NEW YORK STATE OF OPPORTUNITY. Department of Health

# Transparency, Evaluation, and Health Information Technology Workgroup

## Meeting #12

March 16, 2017

# Agenda

| # | Topic | Time | Leader |
|---|---|---|---|
| 1 | Welcome and Introductions | 10:30 – 10:35 | Patrick Roohan |
| 2 | Opening Remarks | 10:35 – 10:40 | Patrick Roohan |
| 3 | APC Practice Transformation Update | 10:40 – 10:55 | Ed McNamara |
| 4 | APC Practice Transformation Tracking System (PTTS) Demo | 10:55 – 11:15 | Jill Byron |
| 5 | APD Update | 11:15 – 12:00 | Mary Beth Conroy |
| 6 | Working Lunch | 12:00 – 12:20 | |
| 7 | APD Presentation | 12:20 – 12:40 | Mary Beth Conroy<br>Steve Johnson (Optum) |
| 8 | SHIN-NY Update | 12:40 – 1:10 | Jim Kirkwood<br>Valerie Grey (NYeC) |
| 9 | Health IT Integrated Quality Measurement | 1:10 – 1:40 | Jim Kirkwood |
| 10 | Discussion and Next Steps | 1:40 – 2:00 | Patrick Roohan |

# 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

| Category | Description |
|---|---|
| **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 |
| **Population Health** | ▪ Actively promote health of patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment |
| **Care management/ coordination** | ▪ 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 |
| **Access to care** | ▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations |
| **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 performance, for over 60% of the practice's patient panel |
| **Quality and performance** | ▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel |

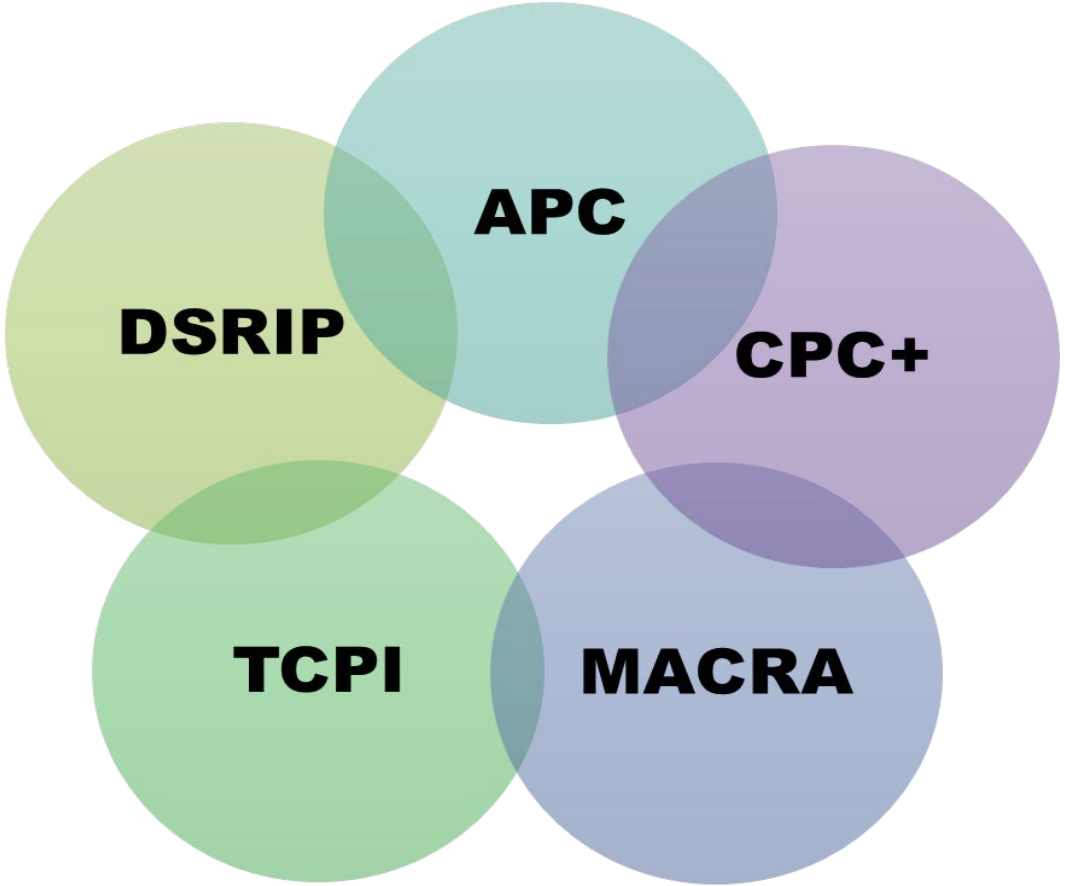
# APC Structural Milestones

| | Commitment<br>Gate 1<br>*What a practice achieves on its own, before any TA or multi-payer financial support* | Readiness for care coordination<br>Gate 2<br>*What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet*<br>**Prior milestones, plus …** | Demonstrated APC Capabilities<br>Gate 3<br>*What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination*<br>**Prior milestones, plus …** |
|---|---|---|---|
| **Participation** | i. APC participation agreement<br>ii. Early change plan based APC questionnaire<br>iii. Designated change agent / practice leaders<br>iv. Participation in TA Entity APC orientation<br>v. Commitment to achieve gate 2 milestones in 1 year | i. Participation in TA Entity activities and learning (if electing support) | |
| **Patient-centered care** | i. Process for Advanced Directive discussions with all patients | i. Advanced Directive discussions with all patients >65<br>ii. Plan for patient engagement and integration into workflows within one year | i. Advanced Directives shared across medical neighborhood, where feasible<br>ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable) |
| **Population health** | | | i. Participate in local and county health collaborative Prevention Agenda activities<br>ii. Annual identification and reach-out to patients due for preventative or chronic care management<br>iii. Process to refer to structured health education programs |
| **Care Management/ Coord.** | i. Commitment to developing care plans in concert with patient preferences and goals<br>ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year | i. Identify and empanel highest-risk patients for CM/CC<br>ii. Process in place for Care Plan development<br>iii. Plan to deliver CM / CC to highest-risk patients within one year<br>iv. Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral | i. Integrate high-risk patient data from other sources (including payers)<br>ii. Care plans developed in concert with patient preferences and goals<br>iii. CM delivered to highest-risk patients<br>iv. Referral tracking system in place<br>v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions<br>vi. Post-discharge follow-up process<br>vii. Behavioral health: Coordinated care management for behavioral health |
| **Access to care** | i. 24/7 access to a provider | i. Same-day appointments<br>ii. Culturally and linguistically appropriate services | i. At least 1 session weekly during non-traditional hours |
| **HIT** | i. Plan for achieving Gate 2 milestones within one year | i. Tools for quality measurement encompassing all core measures<br>ii. Certified technology for information exchange available in practice for<br>iii. Attestation to connect to HIE in 1 year | i. 24/7 remote access to Health IT<br>ii. Secure electronic provider-patient messaging<br>iii. Enhanced Quality Improvement including CDS<br>iv. Certified Health IT for quality improvement, information exchange<br>v. Connection to local HIE QE<br>vi. Clinical Decision Support |
| **Payment model** | i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year | i. Minimum FFS with P4P contracts with APC-participating payers representing 60% of panel | i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel |

# 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



# 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.

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# 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

| Name of Awardee | Region |
|---|---|
| Adirondack Health Institute | Capital District and Adirondacks |
| CDPHP | Capital District |
| HANYS | Capital District and Long Island |
| Chautauqua County Health | Western (Buffalo) |
| Solutions 4 Community Health | Mid-Hudson Valley and Long Island |
| **Institute for Family Health** | **NYC** |
| **IPRO** | **NYC, Central NY (Syracuse) and Long Island** |
| **Fund for Public Health in New York** | **NYC** |
| Finger Lakes | Finger Lakes (Rochester) and Central NY (Syracuse) |

# 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

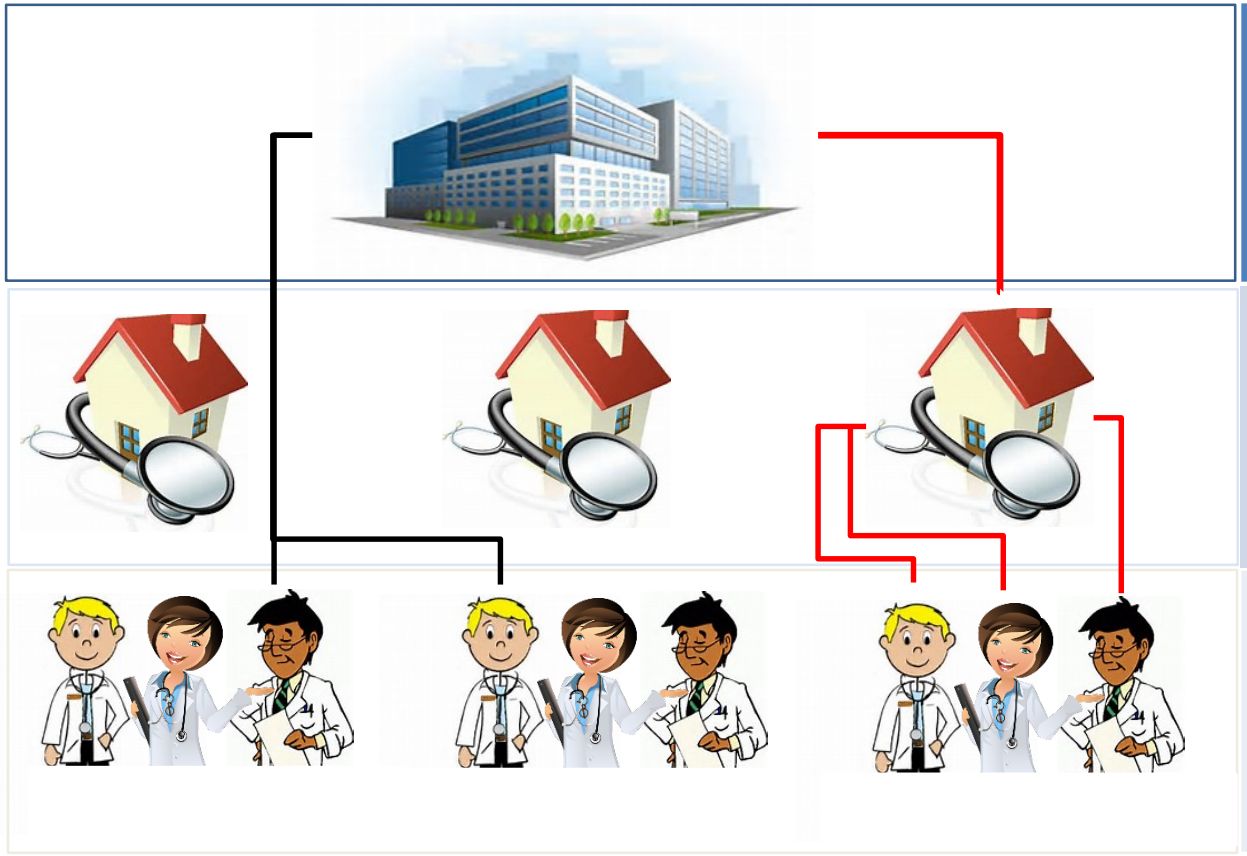


Practice Site/Medical Home
Servicing Location



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”

| | APC | CPC+ | DSRIP | TCPI |
|---|---|---|---|---|
| Practice Site A | | ✓ | | |
| Practice Site B | | | ✓ | |
| Practice Site C | | | | ✓ |
| Practice Site D | ✓ | | | |

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# 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

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# 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

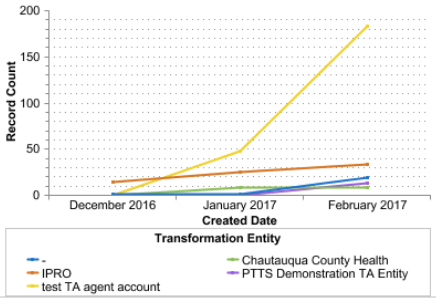
## PTTS Executive Dashboard

Find a dashboard... | Edit | Clone | Refresh | As of March 1, 2017 at 10:03 AM

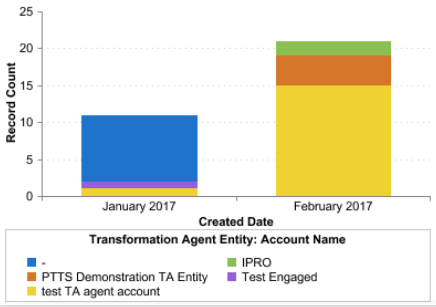
**Practice Site Activity**

| Subject | Record Count |
|---|---|
| Account Claimed | 10 |
| Account Engaged | 6 |
| Account Enrolled | 114 |
| 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 |

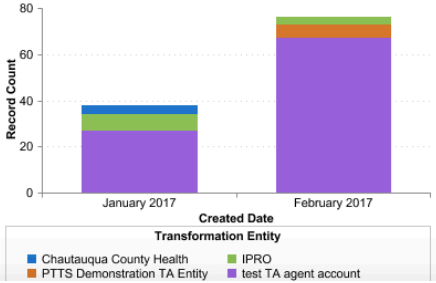
**Activities by Entity**




**Gate One Completed**




**Practice Sites Enrolled**




**Beneficiaries by Payer**

| Payer | Sum of Medicare Beneficiaries | Sum of Medicaid Beneficiaries | Sum of Commercial Beneficiaries |
|---|---|---|---|
| Aetna | 0 | 0 | 0 |
| Affinity | 0 | 0 | 0 |
| Anthem/ Empire BCBS | 0 | 0 | 0 |
| BCBS Western NY | 0 | 0 | 0 |
| CDPHP | 12 | 12 | 2K |
| Emblem | 0 | 0 | 0 |
| Excellus BCBS | 0 | 0 | 0 |
| FFS Medicaid | 0 | 0 | 0 |
| FFS Medicare | 0 | 0 | 0 |
| Fidelis | 0 | 0 | 0 |
| Health First | 0 | 0 | 0 |
| Independent Health | 333 | 444 | 6K |
| Metroplus | 100 | 100 | 100 |
| MVP Health Care | 0 | 0 | 0 |
| Oscar | 0 | 0 | 0 |
| United | 212 | 120 | 342 |
| Wellcare | 0 | 0 | 0 |

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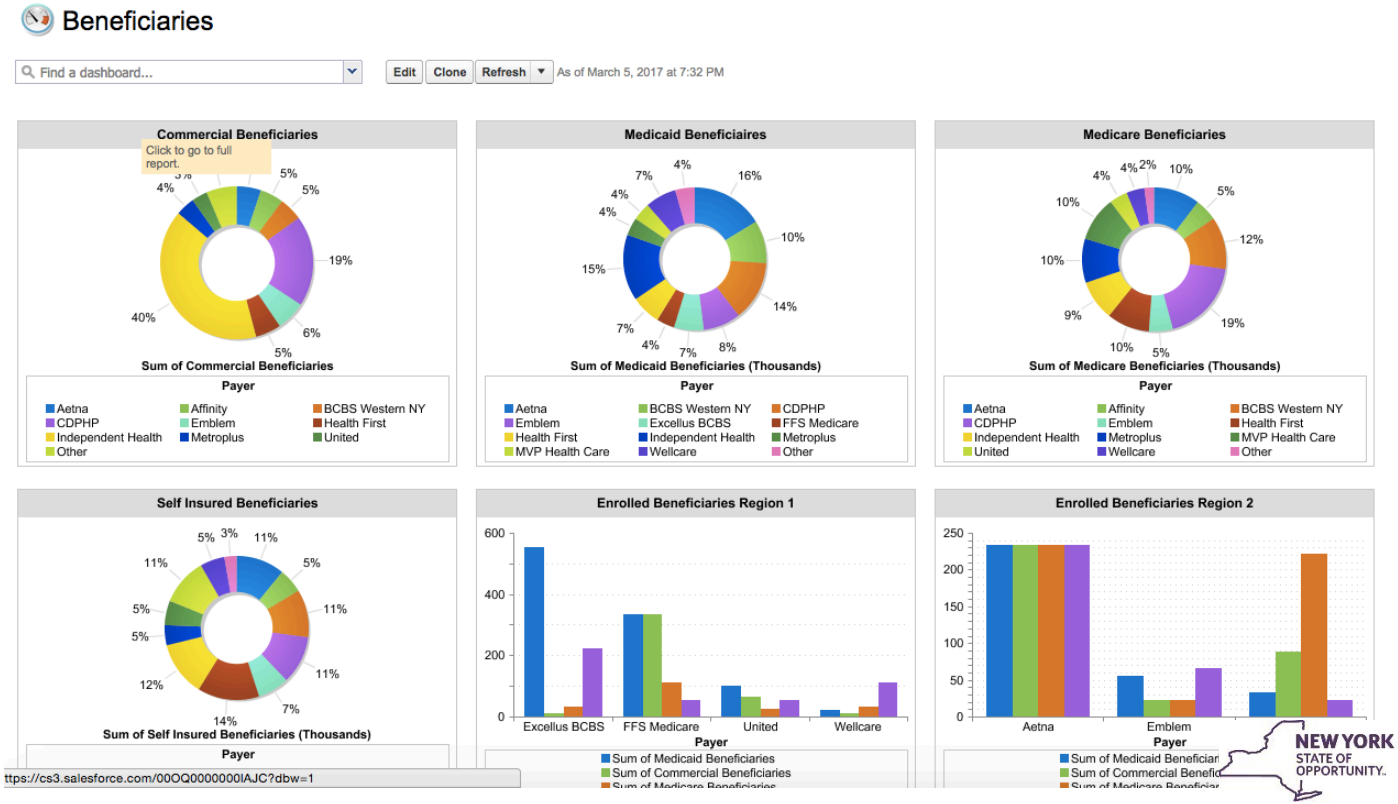
# PTTS Dashboard Continued

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# Practice Site Account Detail

