NEW YORK STATE OF OPPORTUNITY. Department of Health

Transparency, Evaluation, and Health Information Technology Workgroup

Meeting #16

April 9, 2018

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 – 10:45	James Kirkwood
2	All Payer Database Public Facing Portal Demo	10:45 – 11:15	Natalie Helbig Emilio Galan (HonestHealth)
3	A Cancer Screening Clinical Information System and Quality Improvement Project for NYS Federally Qualified Health Centers	11:15 – 11:45	Heather Dacus Lisa Perry (CHCANYS)
4	Provider Directory Project	11:45 – 12:00	Mahesh Nattanmai James Kirkwood
5	Break for Lunch	12:00 – 12:30	
6	National Landscape for Interoperability ▪ Trusted Exchange Framework & Common Agreement (TEFCA)	12:30 – 1:00	Val Grey (NYeC)
7	HIT Enabled Quality Measurement – Vision Document	1:00 – 1:30	James Kirkwood Maria Ayoob (NYSTEC)
8	Bureau of Narcotic Enforcement ▪ Prescription Monitoring Program – EHR Integration	1:30 – 2:00	Josh Vinciguerra Karolina Schabses
9	Discussion and Next Meeting	2:00 – 2:15	James Kirkwood

Webex and Intercall Instructions:

InterCall participant dial-in:

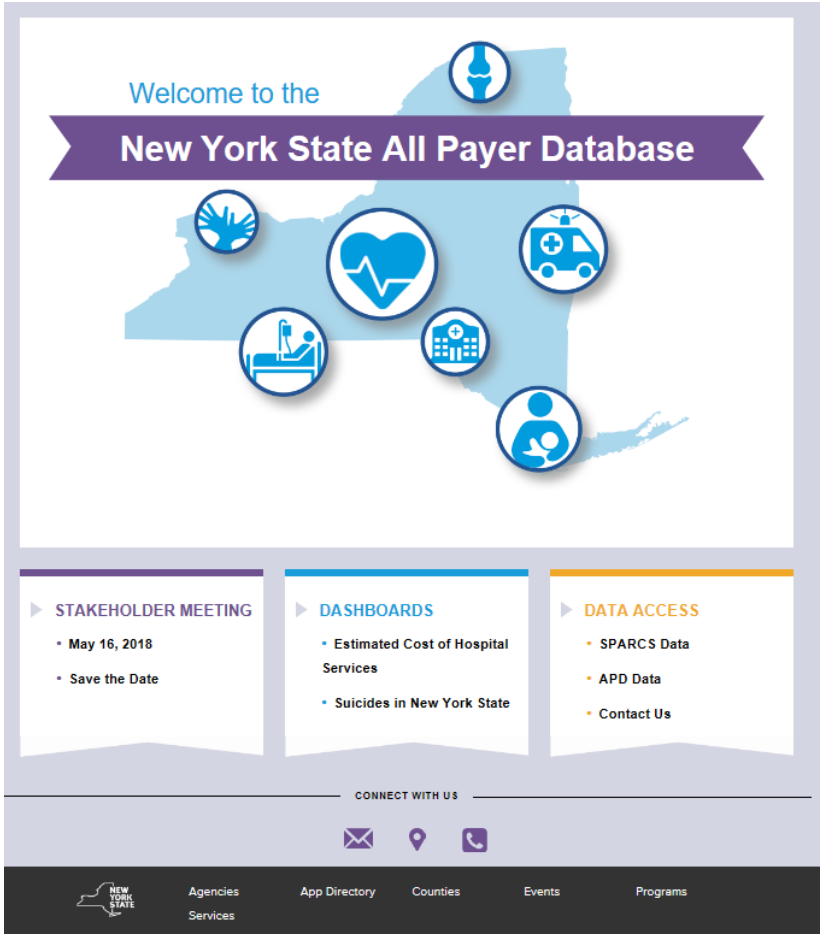
Dial: 866-292-9308 / Conference ID: 5038748

Webex:
https://meetny.webex.com/meetny/j.php?MTID=m8de4115325f0c6fc17e7caf958957972

Please use the InterCall number above, **DO NOT** use the webex call in option.

