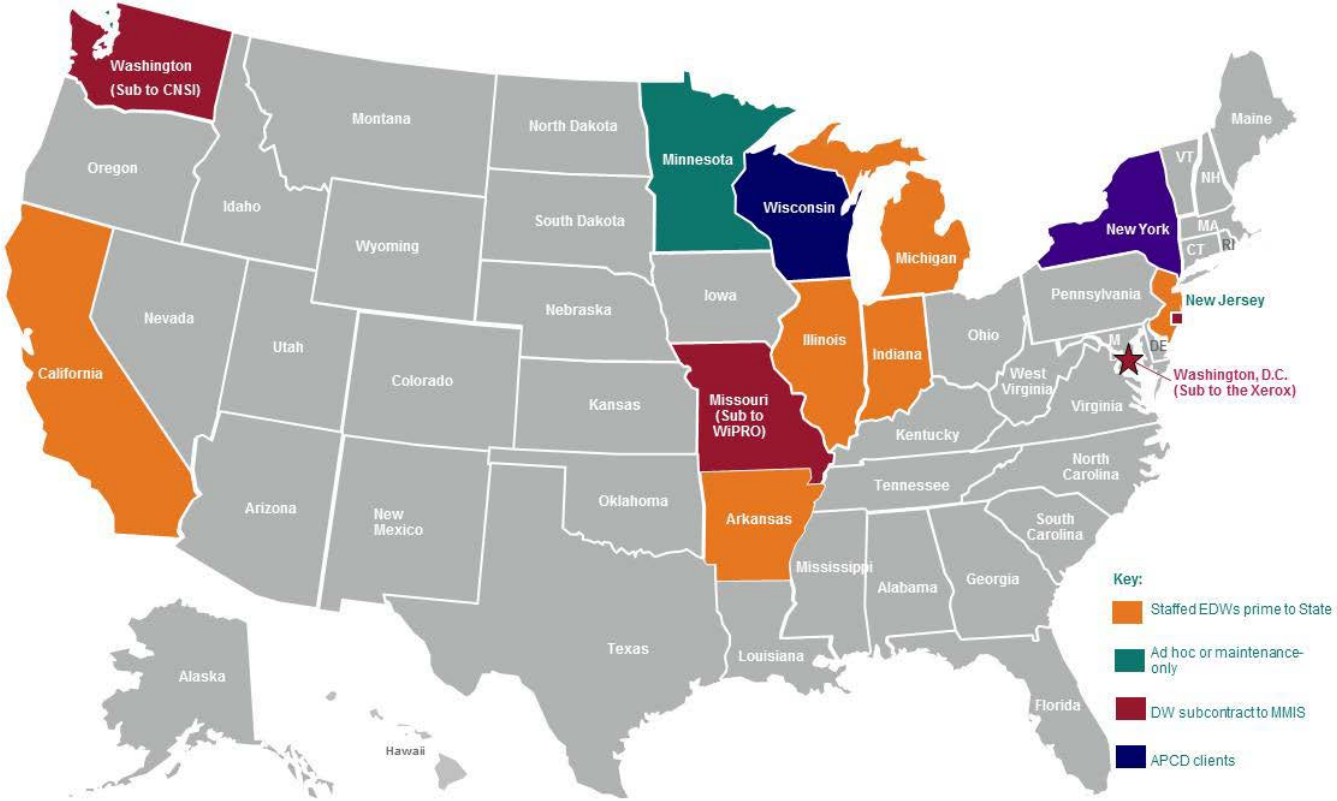
APD Executive Kick Off with Optum

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

Executive Kickoff Meeting Agenda

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

Optum's DW/APCD National Footprint



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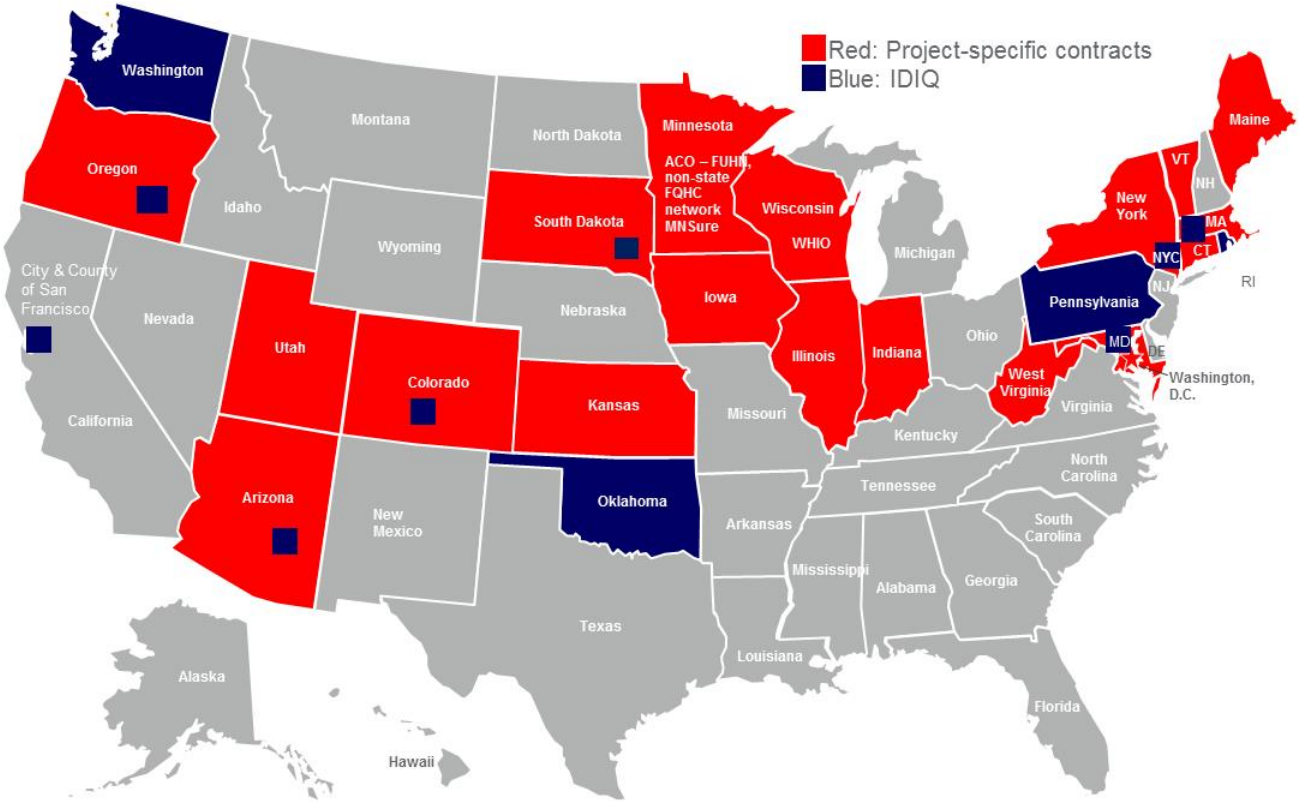
Optum's Data Analytics Engagements



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Optum – Progress to Date

- **Startup Planning Meetings**
  - Project Management, Data Security, Data Sources and Technical Build
- **Data Sharing**
  - Securing approvals for data sharing and providing data files for initial analytics work.
- **Data Connectivity**
  - Working with OITS to establish user connection points for both web-based system access, and APD power user VPN access
  - Commenced work with OHIP DataMart vendor to establish data exchange connectivity for interim analytics solution
- **Other**
  - Analytics Workgroups – Convened groups of data analysts/users to refine analytics tools and requirements
  - Beginning internal design sessions on provider, member, risk analysis and data mappings

APD Regulations: Public Comment Period

- On August 4, 2016, the NYS All Payer Database regulation was presented to the State's Public Health and Health Planning Council (PHHPC*).
- The NYS APD regulation was posted for public comment in the Proposed Rule Making section of NYSDOH's public website on August 31, 2016 and the 45 day public comment period will end on October 17, 2016.
- The regulation can be viewed by all stakeholders at the following link: http://w3.health.state.ny.us/dbspace/propregs.nsf/4ac955878100677485 2569bd00512fda/9304b1b933e4feab8525801e00581b97?OpenDocument.

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

NYS APD Guidance Manual

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

NYS APD Guidance Manual: Overview

What does the APD Guidance Manual help achieve?