**Account Detail** Edit | Delete | Sharing | Manage External Account | Engage | Enroll | Release

| | | | |
|---|---|---|---|
| Account Name | Access Community Health Center [View Hierarchy] | Parent Account | |
| Tax Identification Number | 123045608 | Practice Group | |
| Practice Site NPI | 1039512586 | Phone | |
| Unique Id | NY-000768 | NCQA PCMH Project ID | 242551 |
| Gate | | NCQA PCMH Org ID | 171706 |
| Practice Size | Small | | |

**Address Information**

| | | | |
|---|---|---|---|
| | | County | New York |
| Physical Address | 83 Maiden Lane 6th flr<br>New York, New York 10038-5652 | DFS Region | Region 4 |


**Transformation Agent**

| | | | |
|---|---|---|---|
| Transformation Agent Entity | test TA agent account | Effective Enroll Date | 2/1/2017 |
| | | Effective Release Date | |

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# Practice Site Account Detail Continued

### Transformation Agent

| | | | |
|---|---|---|---|
| Transformation Agent Entity | test TA agent account | Effective Enroll Date | 2/1/2017 |
| | | Effective Release Date | |

### Program Associations

| | | | |
|---|---|---|---|
| APC Status | Under Contract | APC Status Notes | |
| TCPI | ☐ | Anticipated TCPI Graduation Date | |
| DSRIP | ☐ | Anticipated DSRIP Graduation Date | |
| CPC+ | ☐ | Anticipated CPC+ Graduation Date | |

### Beneficiaries Information

| | | | |
|---|---|---|---|
| Medicare | 765 | Percent of Medicare | 25.38% |
| Medicaid | 964 | Percent of Medicaid | 31.98% |
| Commercial | 952 | Percent of Commercial | 31.59% |
| Self Insured | 333 | Percent of Self Insured | 11.05% |
| Total Practice Site Beneficiaries | 3,014 | Total Percentage | 100.00% |

### Practice Site Clinical Workforce

| | | | |
|---|---|---|---|
| Primary Care Physicians | 2.00 | Care Managers | 0.50 |
| Mid Level Physician's Assistants | 0.00 | Integrated BH Specialists | 0.20 |
| Mid Level Nurse Practitioners | 1.00 | Integrated Specialists (Non BH) | 0.00 |

### Site Hours

| | | | |
|---|---|---|---|
| Remote Support Hours | 2.00 | On Site Coaching Hours | 6.00 |

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# Practice Site Technical Capabilities

**Gate Status**

| | |
|---|---|
| Gate One Completed Date | Gate One Completed By |
| Gate Two Completed Date | Gate Two Completed By |
| Gate Three Completed Date | Gate Three Completed By |

**Deliverable AssesmentTracking**

**Gate 2** Edit Save Cancel Back Next Complete

| Milestone | Deliverable | Notes | Completed | Completed via Auto Credit |
|---|---|---|---|---|
| Milestone 1 - Participation | Sign Gate 2 Submit Gate 2 commitment form Participation completed by APC Agreement Clinical Practice Leader and APC Business Practice Leader | | ☐ | |
| Milestone 1 - Participation | Attendance by one practice lead or designee as appropriate to each covered topic as required | | ☐ | |
| Milestone 1 - Participation | Engagement in learning activites that include sharing practice and APC-wide learning opportunities | | ☐ | |
| Milestone 2 - Patient Centered Care | Plan for either a patient satisfaction survey, focus group or Patient- Family Advisory Council (PFAC) that includes representative practice populations | | ☐ | |
| Milestone 2 - Patient Centered Care | Practice uses protocols/processes with goal of reporting Advanced Directives (AD) on all patients >65 years | | ☐ | ☐ |
| Milestone 5 - Access to Care | Print and/or electronically provide preferred language materials to patients that meet practice community needs | | ☐ | ☐ |
| Milestone 5 - Access to Care | Engage interpretation services as applicable to the practices population needs, incl. visual or hearing impaired | | ☐ | ☐ |
| Milestone 5 - Access to Care | Assess need and develop plan to address population diversity and cultural needs | | ☐ | ☐ |
| Milestone 5 - Access to Care | Assess practice's demands for same day appointments with goal to satisfy at least 80% of demand | | ☐ | |
| Milestone 5 - Access to Care | Describe policy and process for same day appointments | | ☐ | ☐ |
| Milestone 5 - Access to Care | Review hours of operation and scheduling patterns to determine most successful method of ensuring same day appointment availability | | ☐ | ☐ |
| Milestone 5 - Access to Care | 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 referrals to educational resources (e.g. diabetic education tools, navig | | ☐ | ☐ |
| Milestone 6 - HIT | Attestation to connect to HIE in 1 year by establishing a participation agreement with their RHIO | | ☐ | |
| Milestone 6 - HIT | Develop basic Information Exchange | | ☐ | |
| Milestone 6 - HIT | Ability to capture, calculate and report all core measures | | ☐ | ☐ |

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# NCQA PCMH Scoring

**NCQA PCMH Scoring Detail** Expand All Collapse All

**Information**

| | | | |
|---|---|---|---|
| Practice Site | | Standard Year | 2014 |
| Org ID | 171706 | Level | Recognized-Level 3 |
| Project ID | 242551 | Begin Recognition Date | 2/25/2016 |
| Recognition ID | 181739 | End Recognition Date | 2/25/2019 |

**Standard 1 Patient-Centered Access**

Received Standard Score 8.625
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

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# NCQA PCMH Scoring Detail

**Standard 1 Patient-Centered Access**

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

| | | | |
|---|---|---|---|
| Standard Description | The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times. | | |
| A Max: Maximum Element Score | 4.500 | A Points: Received Element Score | 4.500 |
| A Percent Score: Received Element Percent Score | 100.00% | A Percent Score: Received Element Percent Score | 6.000 |
| A Factor 1: Providing same-day appointments for routine and urgent care (CRITICAL FACTOR) | Yes | A Factor 2: Providing routine and urgent-care appointments outside regular business hours | Yes |
| A Factor 3: Providing alternative types of clinical encounters | No | A Factor 4: Availability of appointments | Yes |
| A Factor 5: Monitoring no-show rates | Yes | A Factor 6: Acting on identified opportunities to improve access | Yes |
| A Max: Maximum Element Score | 3.500 | B Points: Received Element Score | 2.625 |
| B Percent Score: Received Element Percent Score | 75.00% | B Factor Count: Total Factor Numbers | 4.000 |
| B Factor 1: Providing continuity of medical record information for care and advice when office is closed | Yes | B Factor 2: Providing timely clinical advice by telephone (CRITICAL FACTOR) | Yes |
| B Factor 3: Providing timely clinical advice using a secure, interactive electronic system | No | B Factor 4: Documenting clinical advice in patient records | Yes |
| C Max: Maximum Element Score | 2.000 | C Score: Received Element Score | |
| C Percent Score: Received Element Percent Score | 75.00% | C Factor Count: Total Factor Numbers | |

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# 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

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# 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

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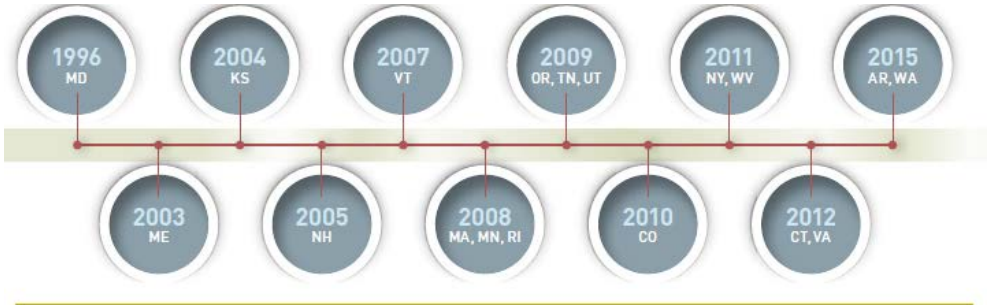
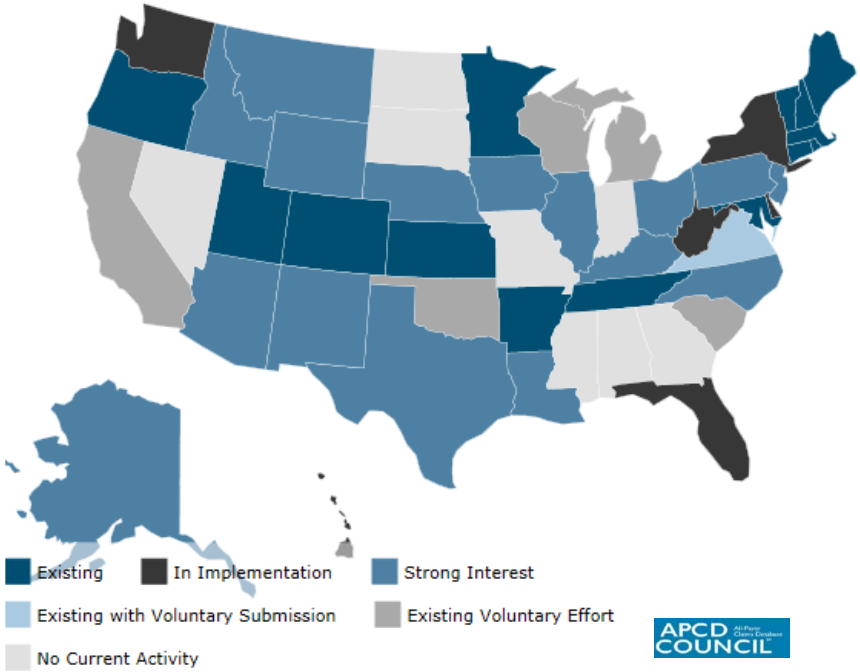
# National Efforts in APCD Implementation

Nationwide:

- 14 Existing
- 7 Existing (Voluntary)
- 5 In Implementation
- 16 Strong Interest
- 8 No Current Activity




APCD COUNCIL

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# Update on the Supreme Court Decision on Self Insured Data Collection

- 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/

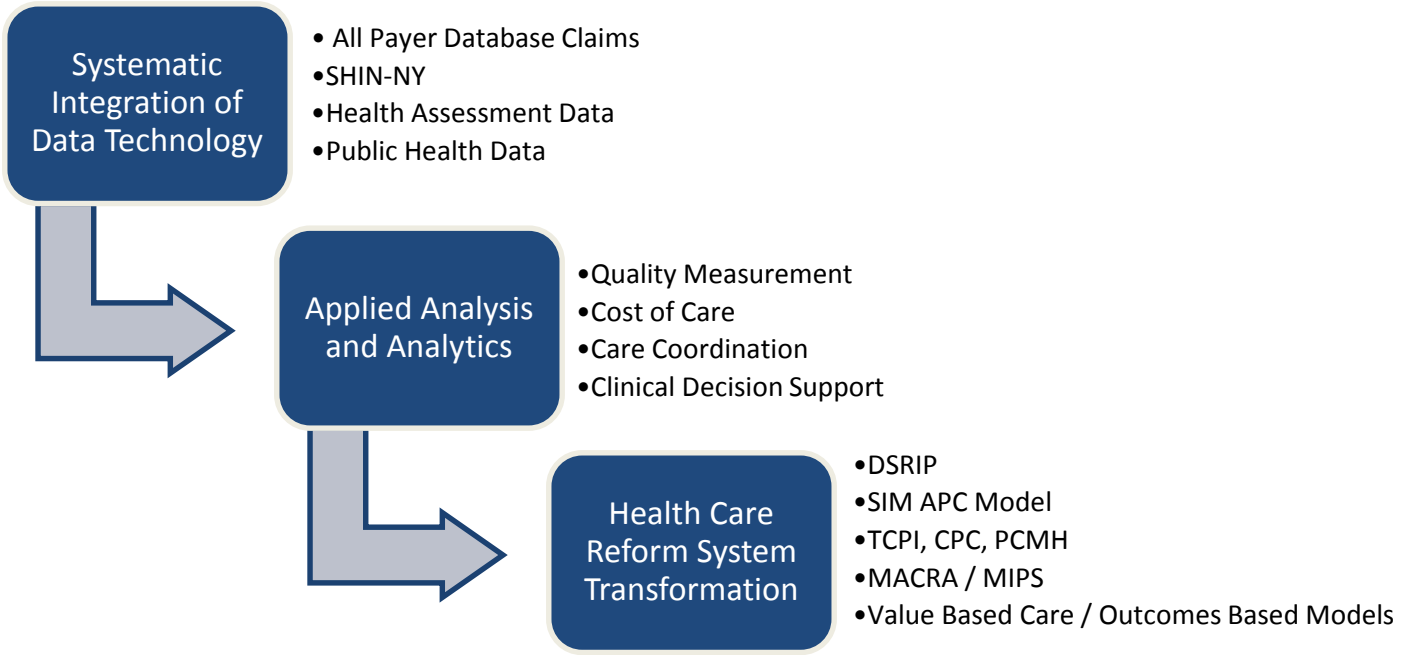
# Federal Alternatives to SCOTUS Ruling

- 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)

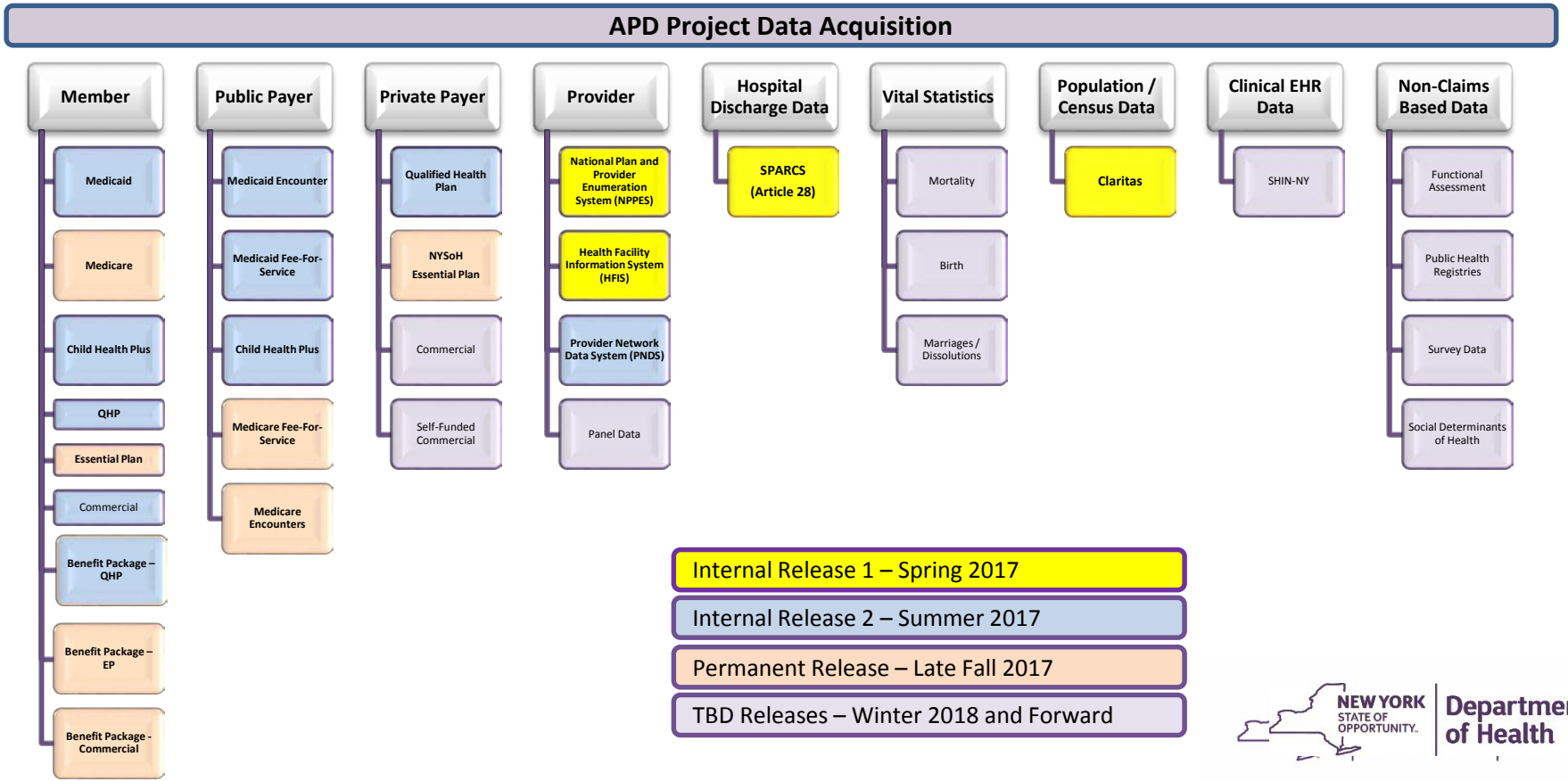
- Advancing health care transformation in an effective and accelerated manner requires data to support decision making into the challenges of access, quality, and affordability.
- The Department of Health recognizes that integrating data about the health care system into an APD that includes not only 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




Transformation Goal of The Triple Aim: Better Health, Better Care, Lower

# What data will the NYS APD contain and when?

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# 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)