Opening Remarks

All Payer Database Public Facing Portal Demo



- Targeted Release April/May 2018
- Tableau Server
- Estimated Cost of Hospital Services
- Suicides in New York State

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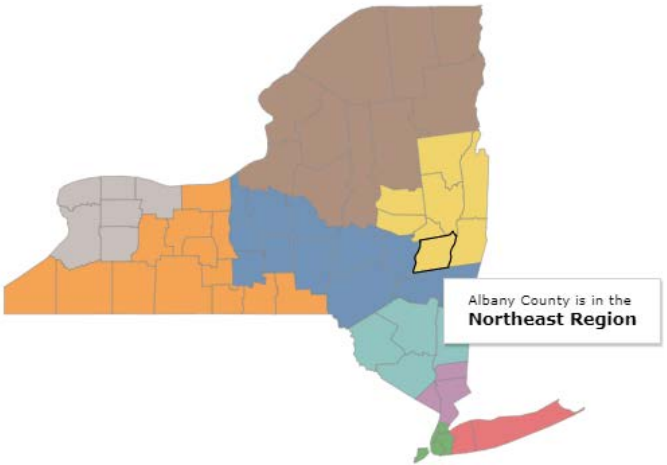
Discharge Volume and Estimated Cost of Hospital Services

Cardiac Procedures

Newborns & Deliveries

Joint Replacement Surgeries

What Is My Hospital Region?



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Joint Replacement Surgeries

Hover over the "i" for Information

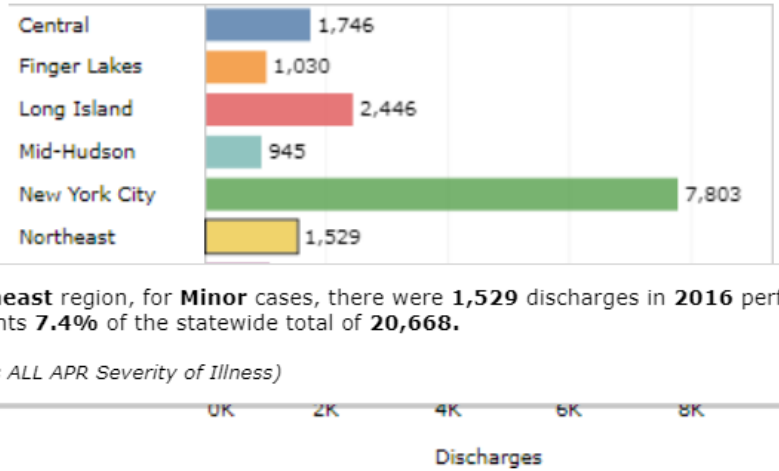
Click a Service to see the Regional Comparison on the Right

Hip Joint Replacement

Knee Joint Replacement

Discharge Volume for Knee Joint Replacement in 2016

Click on a Region to see Hospital Detail Below



In the **Northeast** region, for **Minor** cases, there were **1,529** discharges in **2016** performed by **10** facilities. This represents **7.4%** of the statewide total of **20,668.**

(Represents ALL APR Severity of Illness)*

Back to Landing Page

Metric

- (•) Discharge Volume
- ( ) Median Costs

Year

2016

Patient Severity*

Minor

*All option for Patient Severity does not apply to Median Costs

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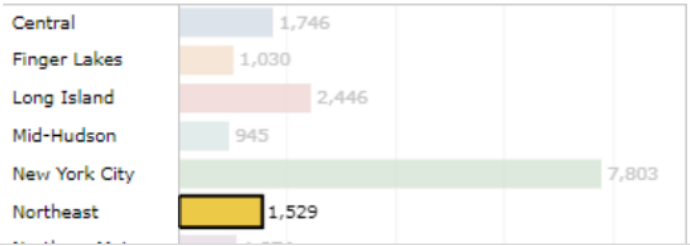

Discharge Volume for Knee Joint Replacement in 2016 in the Northeast Region

Hover or Click on Discharge Volume values for more information and to vist the NYS Health Profile Quality page for that Facility.