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

1) APD Guidance Manual: Program Operations

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

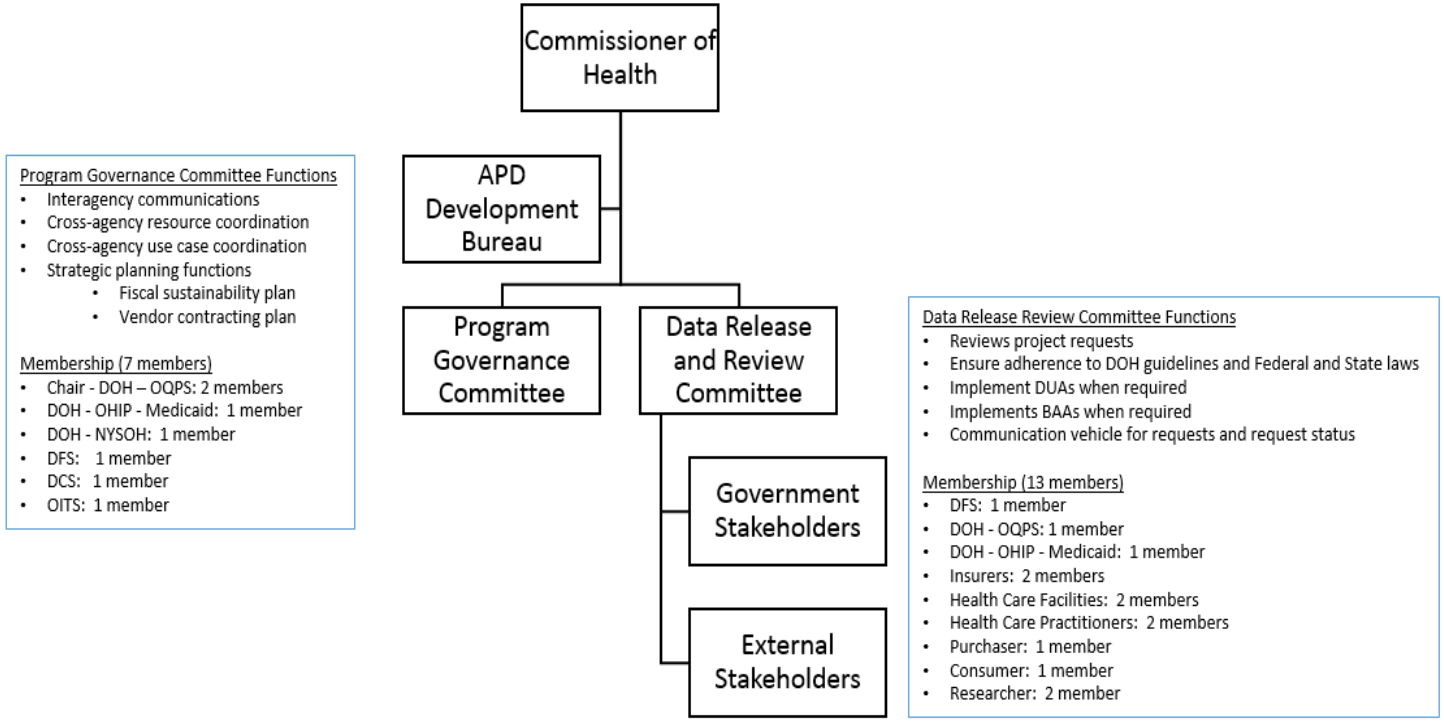
- Program Purpose: *Why is NYS pursuing an APD?*
- Legal Authority: *How can NYS pursue an APD?*
- APD Scope and Objectives: *What are the operational objectives of the APD?*

2) Guidance Manual: Data Governance

Two Governance Related Committees are Proposed

- **Program Governance Committee** (PGC) - responsible for overall program guidance and comprised of representatives from a variety of State entities that have both a short- and long-term APD vested interest. A newly devised Memorandum of Understanding (MOU) will assist necessary multi-agency coordination efforts.
- **Data Release Review Committee** (DRRC) - chaired by the Commissioner of Health's designee to provide non-binding advice and opinions on applications for access to limited identifiable data. The DRRC provides comments on the merits of the application and the research protocol described therein within thirty (30) days of receipt (regularly scheduled meeting times will be posted to APD website).

2) Guidance Manual: Data Governance (cont.)



2) Guidance Manual: Data Governance (cont.)
Further DRRC Considerations

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

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

Release of data currently collected by DOH and shared under ***existing law, regulation, rule, or policy shall continue under such existing law, regulation, rule, or policy. Explicit documentation of such must be included with the data release request.