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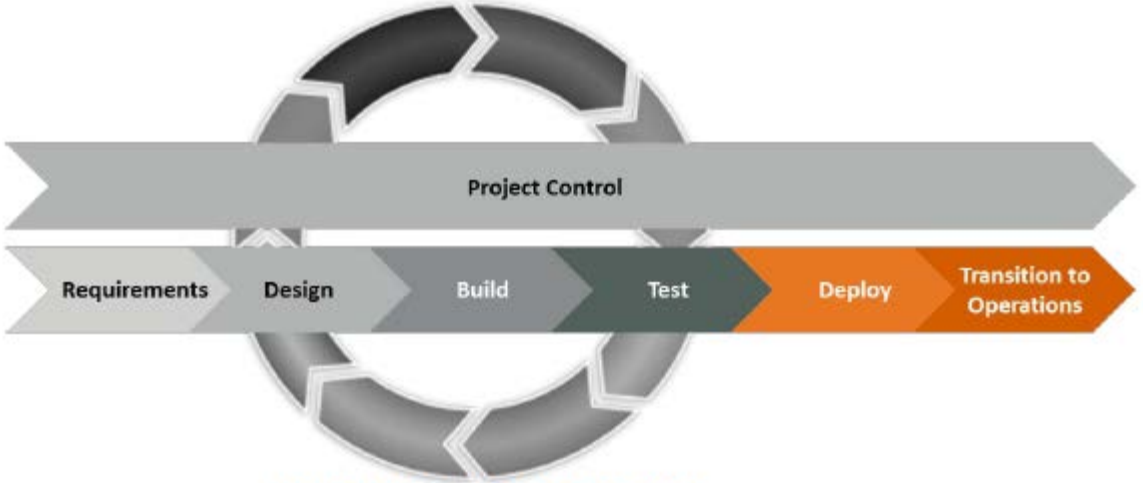
# APD Project Approach to Development

- Agile Project Methodology

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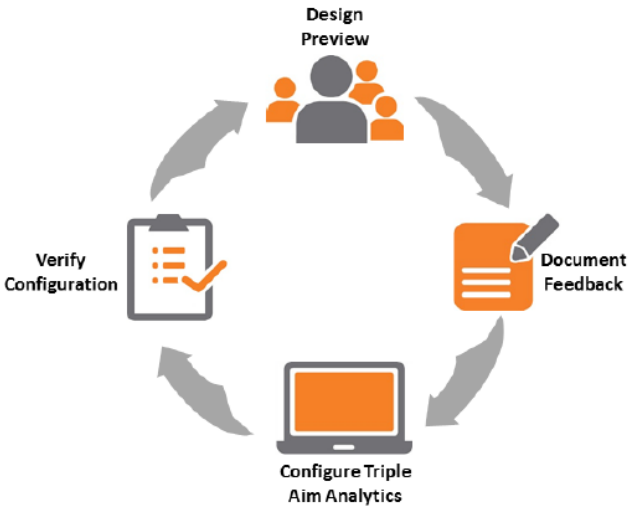
# NYS APD Design Session Topics

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

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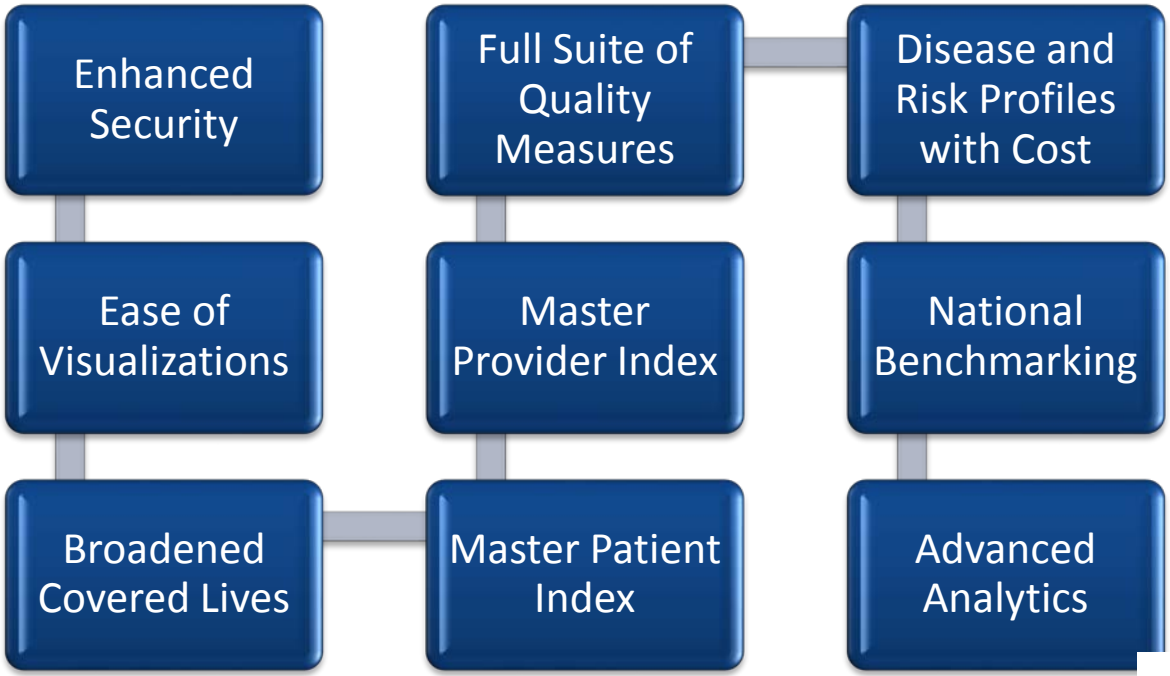
# Symmetry Toolkit

OPTUM®

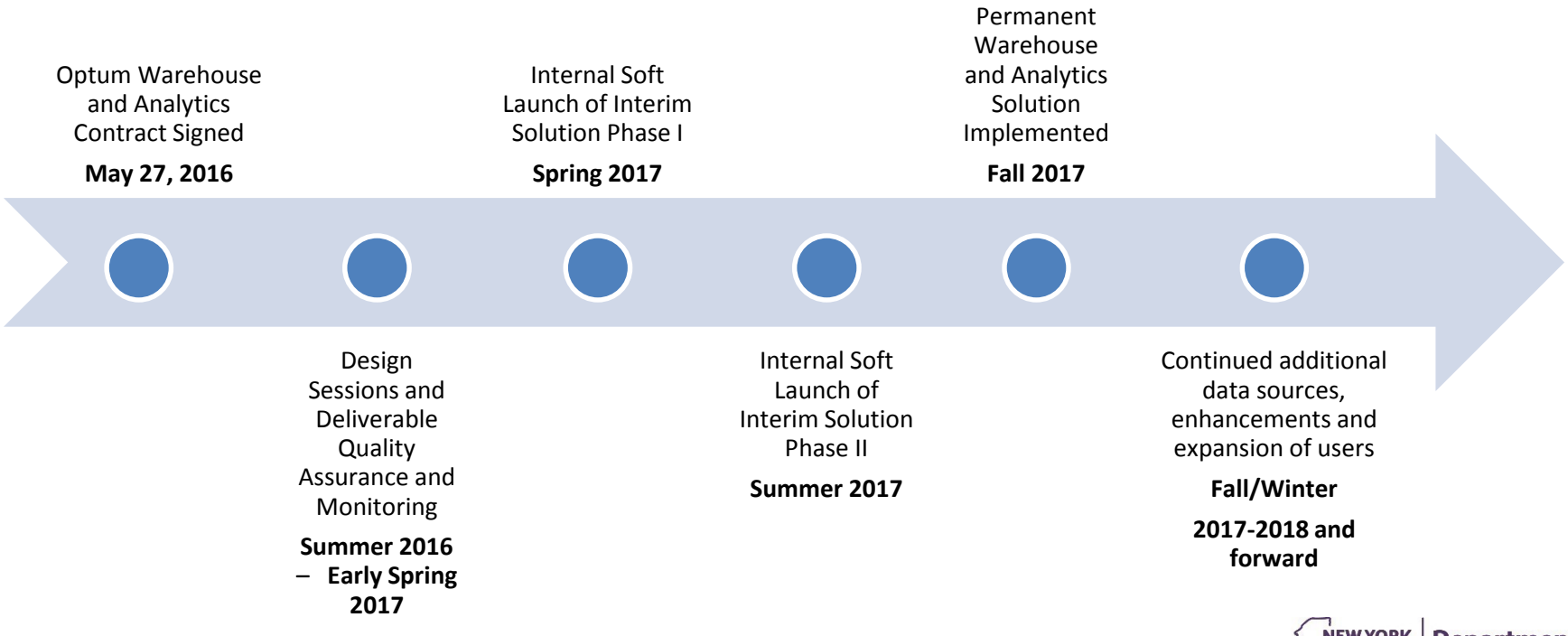
| Episode Treatment Groups (ETGs) | Episode Risk Groups (ERGs) | Evidence Based Medicine (EBM Connect) |
|---|---|---|
| • Episode Grouper<br>• Clinical Resource Measurement | • Risk Adjustment<br>• Predictive Modeling | • Quality Measurement<br>• Endorsed by AHRQ and HEDIS<br>• Over 650 Quality Measures<br>• Managed Care Plan Validation |

# Benefits already being realized as we develop and implement…




NEW YORK STATE OF OPPORTUNITY. Department of Health

# All Payer Database Key Milestones

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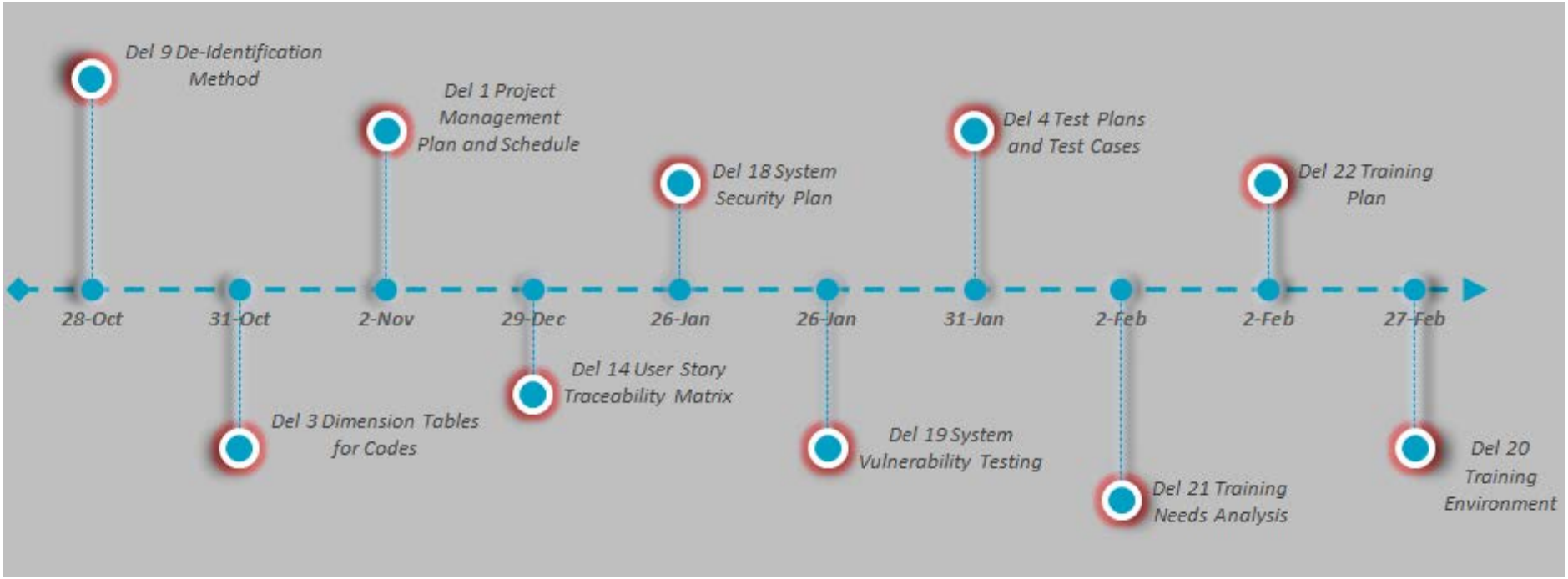
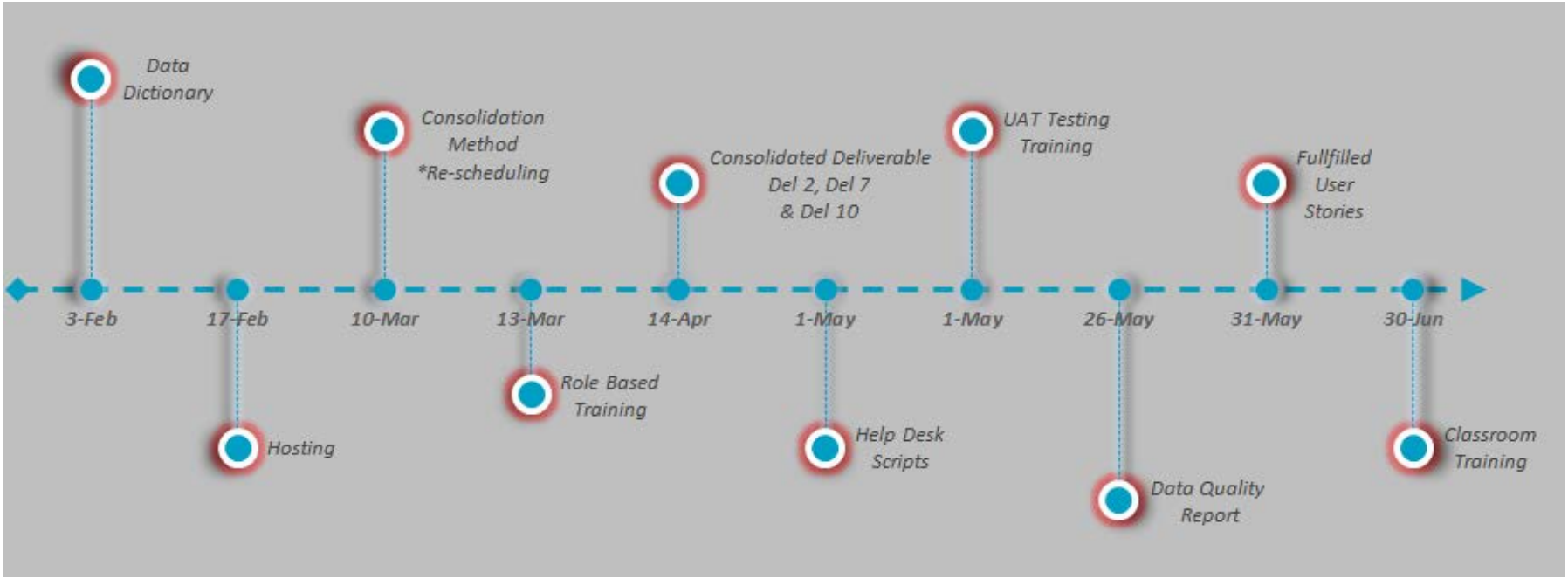
# Deliverable Approvals Since Project Initiation



# Currently Active Deliverables Through June 2017

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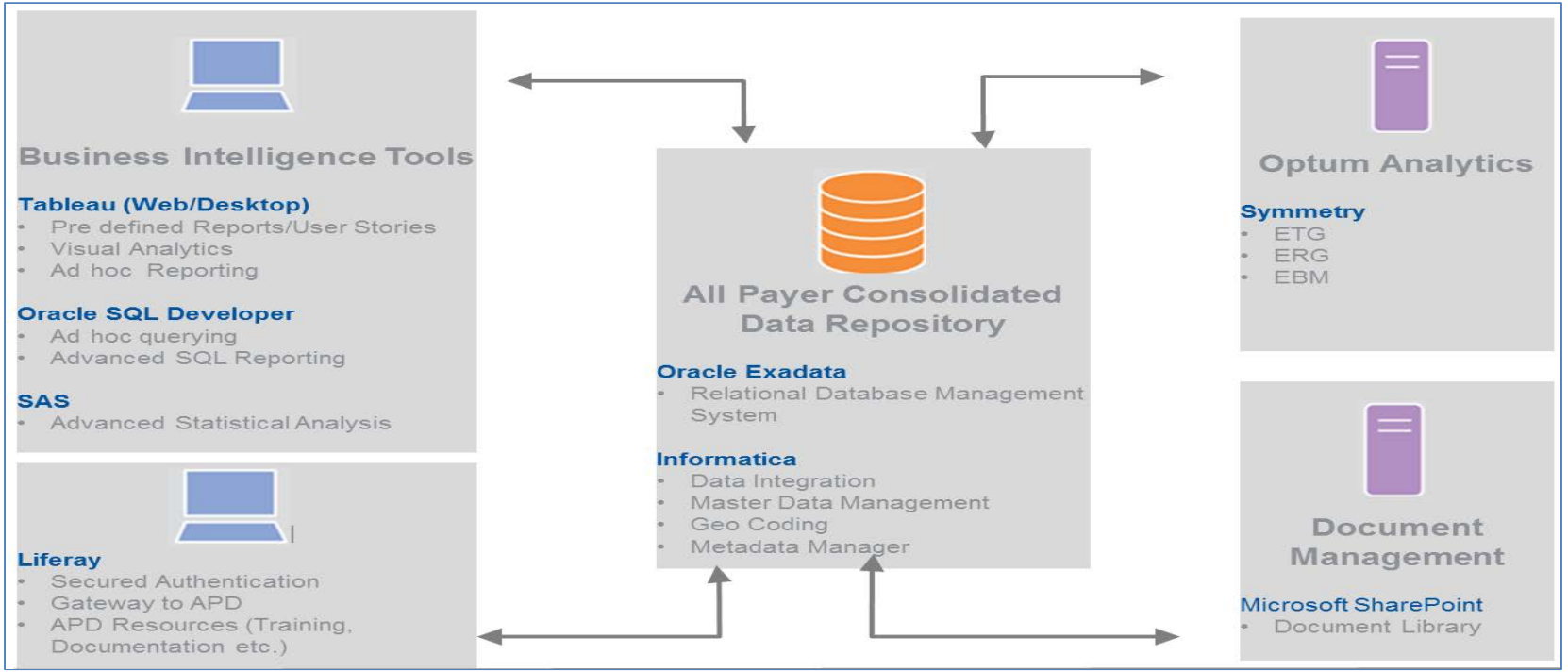
# Optum Triple Aim Analytic Services Technology Stack

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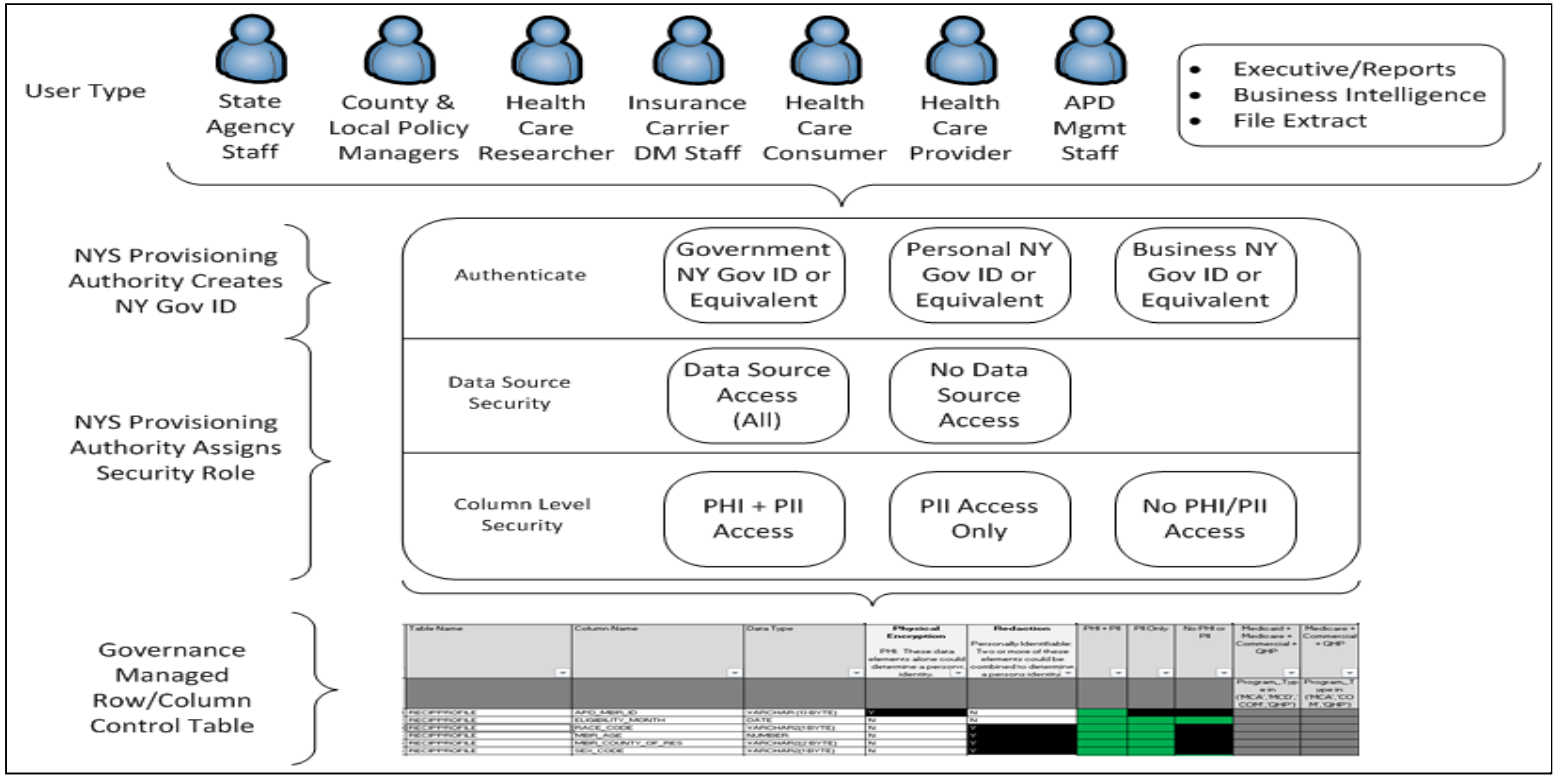
# Data Access and De-identification



# 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.

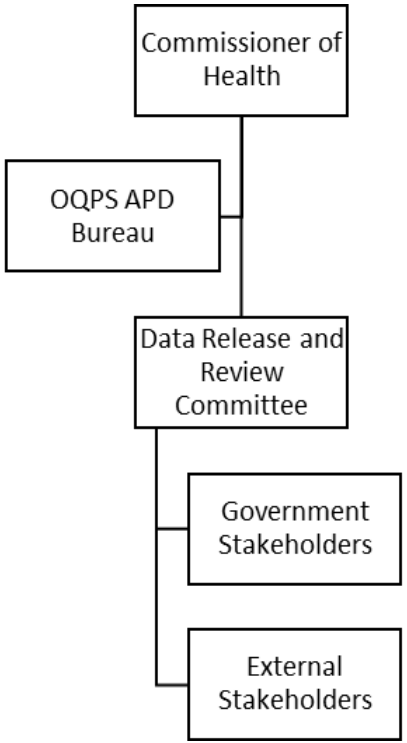
# Data Release and Review Committee

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

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# 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

NEW YORK STATE | Department of Health | All Payer Database

Save the Date

NYS APD Stakeholder Forum

**When:** Wednesday, April 26, 2017

**Where:** Concourse Meeting Room #6

Empire State Plaza – Albany, New York

- *Onsite participation is strongly encouraged*

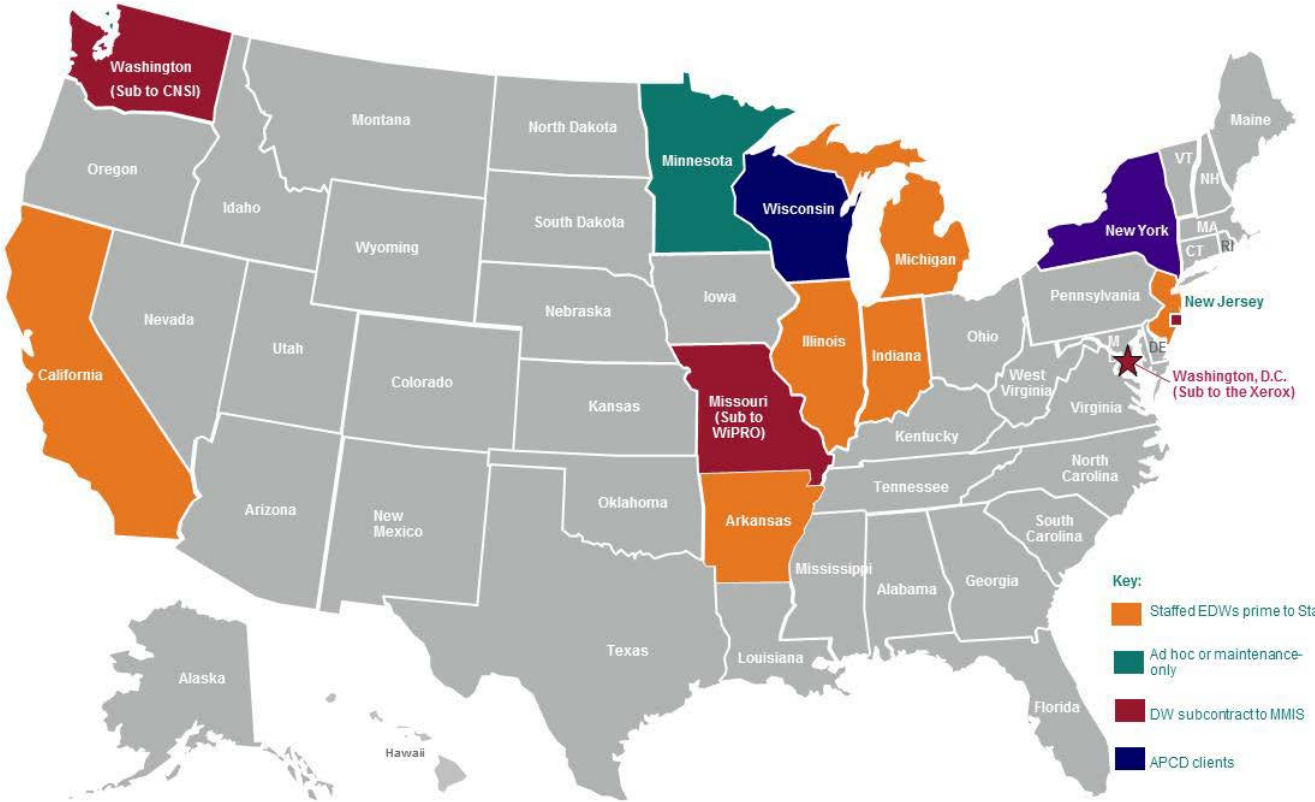
**Time:** 11:00am – 3:15pm (Registration begins at 10:00am)

**RSVP:** nysapd@health.ny.gov by April 14, 2017

- *Agenda, directions and WebEx availability will be forthcoming to pre-registered participants*
- *Please include the following information in the RSVP:*
  - *Name of Attendee(s)*
  - *Organization*
  - *Email*
  - *Phone Number*
  - *Preferred Parti*
    - *Onsite: _____ WebEx: _____*

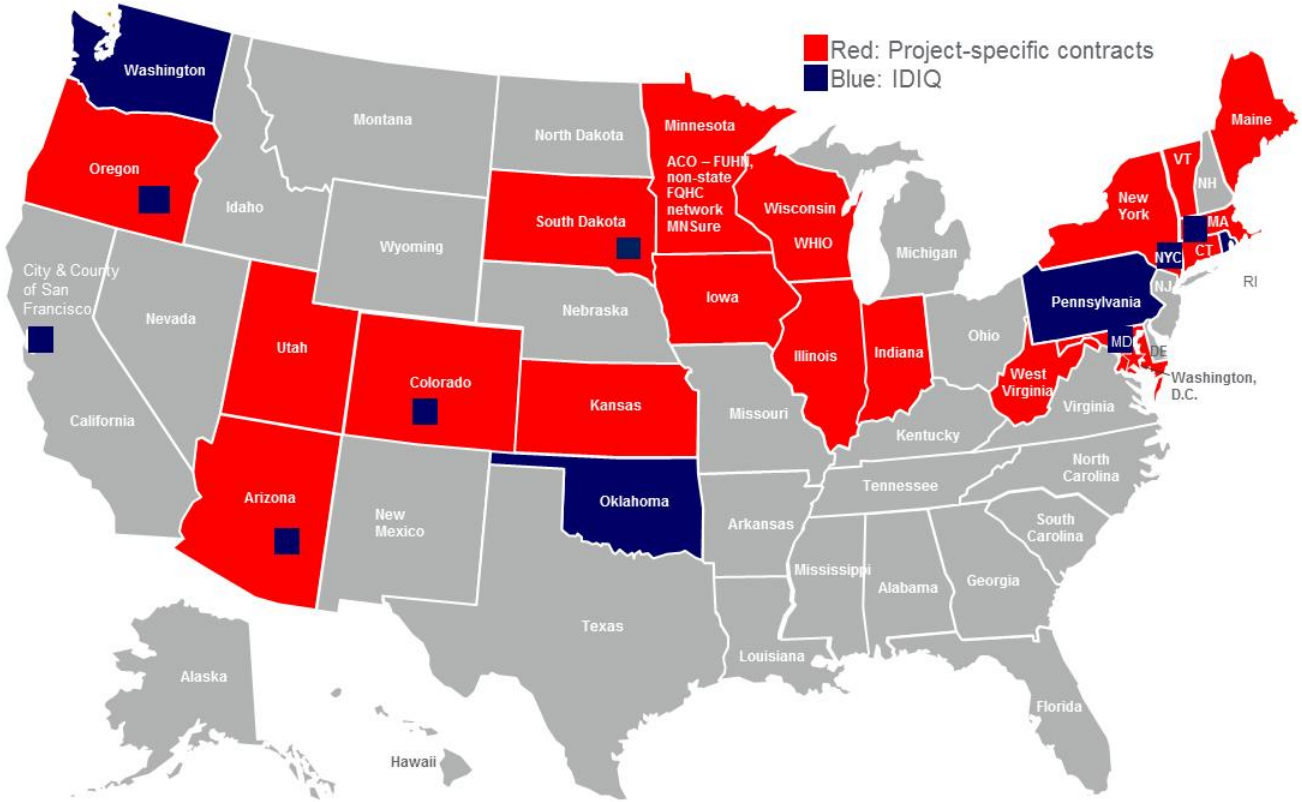
NEW YORK STATE OF OPPORTUNITY. Department of Health

# Optum's DW/APCD National Footprint



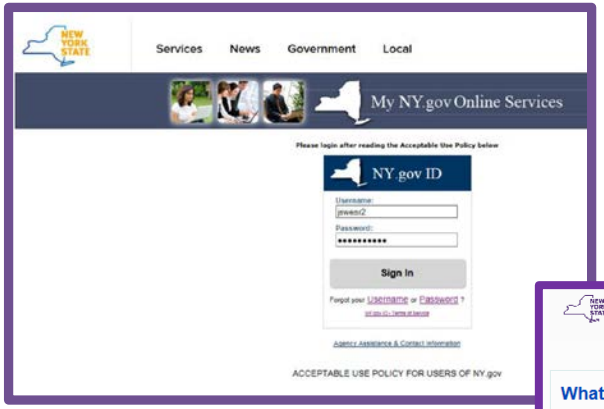

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Optum's Data Analytics Engagements

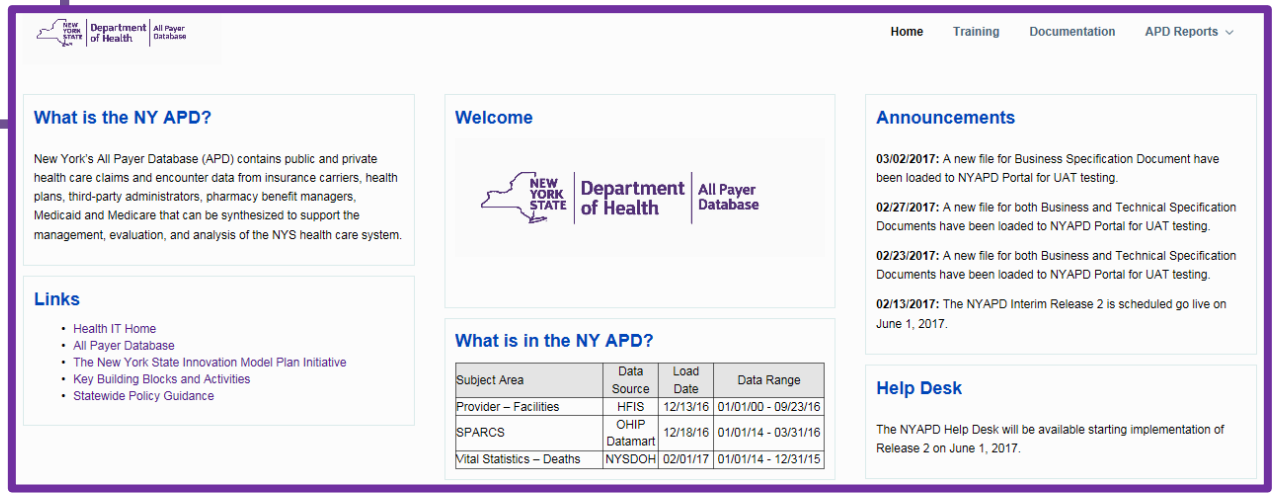



NEW YORK STATE OF OPPORTUNITY. Department of Health

# Single Sign-On Using NY.Gov




## APD Portal

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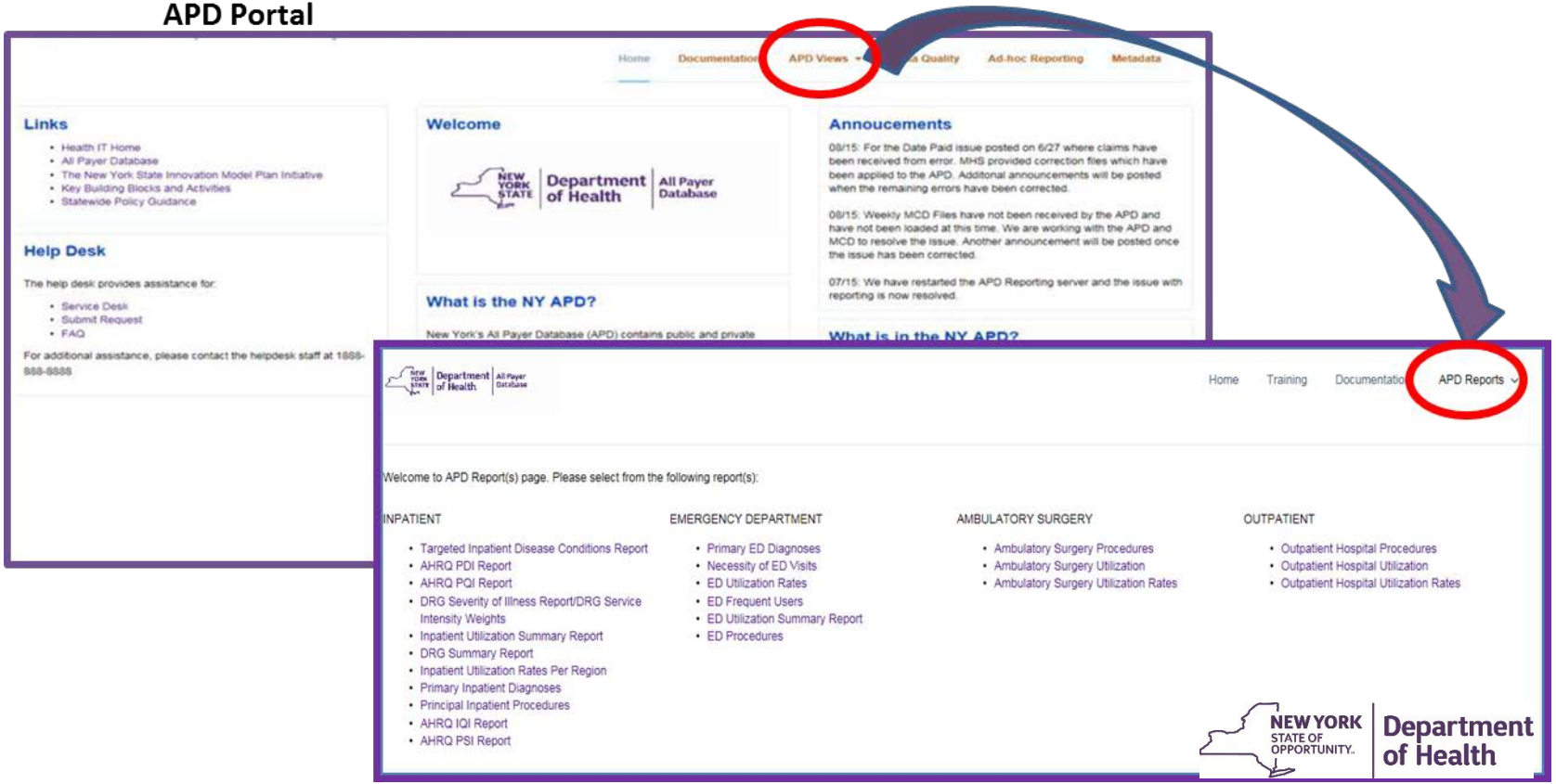
## APD Portal