2) Guidance Manual: Governance, Data Types and Related Access

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

- Identifiable data including the following data fields will not be released by the APD: patient name (first, middle, last); subscriber name (first, middle, last); exact address; and any unique identifier related to any insurance entity (commercial, Medicaid, or Medicare).
- Current policy limits the release of specific identifiable data elements to requestors from internal DOH programs only. Release of limited identifiable data elements may be made to other entities, in accordance with APD data release policies and procedures.
- Any data user that violates applicable law or regulation, or any executed DUA, is subject to penalties pursuant to the provisions of applicable law including, but not limited to, Sections 12 and 12-d of the Public Health Law, and applicable sections of New York State Insurance Law and regulations.
- Table 2 in the APD Guidance Manual provides a full description of APD File Types and Data Access protocol.

3) APD Guidance Manual: Submission Specs

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

- *Who is required to submit data*
- *Data submission types and transaction formats*
- *Timing of submissions (frequency and timing)*
- *Method of submissions (electronically)*
- *Resubmission of rejected data*
- *Data validation and submission compliance*
- *Extensions, variances or waivers*
- *How to receive technical assistance*

Working Lunch

SHIN-NY Update

Jim Kirkwood, Director
Health Information Exchange Bureau
Office of Quality and Patient Safety
Valerie Grey, Executive Director
New York eHealth Collaborative

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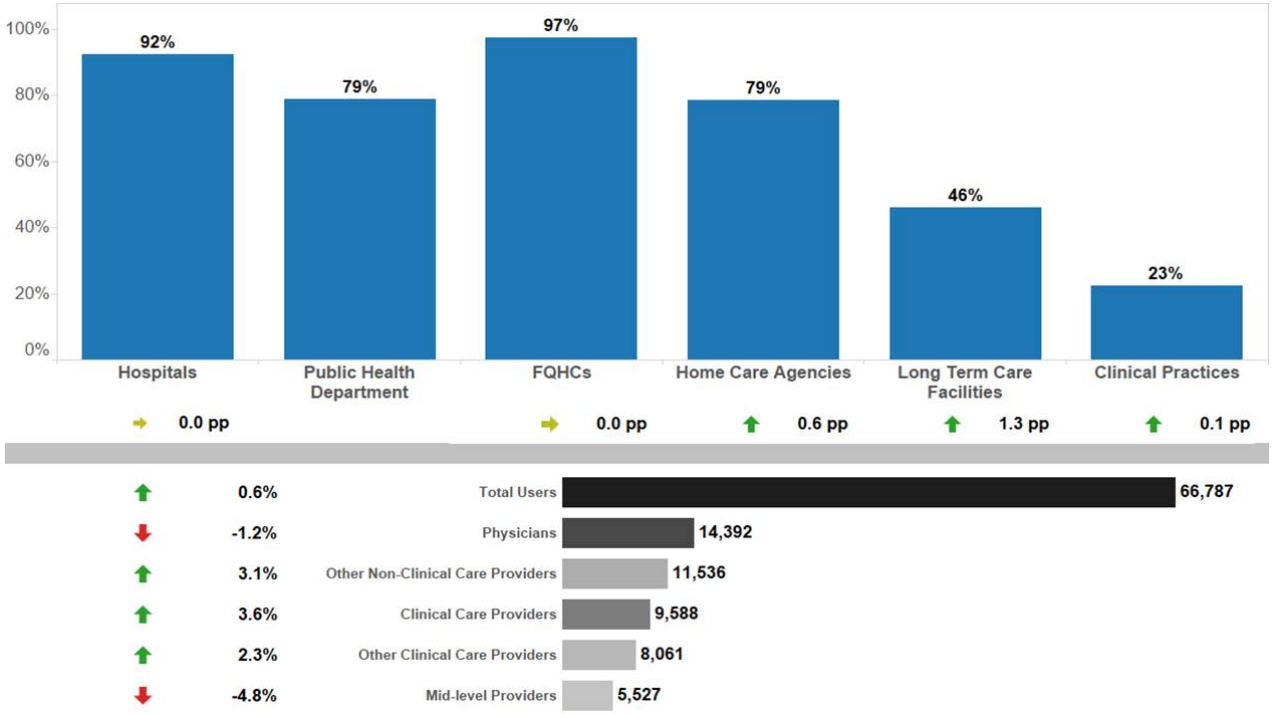
Significant Activities of the SHIN-NY