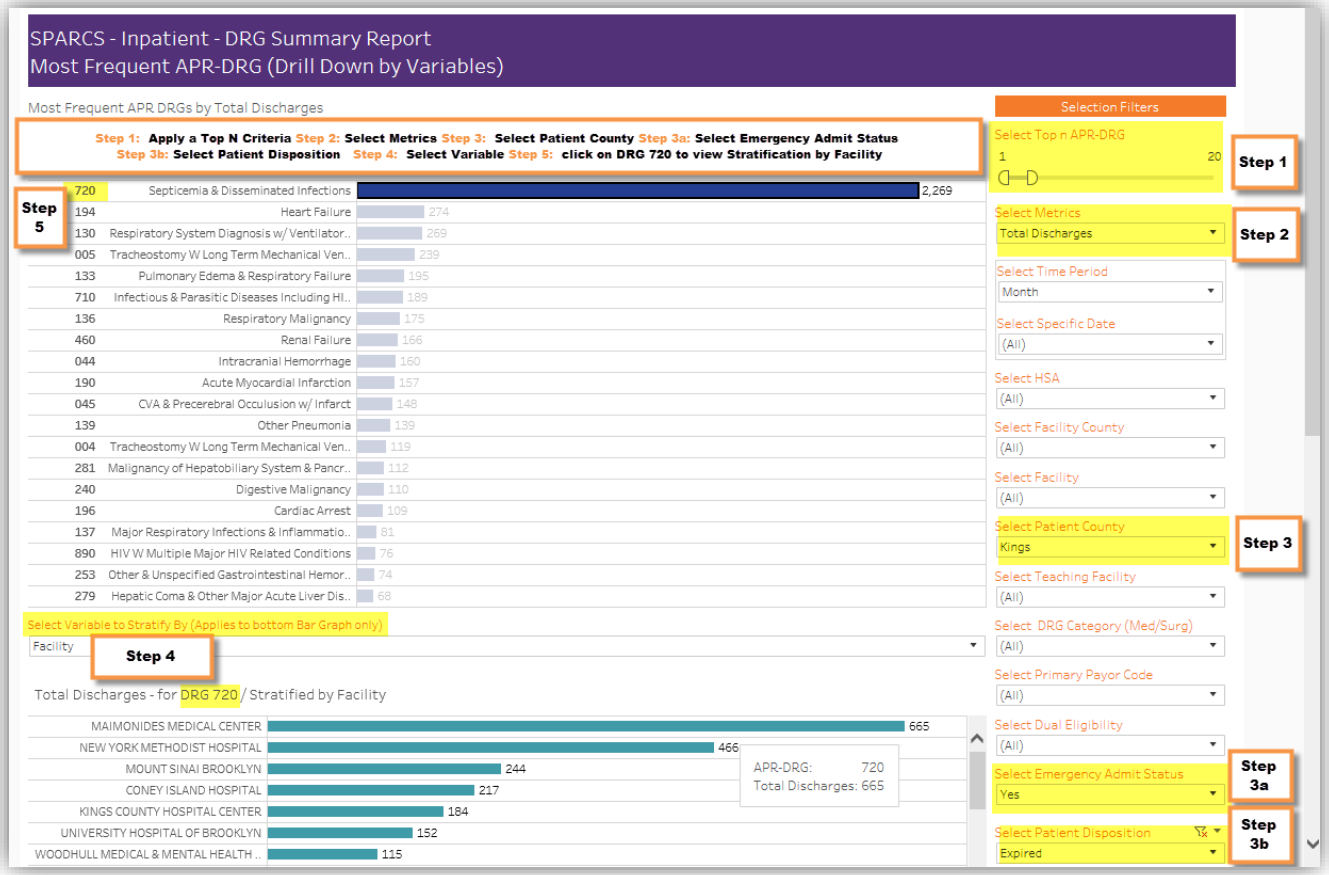

Home
Documentation
APD Views
Ad-hoc Reporting
Metadata
Links
Health IT Home
All Payer Database
The New York State Innovation Model Plan Initiative
Key Building Blocks and Activities
Statewide Policy Guidance
Help Desk
The help desk provides assistance for:
Service Desk
Submit Request
FAQ
For additional assistance, please contact the helpdesk staff at 1888-888-8888
Welcome
Department of Health
All Payer Database
What is the NY APD?
New York's All Payer Database (APD) contains public and private
Annoucements
08/15: For the Date Paid issue posted on 6/27 where claims have been received from error. MHS provided correction files which have been applied to the APD. Additonal announcements will be posted when the remaining errors have been corrected.
08/15: Weekly MCD Files have not been received by the APD and have not been loaded at this time. We are working with the APD and MCD to resolve the issue. Another announcement will be posted once the issue has been corrected.
07/15: We have restarted the APD Reporting server and the issue with reporting is now resolved.
What is in the NY APD?
Department of Health
All Payer Database
Home
Training
Documentation
APD Reports
Welcome to APD Report(s) page. Please select from the following report(s):
INPATIENT
Targeted Inpatient Disease Conditions Report
AHRQ PDI Report
AHRQ PQI Report
DRG Severity of Illness Report/DRG Service Intensity Weights
Inpatient Utilization Summary Report
DRG Summary Report
Inpatient Utilization Rates Per Region
Primary Inpatient Diagnoses
Principal Inpatient Procedures
AHRQ IQI Report
AHRQ PSI Report
EMERGENCY DEPARTMENT
Primary ED Diagnoses
Necessity of ED Visits
ED Utilization Rates
ED Frequent Users
ED Utilization Summary Report
ED Procedures
AMBULATORY SURGERY
Ambulatory Surgery Procedures
Ambulatory Surgery Utilization
Ambulatory Surgery Utilization Rates
OUTPATIENT
Outpatient Hospital Procedures
Outpatient Hospital Utilization
Outpatient Hospital Utilization Rates
NEW YORK STATE OF OPPORTUNITY.
Department of Health

# Working Lunch

# APD Presentation

## Mary Beth Conroy
## Steve Johnson (Optum)

# Use Case 1 – SPARCS Inpatient APR-DRG Summary Report

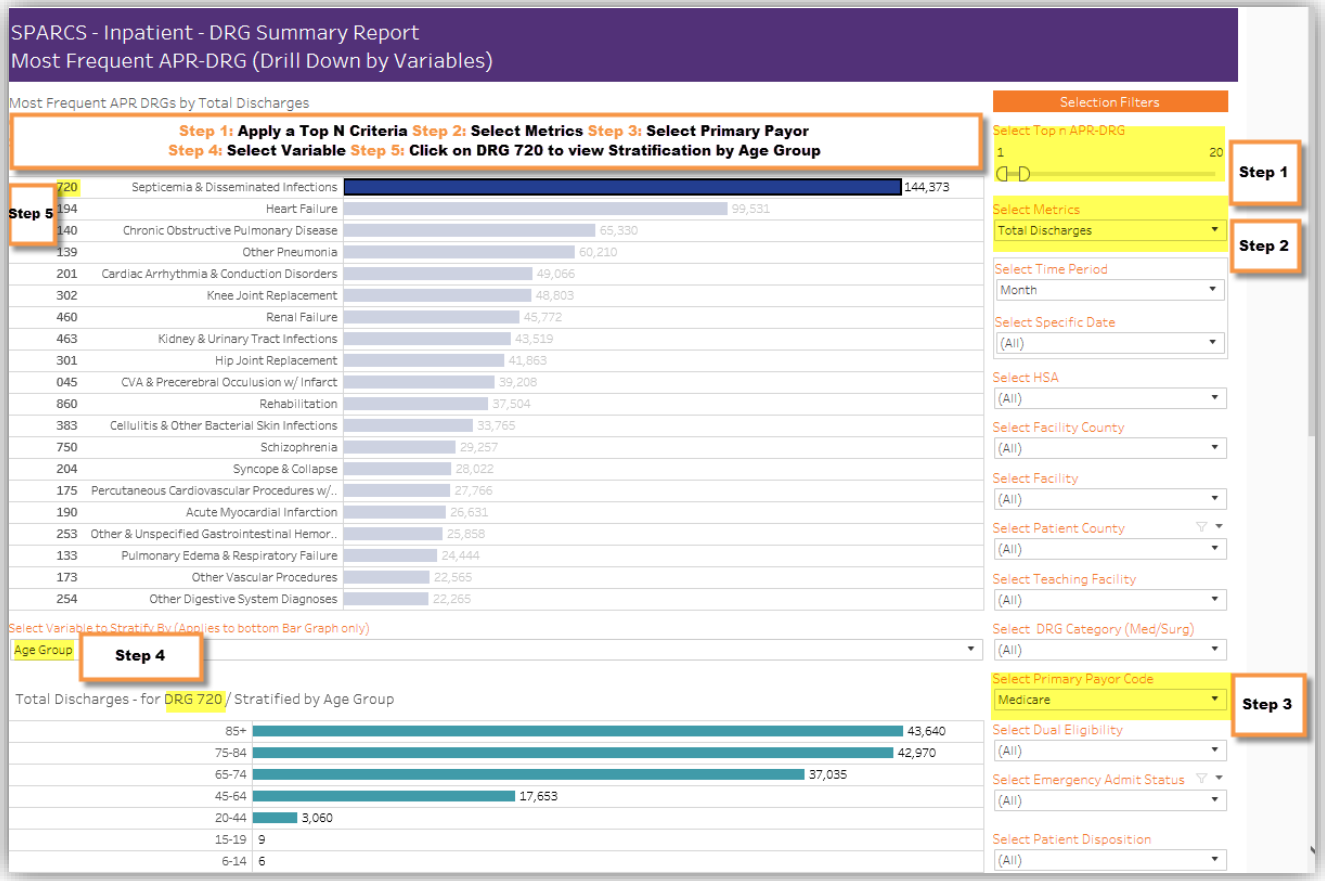



Sample
*Illustration*

Top 20 APR-DRGs by Total Discharges for all residents of Kings County that expired in the hospital, stratified by facility

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 1a – SPARCS Inpatient APR-DRG Summary Report

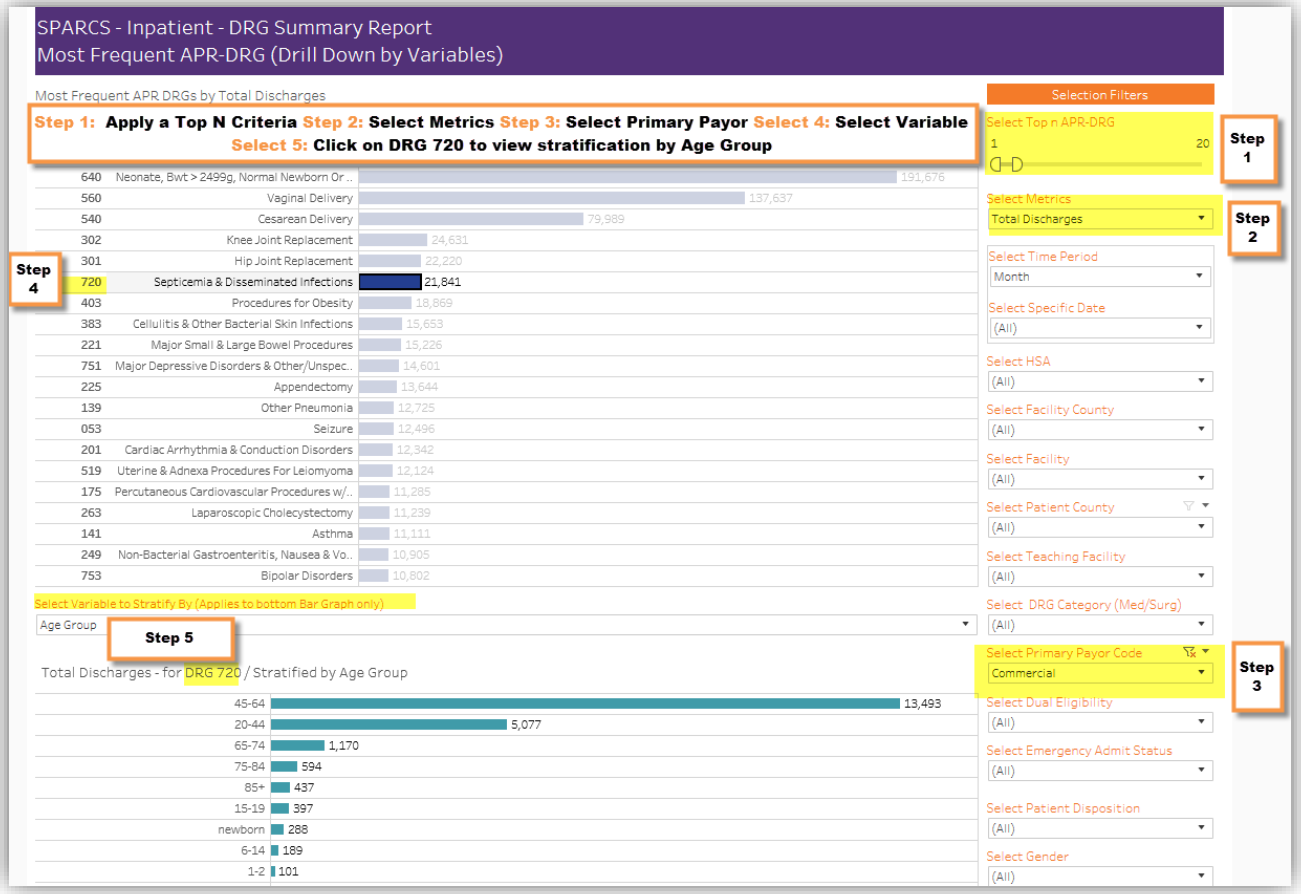



Sample
*Illustration*

Top 20 APR-DRGs by Total Discharges for Statewide Medicare members, stratified by age

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 1b – SPARCS - Inpatient APR-DRG Summary Report

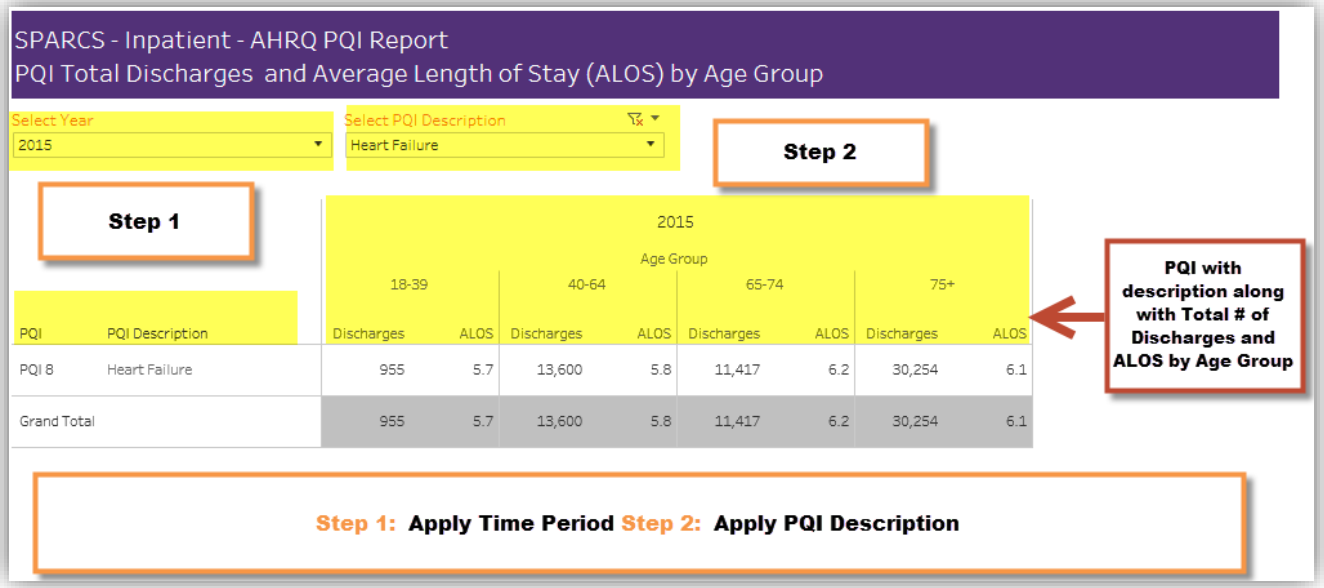



Sample
*Illustration*

Top 20 APR-DRGs by Total Discharges for Statewide Commercial members, stratified by age

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 2 - SPARCS - Inpatient AHRQ Prevention Quality Indicator (PQI)

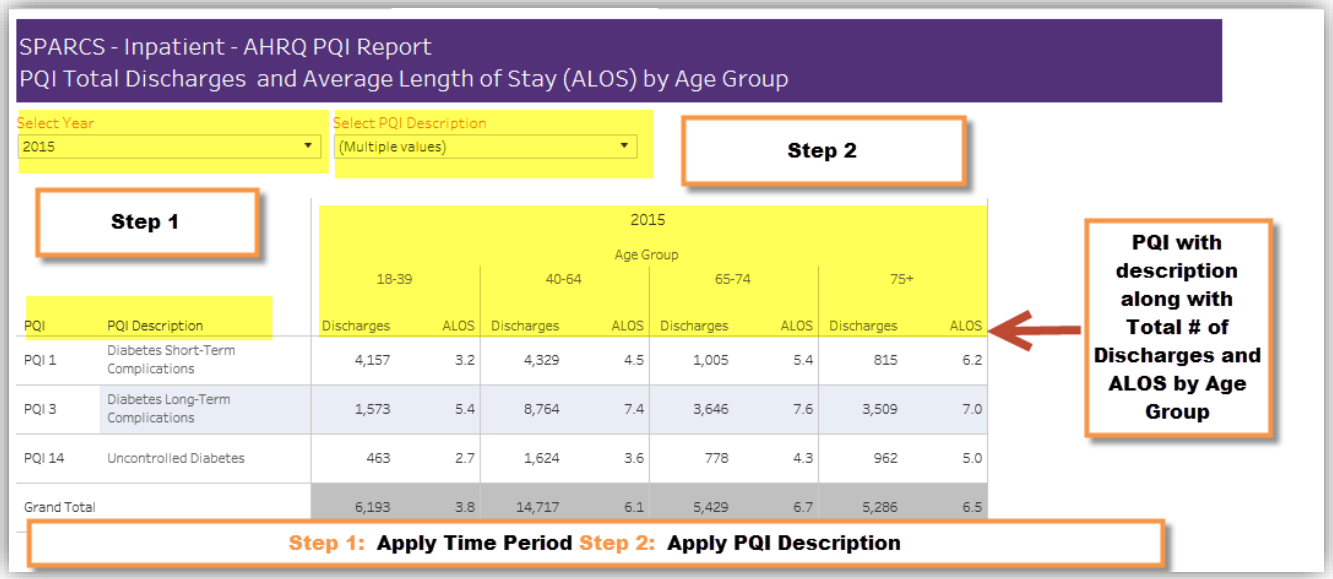



Sample
*Illustration*

Rates of preventable hospitalizations for the Heart Failure PQI for 2015

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 2a - SPARCS – SPARCS Inpatient AHRQ PQI report

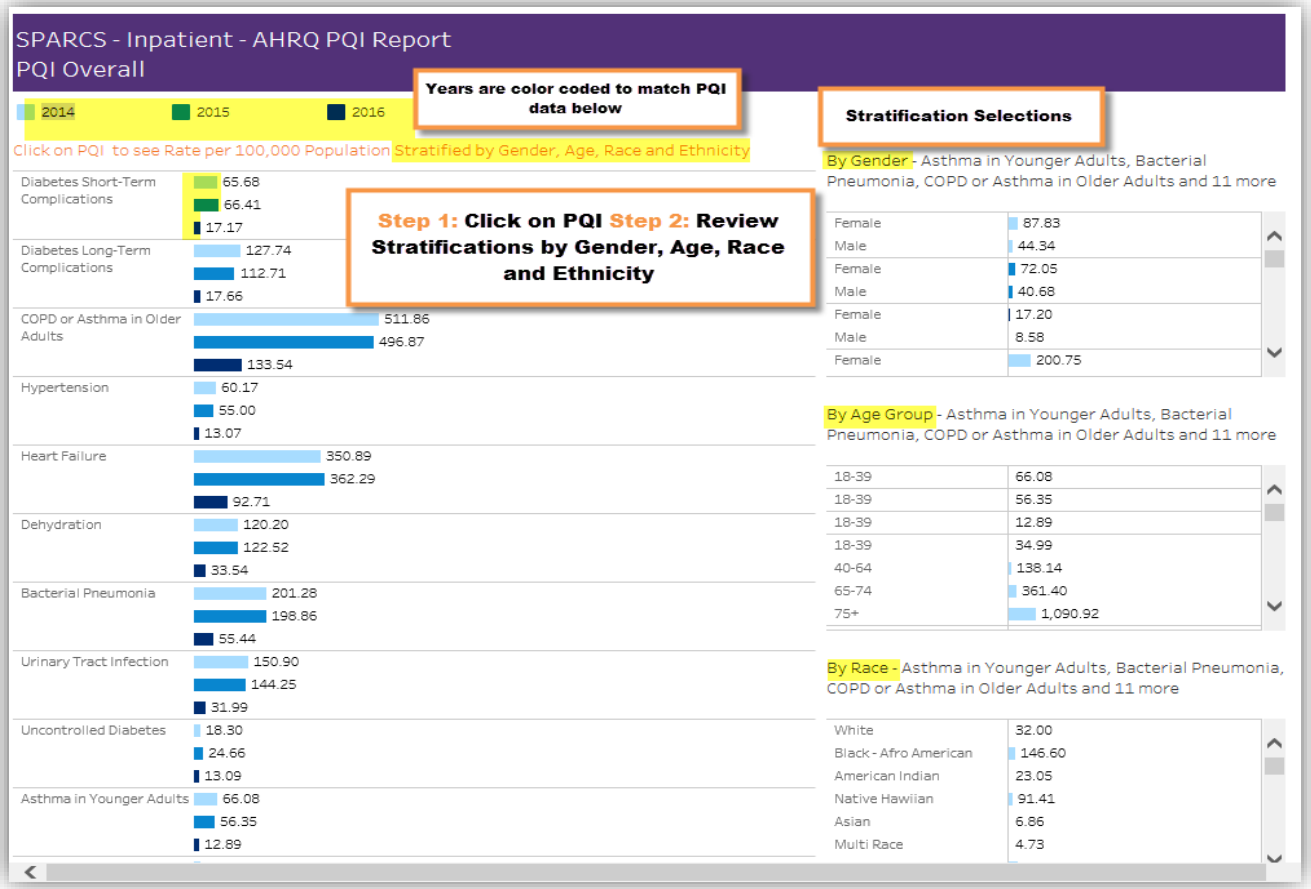



Sample
*Illustration*

Rates of preventable hospitalizations for diabetes related PQIs for 2015

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 2b – SPARCS Inpatient AHRQ PQI Report

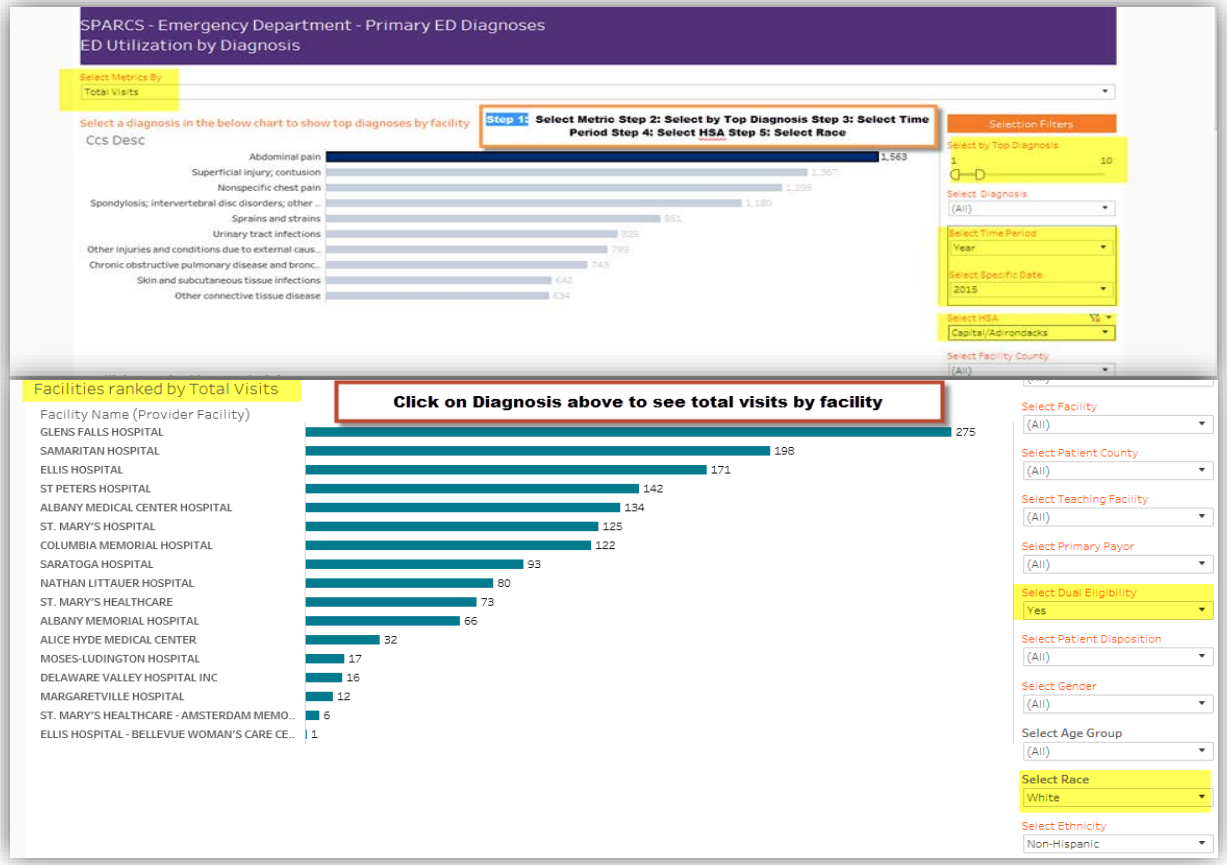



Sample
*Illustration*

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

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 3 - SPARCS Necessity of Emergency Department Visits

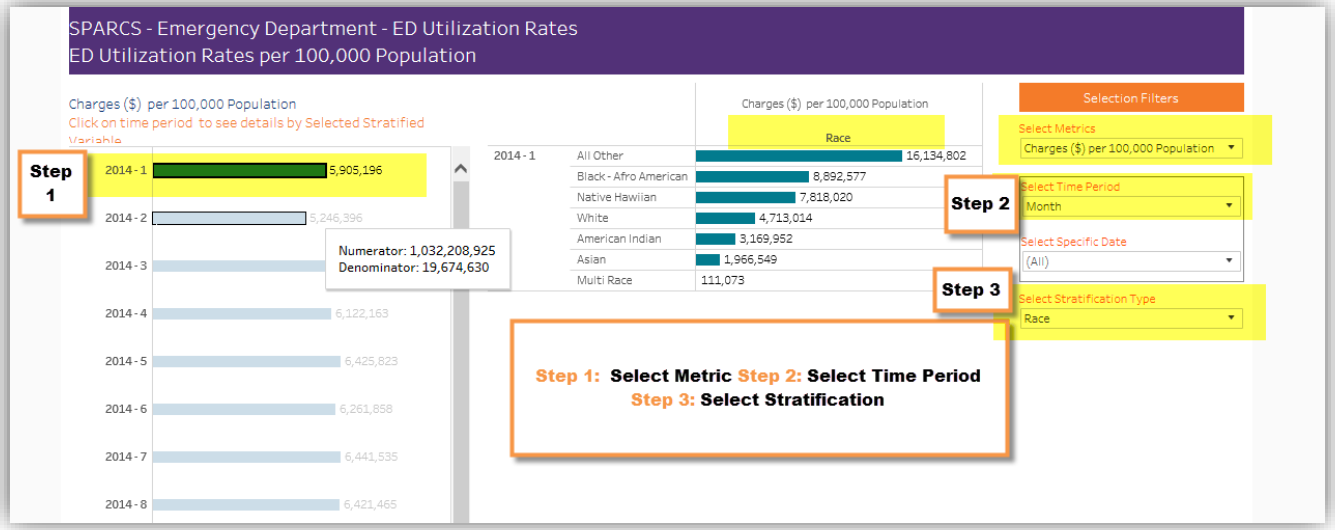



**Sample**
*Illustration*

Top 10 Diagnosis Groupings for ED visits for residents of the Capital District and Adirondack HSAs in 2015, stratified by facility

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 4 – SPARCS Emergency Department Utilization




Sample
*Illustration*

Emergency visit charges for first quarter of 2014, stratified by race

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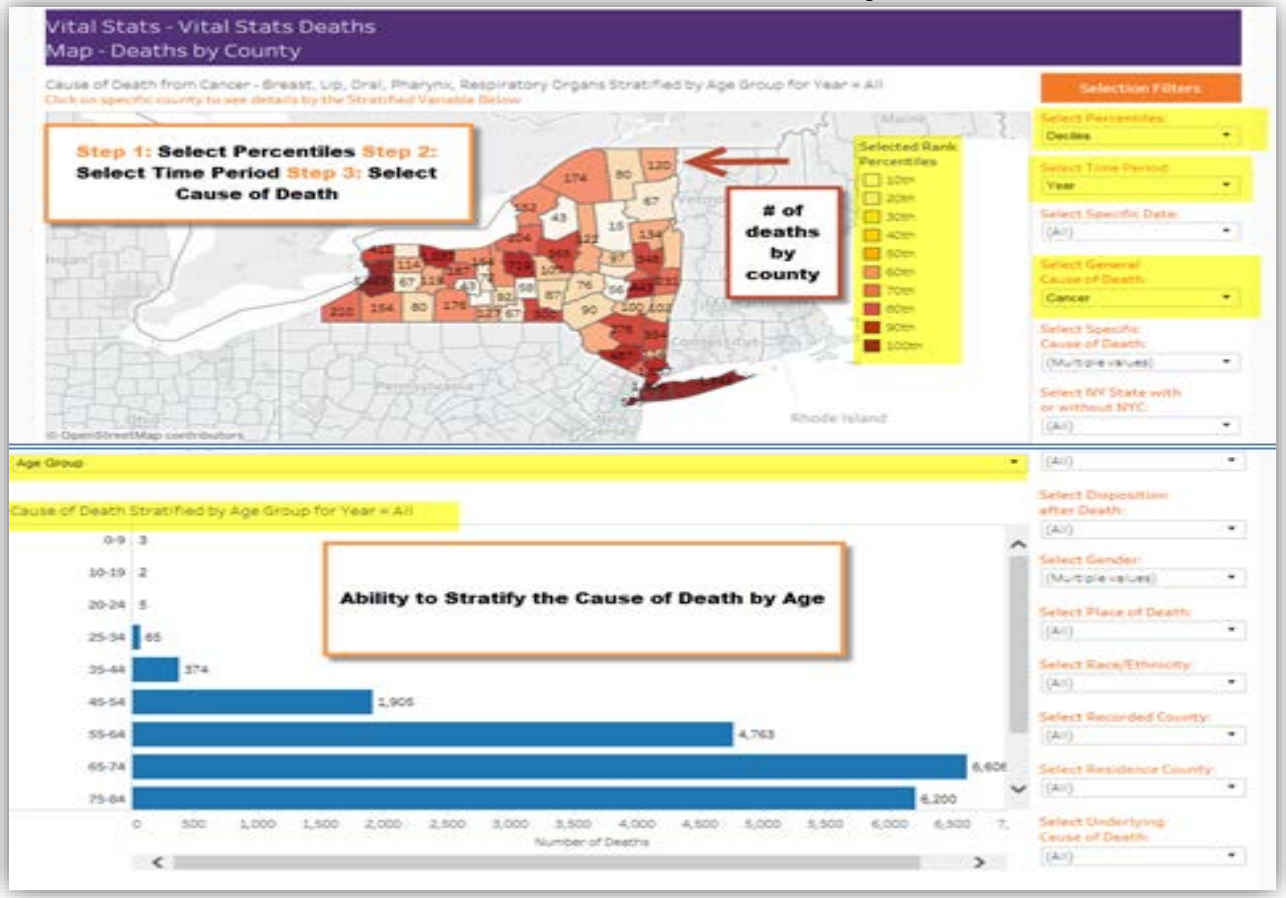
# Use Case 5 – Vital Statistics Cancer Mortality Data

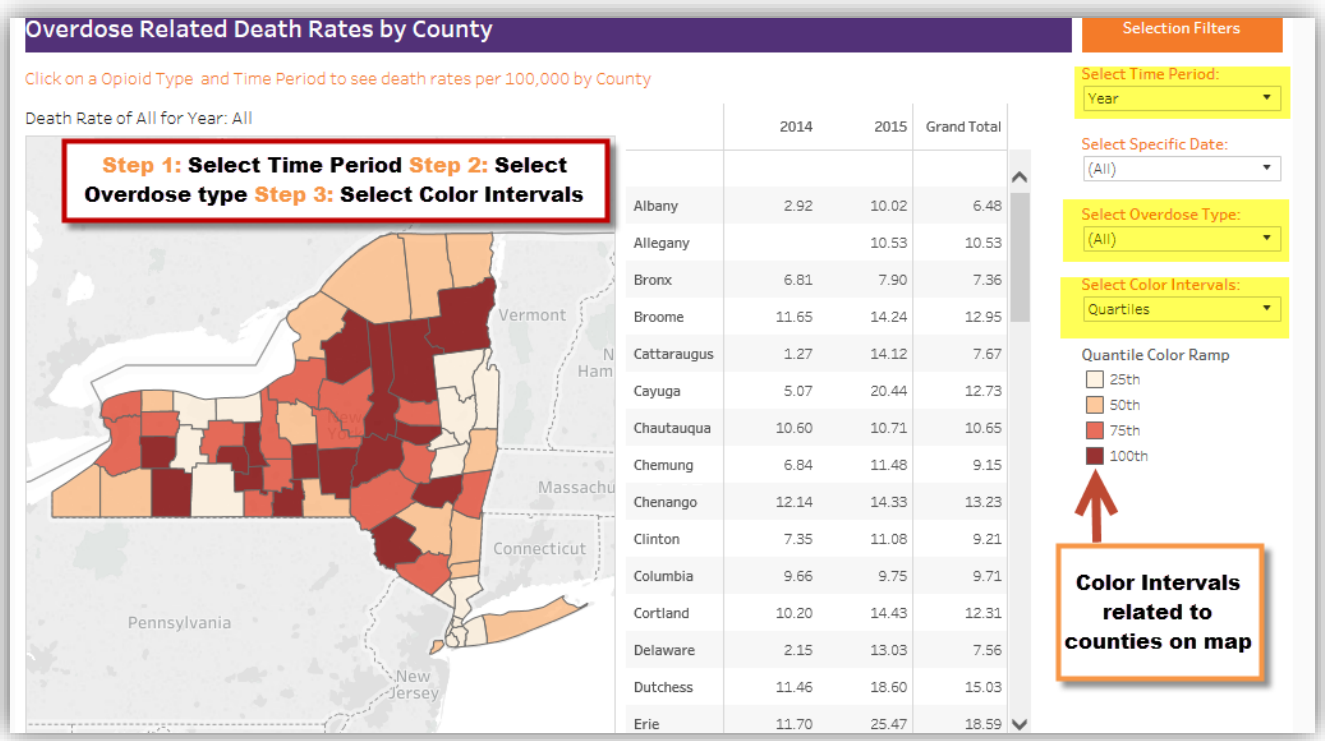



Sample
*Illustration*

Map of cancer deaths by county, stratified by age

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 6 – Vital Statistics - Opioid Overdose Death Rates