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

SHIN-NY Stakeholder Adoption



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Health IT Integrated Quality Measurement

Jim Kirkwood, Director
Health Information Exchange Bureau
Office of Quality and Patient Safety

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Health IT-enabled Quality Measurement

(EHR + Registry + Claims + Other)

Significant Quality Measurement Activities in DOH

- QARR - managed care quality measurement system
  - Commercial HMO, Commercial PPO, NYSoH, Essential Plan, HIV SNPs
- Managed Long Term Care
- DSRIP Value Based Payment initiative
- Hospital, nursing home and home care measurement
  - Available on Health Profiles

Initiatives that collect or intend to collect EHR data for use in quality measurement

To name a few of the current ones…

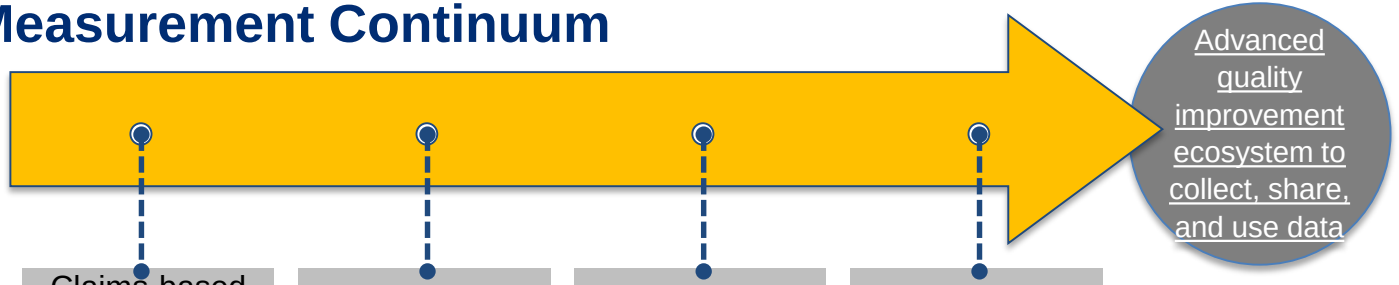
- Adirondack multi-payer initiative
- Value Based Payment initiatives
  - APC Scorecard as part of SIM
  - DSRIP PPS
  - CMS MACRA with MIPS/APM
- MEIPASS(Medicaid Meaningful Use)
  - Providers must report eCQMs generated EHRs

KEY REQUIREMENT – Alignment of capability to integrate data for calculation of quality measures for various uses