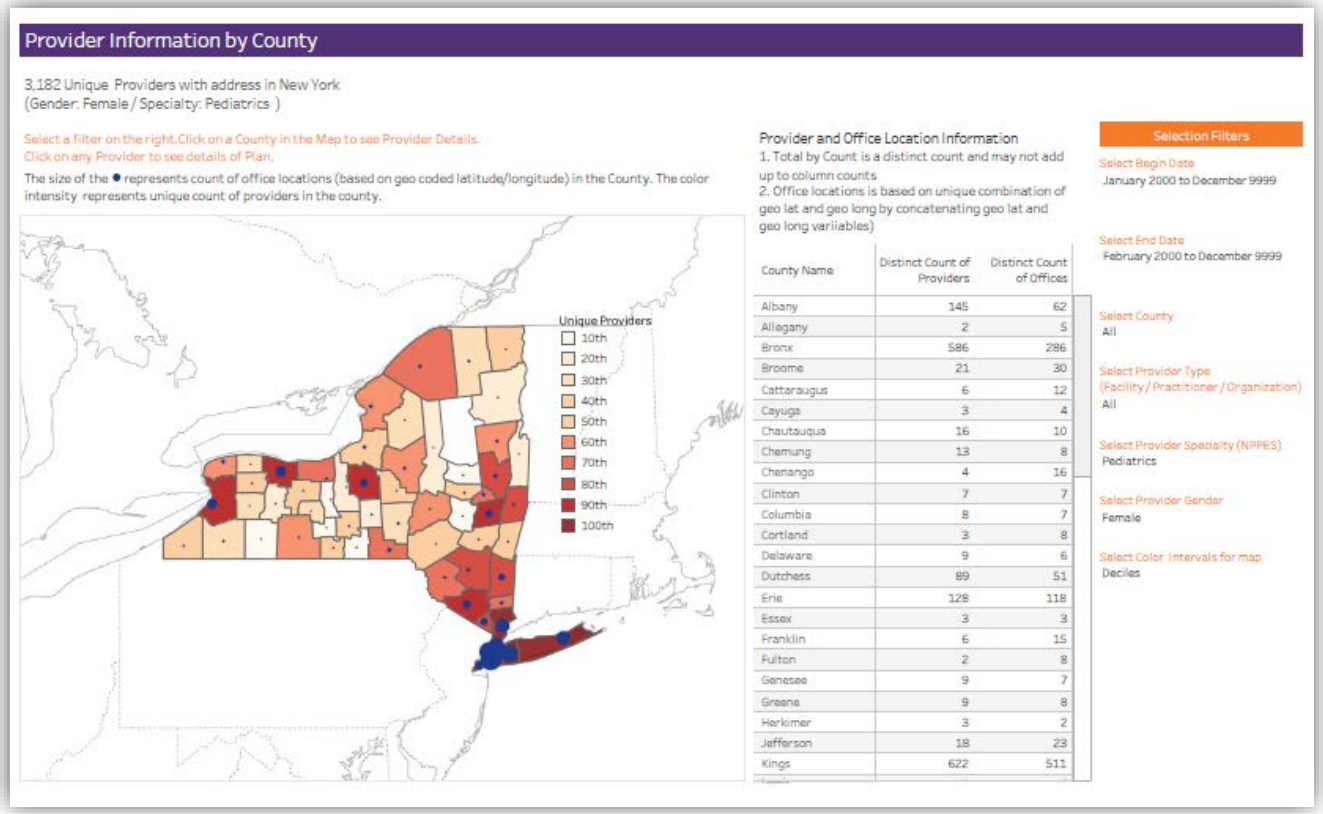



Sample
*Illustration*

Map of opioid overdose death rates by county

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 7 – Provider Availability




**Sample**
*Illustration*

Count of female pediatricians in each county (showing the map and table views)

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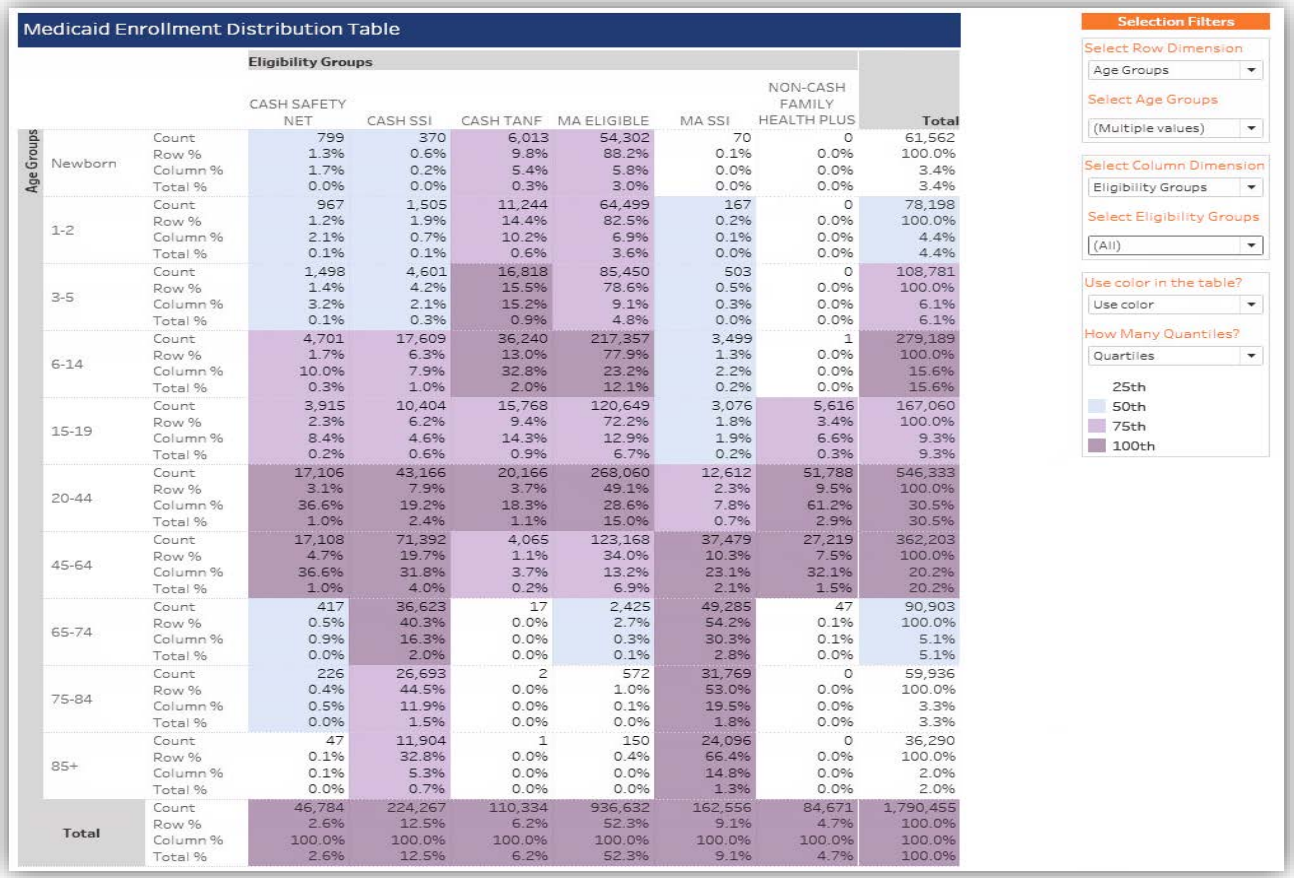
# Use Case 8 – Member Enrollment



Medicaid Enrollment Distribution Table

| Age Groups | | Eligibility Groups: CASH SAFETY NET | CASH SSI | CASH TANF | MA ELIGIBLE | MA SSI | NON-CASH FAMILY HEALTH PLUS | Total |
|---|---|---|---|---|---|---|---|---|
| Newborn | Count | 799 | 370 | 6,013 | 54,302 | 70 | 0 | 61,562 |
| | Row % | 1.3% | 0.6% | 9.8% | 88.2% | 0.1% | 0.0% | 100.0% |
| | Column % | 1.7% | 0.2% | 5.4% | 5.8% | 0.0% | 0.0% | 3.4% |
| | Total % | 0.0% | 0.0% | 0.3% | 3.0% | 0.0% | 0.0% | 3.4% |
| 1-2 | Count | 967 | 1,505 | 11,244 | 64,499 | 167 | 0 | 78,198 |
| | Row % | 1.2% | 1.9% | 14.4% | 82.5% | 0.2% | 0.0% | 100.0% |
| | Column % | 2.1% | 0.7% | 10.2% | 6.9% | 0.1% | 0.0% | 4.4% |
| | Total % | 0.1% | 0.1% | 0.6% | 3.6% | 0.0% | 0.0% | 4.4% |
| 3-5 | Count | 1,498 | 4,601 | 16,818 | 85,450 | 503 | 0 | 108,781 |
| | Row % | 1.4% | 4.2% | 15.5% | 78.6% | 0.5% | 0.0% | 100.0% |
| | Column % | 3.2% | 2.1% | 15.2% | 9.1% | 0.3% | 0.0% | 6.1% |
| | Total % | 0.1% | 0.3% | 0.9% | 4.8% | 0.0% | 0.0% | 6.1% |
| 6-14 | Count | 4,701 | 17,609 | 36,240 | 217,357 | 3,499 | 1 | 279,189 |
| | Row % | 1.7% | 6.3% | 13.0% | 77.9% | 1.3% | 0.0% | 100.0% |
| | Column % | 10.0% | 7.9% | 32.8% | 23.2% | 2.2% | 0.0% | 15.6% |
| | Total % | 0.3% | 1.0% | 2.0% | 12.1% | 0.2% | 0.0% | 15.6% |
| 15-19 | Count | 3,915 | 10,404 | 15,768 | 120,649 | 3,076 | 5,616 | 167,060 |
| | Row % | 2.3% | 6.2% | 9.4% | 72.2% | 1.8% | 3.4% | 100.0% |
| | Column % | 8.4% | 4.6% | 14.3% | 12.9% | 1.9% | 6.6% | 9.3% |
| | Total % | 0.2% | 0.6% | 0.9% | 6.7% | 0.2% | 0.3% | 9.3% |
| 20-44 | Count | 17,106 | 43,166 | 20,166 | 268,060 | 12,612 | 51,788 | 546,333 |
| | Row % | 3.1% | 7.9% | 3.7% | 49.1% | 2.3% | 9.5% | 100.0% |
| | Column % | 36.6% | 19.2% | 18.3% | 28.6% | 7.8% | 61.2% | 30.5% |
| | Total % | 1.0% | 2.4% | 1.1% | 15.0% | 0.7% | 2.9% | 30.5% |
| 45-64 | Count | 17,108 | 71,392 | 4,065 | 123,168 | 37,479 | 27,219 | 362,203 |
| | Row % | 4.7% | 19.7% | 1.1% | 34.0% | 10.3% | 7.5% | 100.0% |
| | Column % | 36.6% | 31.8% | 3.7% | 13.2% | 23.1% | 32.1% | 20.2% |
| | Total % | 1.0% | 4.0% | 0.2% | 6.9% | 2.1% | 1.5% | 20.2% |
| 65-74 | Count | 417 | 36,623 | 17 | 2,425 | 49,285 | 47 | 90,903 |
| | Row % | 0.5% | 40.3% | 0.0% | 2.7% | 54.2% | 0.1% | 100.0% |
| | Column % | 0.9% | 16.3% | 0.0% | 0.3% | 30.3% | 0.1% | 5.1% |
| | Total % | 0.0% | 2.0% | 0.0% | 0.1% | 2.8% | 0.0% | 5.1% |
| 75-84 | Count | 226 | 26,693 | 2 | 572 | 31,769 | 0 | 59,936 |
| | Row % | 0.4% | 44.5% | 0.0% | 1.0% | 53.0% | 0.0% | 100.0% |
| | Column % | 0.5% | 11.9% | 0.0% | 0.1% | 19.5% | 0.0% | 3.3% |
| | Total % | 0.0% | 1.5% | 0.0% | 0.0% | 1.8% | 0.0% | 3.3% |
| 85+ | Count | 47 | 11,904 | 1 | 150 | 24,096 | 0 | 36,290 |
| | Row % | 0.1% | 32.8% | 0.0% | 0.4% | 66.4% | 0.0% | 100.0% |
| | Column % | 0.1% | 5.3% | 0.0% | 0.0% | 14.8% | 0.0% | 2.0% |
| | Total % | 0.0% | 0.7% | 0.0% | 0.0% | 1.3% | 0.0% | 2.0% |
| Total | Count | 46,784 | 224,267 | 110,334 | 936,632 | 162,556 | 84,671 | 1,790,455 |
| | Row % | 2.6% | 12.5% | 6.2% | 52.3% | 9.1% | 4.7% | 100.0% |
| | Column % | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | Total % | 2.6% | 12.5% | 6.2% | 52.3% | 9.1% | 4.7% | 100.0% |

Selection Filters

Select Row Dimension: Age Groups

Select Age Groups: (Multiple values)

Select Column Dimension: Eligibility Groups

Select Eligibility Groups: (All)

Use color in the table?: Use color

How Many Quantiles?: Quartiles

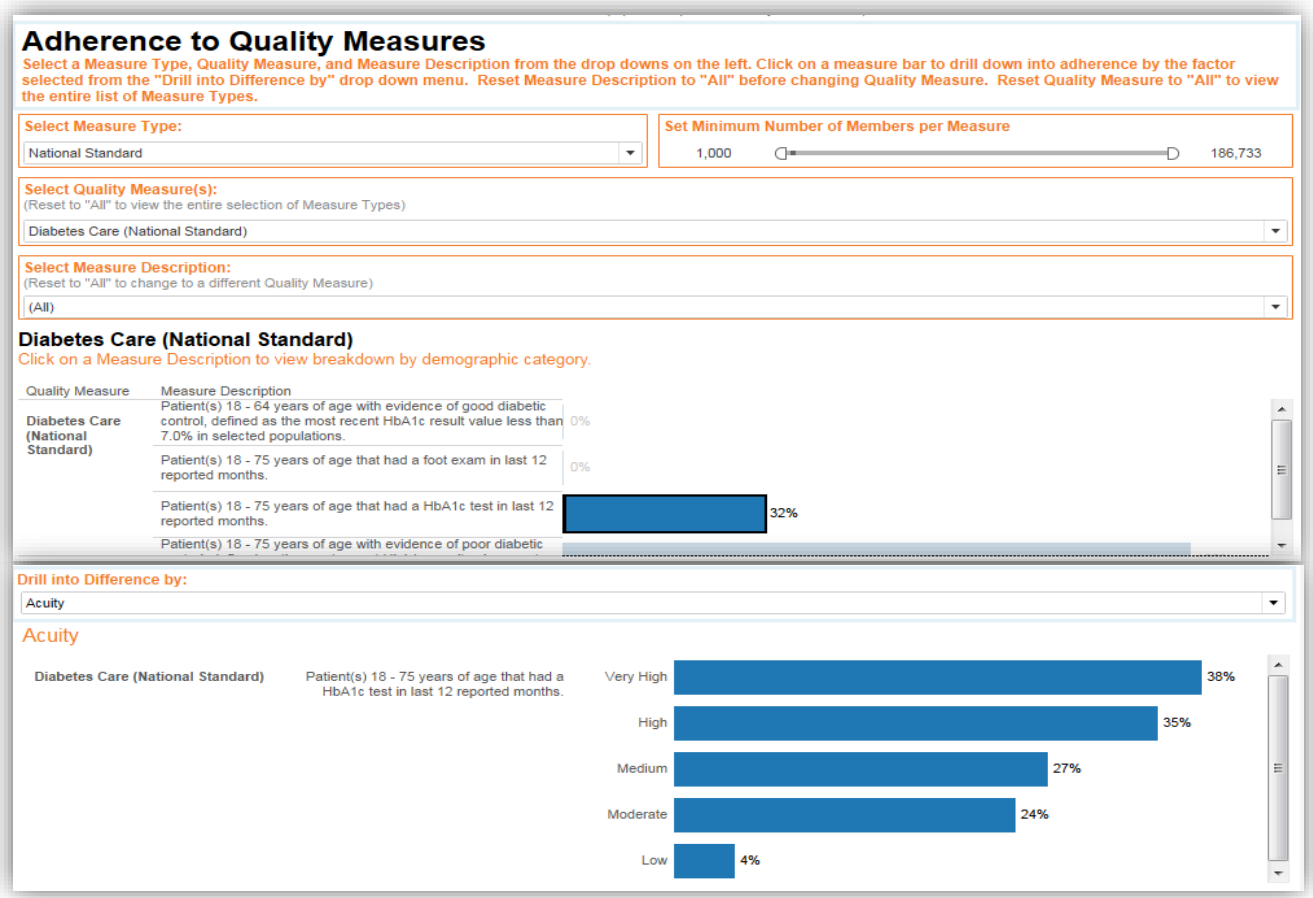
25th
50th
75th
100th

**Sample**
*Illustration*

Count and percentage of Medicaid enrollees by eligibility group and age group

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Use Case 9 – Quality Adherence