Principles and Assumptions for Data Collection

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

Quality Measurement Continuum



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

Provider/Practice/Encounter Level Data

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

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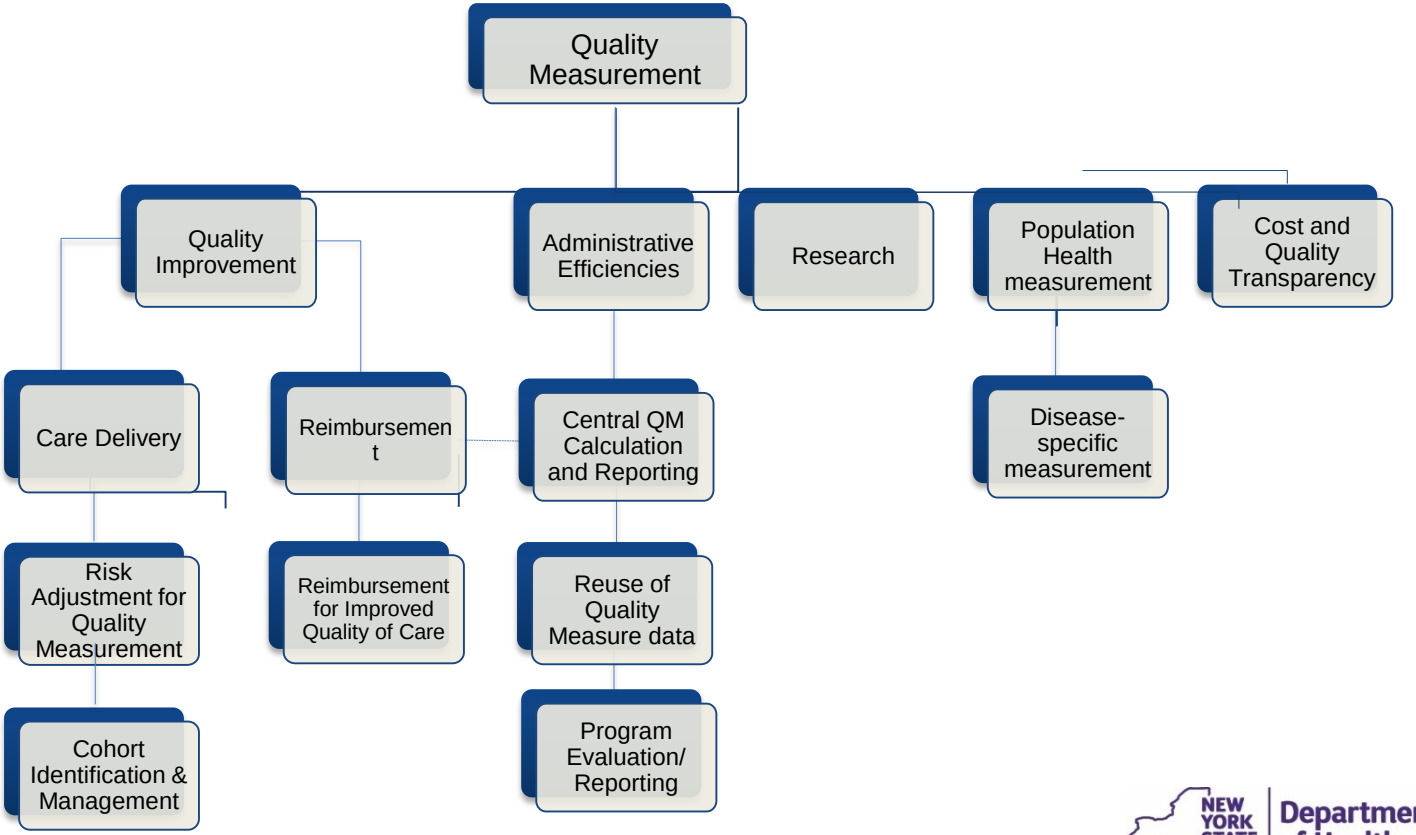
Priority Use Cases for Clinical Quality Measure Information