**Sample**
*Illustration*

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

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# SHIN-NY Update

Jim Kirkwood
Valerie Grey

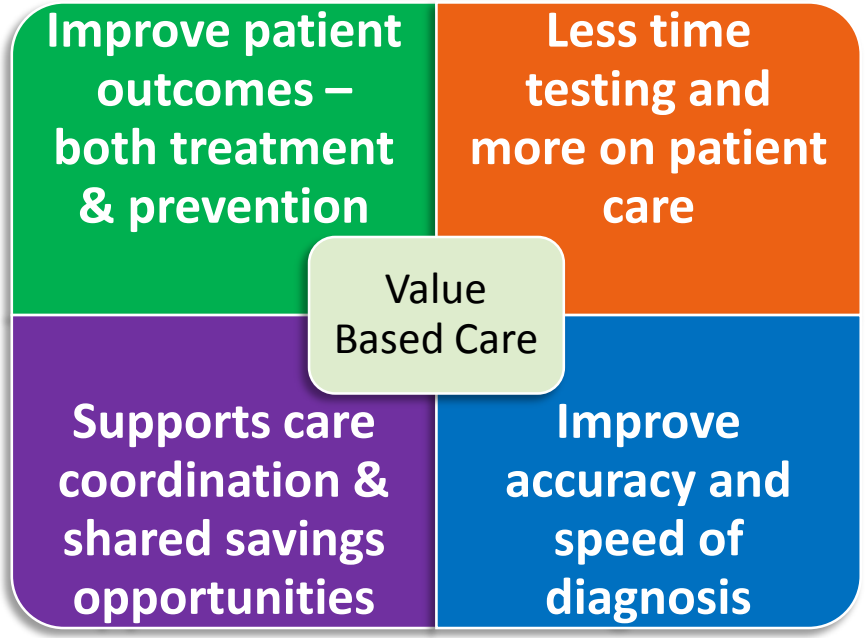
NYeC
NEW YORK eHEALTH COLLABORATIVE

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Heath Information Exchange Value


**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**

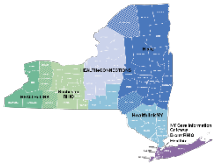
*Journal of the American Medical Informatics Association*
June 27, 2015

NYeC

# Listening & Seeking Customer and Stakeholder Input

## Stakeholder Focus Groups

- All Provider Types
- Health Plans
- Consumers
- Qualified Entities
- DOH Workgroups

NYACP New York Chapter American College of Physicians Advancing Internal Medicine, Improving Patient Care

Medical Society of the State of New York

Greater New York Hospital Association GNYHA

HANYS

HCA Home Care Association of New York State

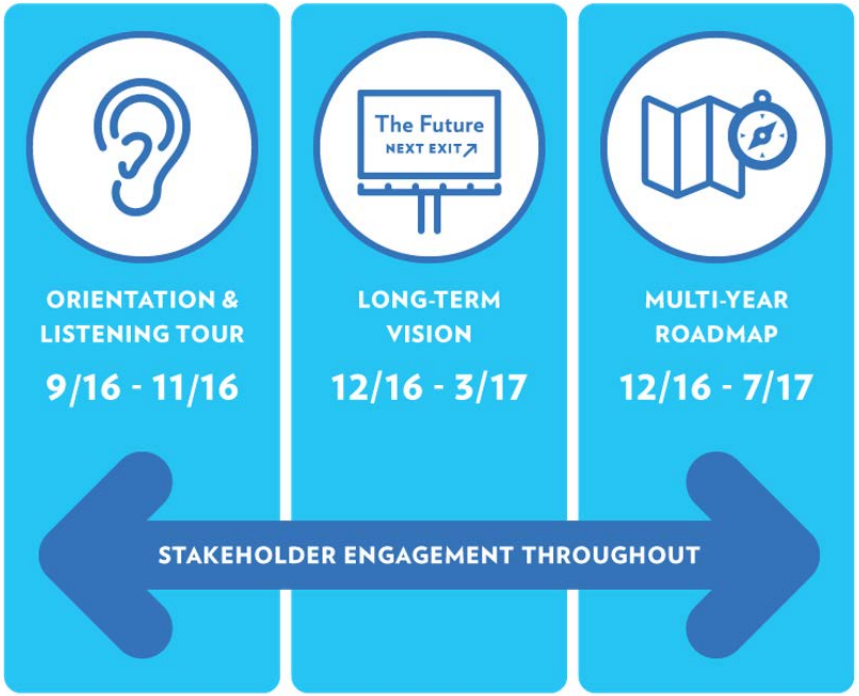
LeadingAge New York

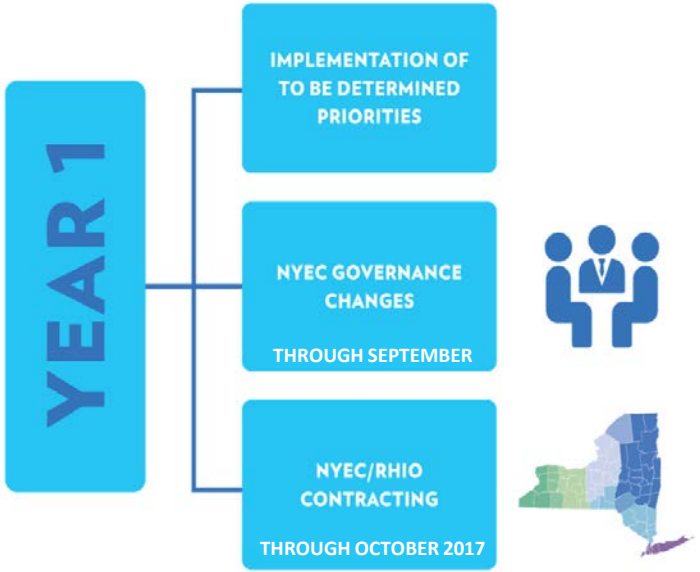
CCLC

NYeC

# What Are We Hearing? What Do Providers Want?

# Game Plan & Target Timelines



# 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


Contraction in Funding
Continuous Technology Advances
Care Delivery Changes
Driving Forces
Health System & HIE
Consumer Expectations
Consolidation
Competition (Opportunity?)
FHIR

# 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

**Shared Vision**

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

**SHIN-NY**

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

**NYeC**

**Our mission is to improve healthcare by collaboratively leading, connecting, and integrating health information exchange across the State**

# Proposed Guiding Principles

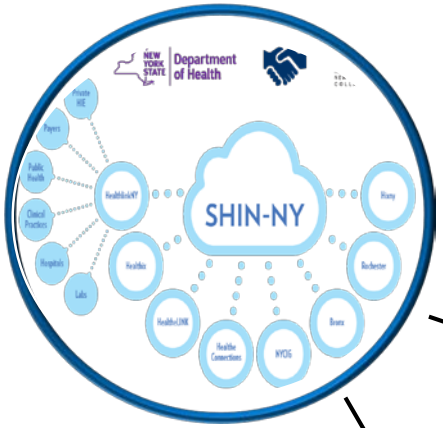
## Passionate Beliefs

- 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

NYeC

# 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

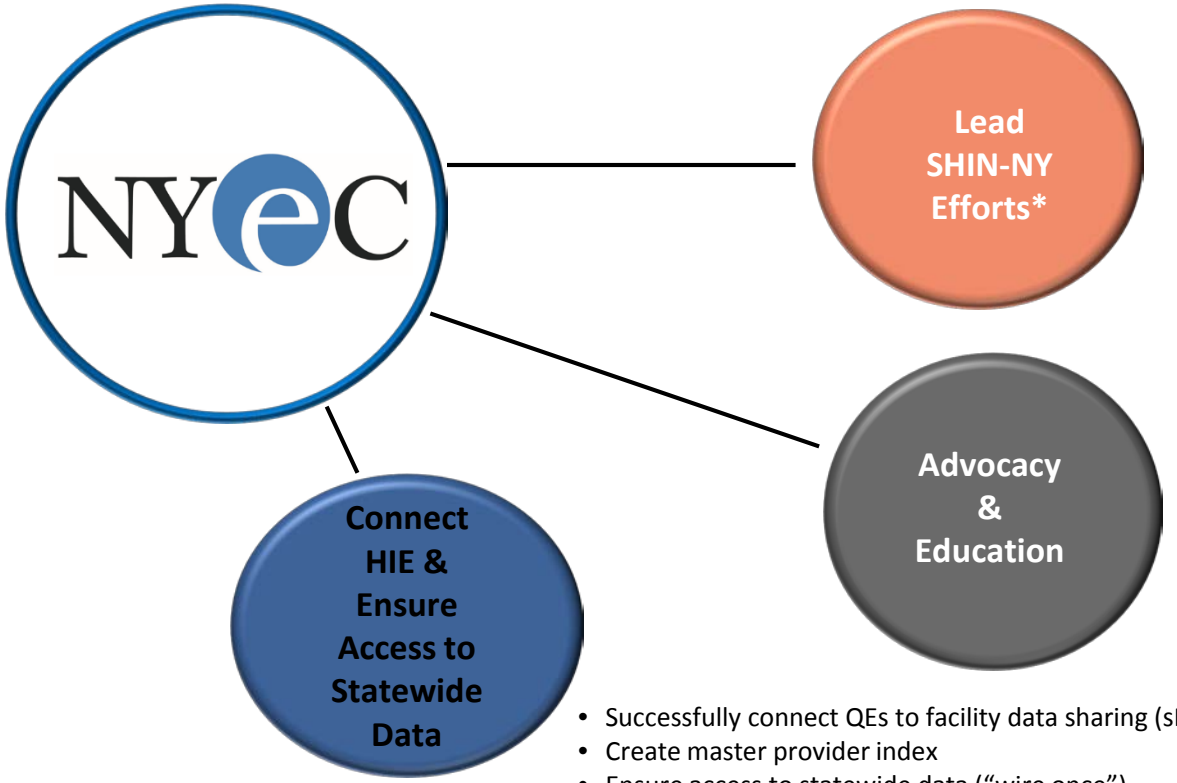
**Integration & accessibility**

- 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




- 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

- 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

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

**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

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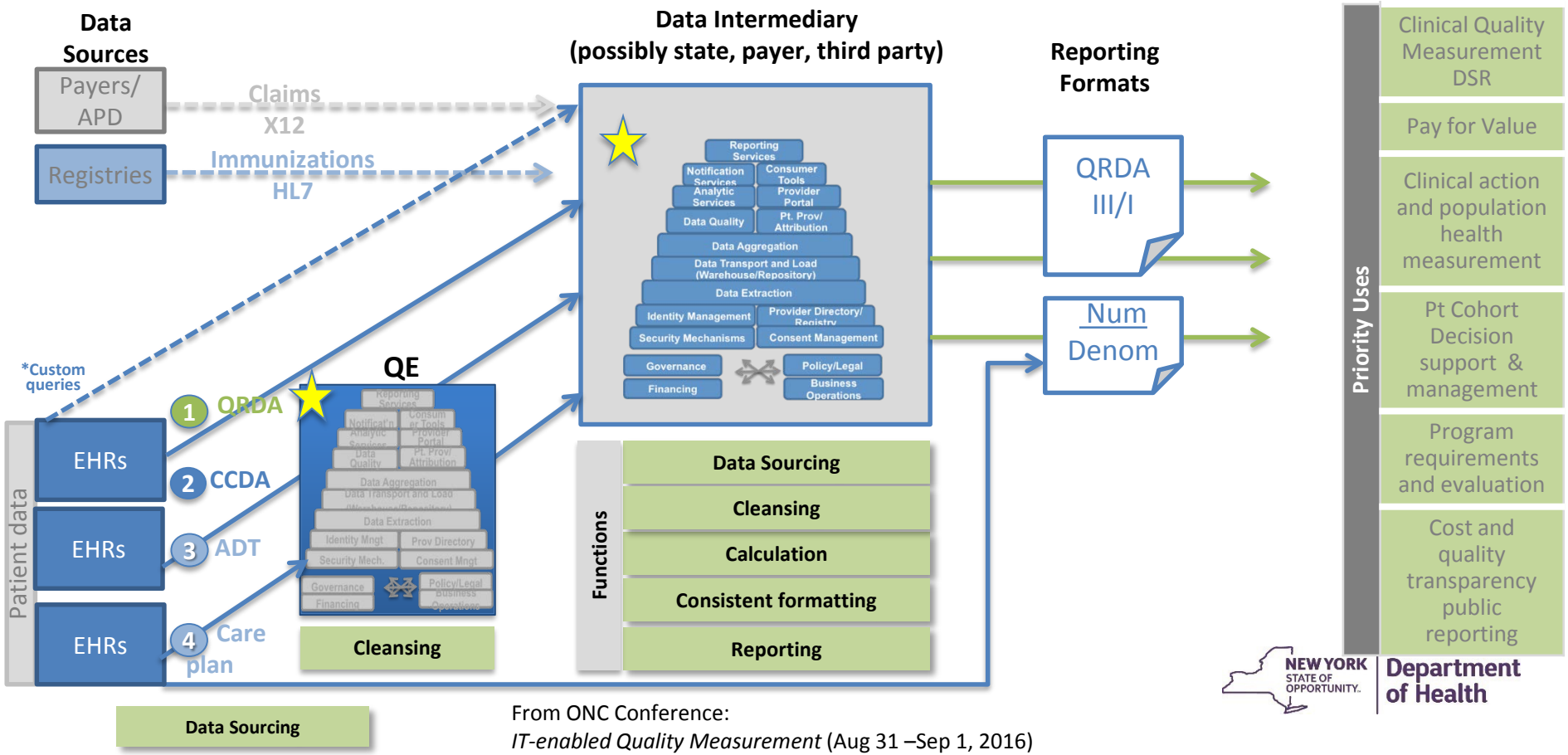
# HIT Enabled Quality Measurement

## Jim Kirkwood

# CQM Data Sources & Intermediaries




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

NEW YORK STATE OF OPPORTUNITY. Department of Health

# 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)

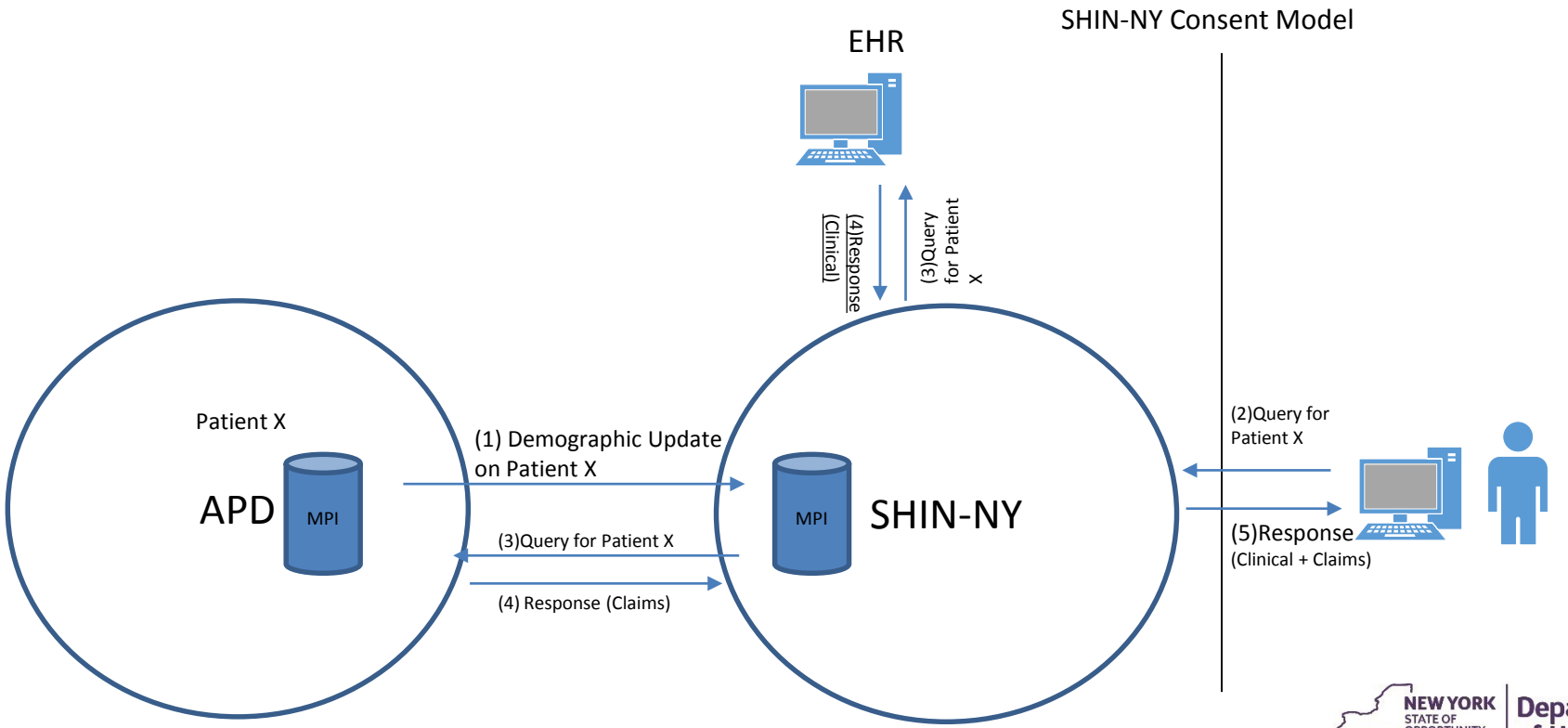
# Current SHIN-NY Activities Related to Quality Measurement

- 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

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# Discussion and Next Steps

**Patrick Roohan**
**Director**
**Office of Quality and Patient Safety**

*Next meeting: June 6, 2017 (NYC)*

NEW YORK STATE | Department of Health