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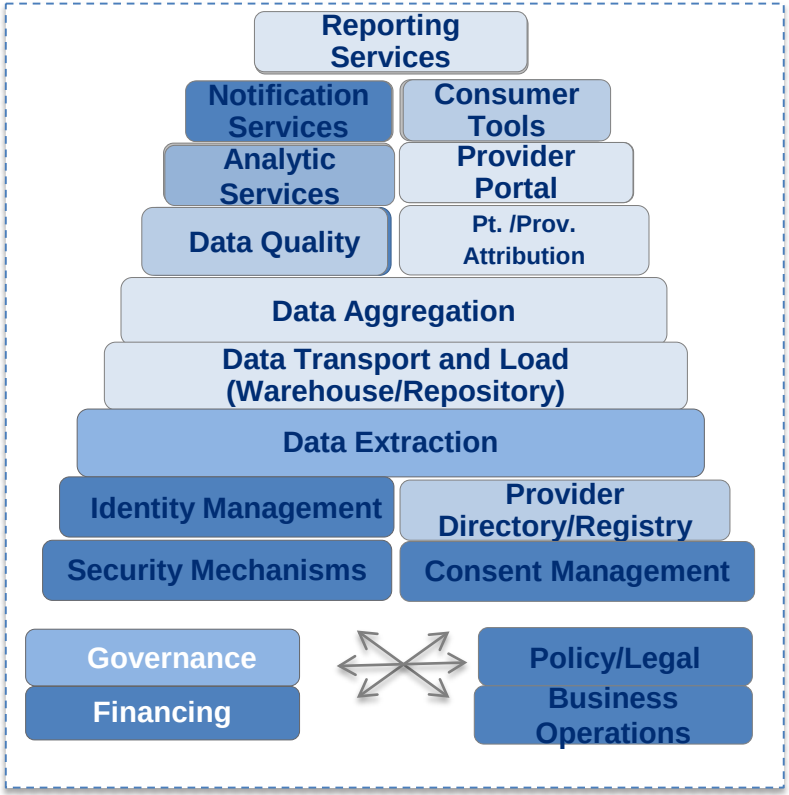
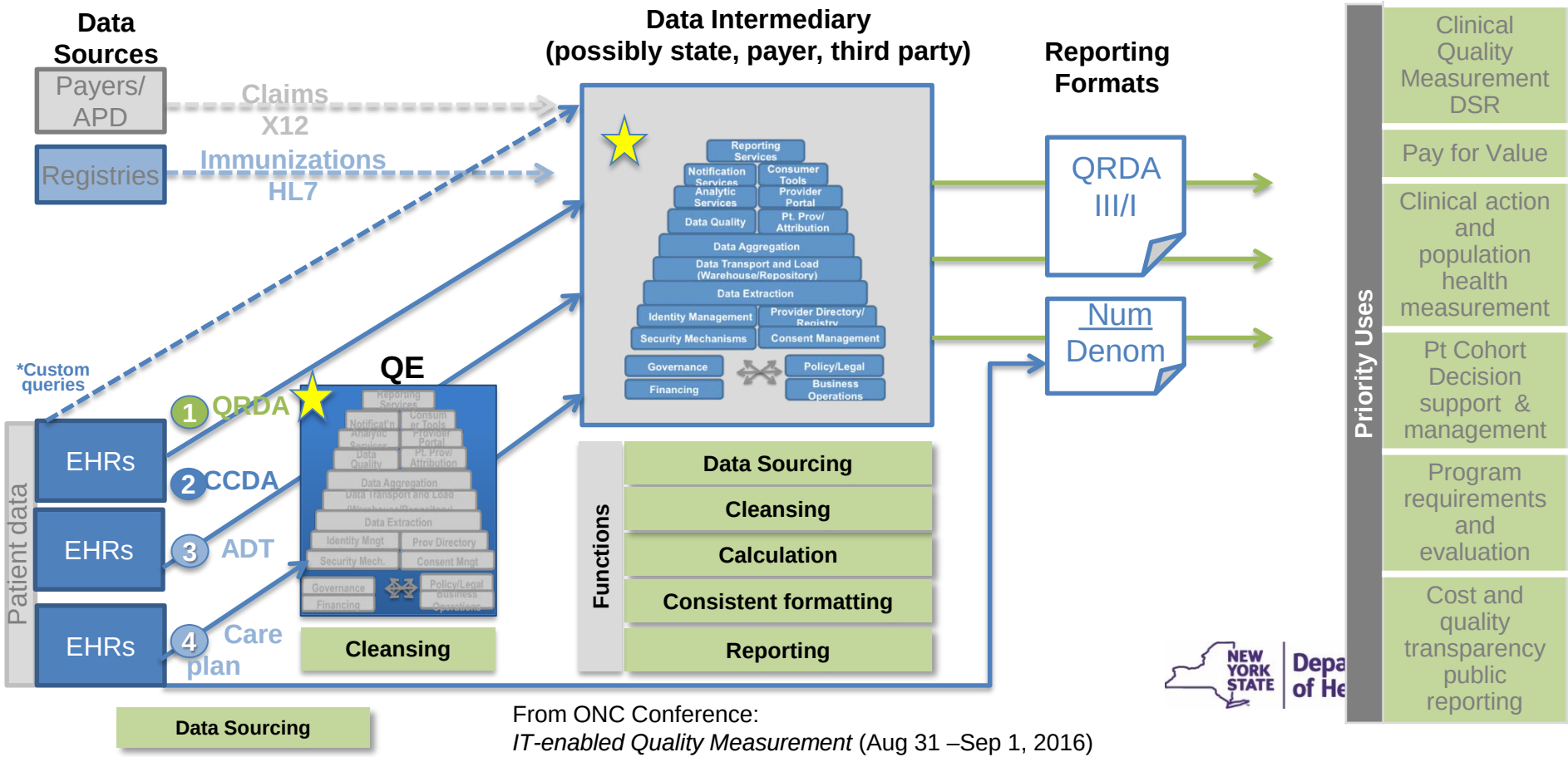
Infrastructure Needed for Quality Measurement

Major Dependencies

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



CQM Data Sources & Intermediaries



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Next Steps

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

Discussion and Next Steps

Patrick Roohan
Director
Office of Quality and Patient Safety

Next meeting: December 16, 2016 (NYC)

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