Facility Name	County Name	City	Discharges
St Peters Hospital	Albany	Albany	590
Albany Medical Center Hospital	Albany	Albany	297
Saratoga Hospital	Saratoga	Saratoga Springs	220
Ellis Hospital	Schenectady	Schenectady	176
Glens Falls Hospital	Warren	Glens Falls	140
St. Mary's Healthcare	Montgomery	Amsterdam	50
Samaritan Hospital	Rensselaer	Troy	33
Nathan Littauer Hospital	Fulton	Gloversville	
Albany Memorial Hospital	Albany	Albany	
St. Mary's Hospital	Rensselaer	Troy	

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Joint Replacement Surgeries

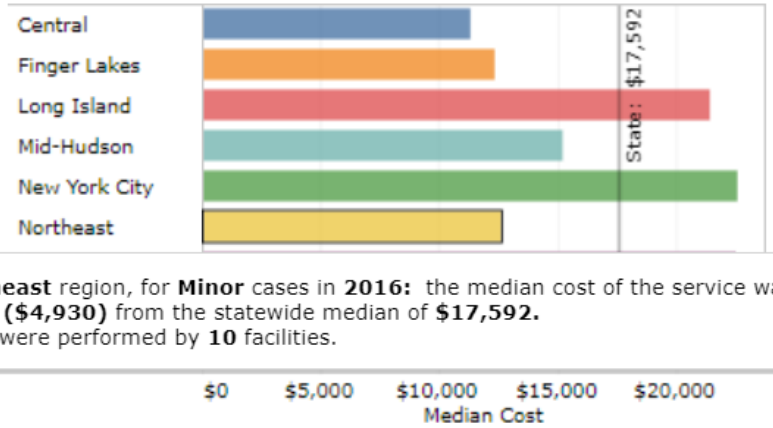
Click a Service to see the Regional Comparison on the Right

Hip Joint Replacement

Knee Joint Replacement

Median Costs for None in 2016

Click on a Region to see Hospital Detail Below



In the **Northeast** region, for **Minor** cases in **2016:** the median cost of the service was **$12,662** which is a difference of **($4,930)** from the statewide median of **$17,592.**
These cases were performed by **10** facilities.

Back to Landing Page

Metric

- ○ Discharge Volume
- ◉ Median Costs

Year

2016

Patient Severity*

Minor

*All option for Patient Severity does not apply to Median Costs

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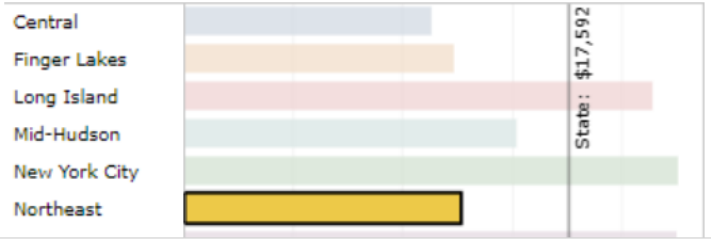

Year
2016

Patient Severity*
Minor

*All option for Patient Severity does not apply to Median Costs

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These cases were performed by **10** facilities.

Median Costs for Knee Joint Replacement in 2016 in the Northeast Region

Hover or Click on Median Costs values for more information and to vist the NYS Health Profile Quality page for that Facility.

Facility Name	County Name	City	Median Cost
Albany Memorial Hospital	Albany	Albany	$15,430
Glens Falls Hospital	Warren	Glens Falls	$14,925
Nathan Littauer Hospital	Fulton	Gloversville	$14,103
Albany Medical Center Hospital	Albany	Albany	$13,735
Ellis Hospital	Schenectady	Schenectady	$13,112
Saratoga Hospital	Saratoga	Saratoga Springs	$12,384
St Peters Hospital	Albany	Albany	$10,984
St. Mary's Hospital	Rensselaer	Troy	$9,229
Samaritan Hospital	Rensselaer	Troy	
St. Mary's Healthcare	Montgomery	Amsterdam	

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Median Costs for Knee Joint Replacement in 2016 in the Northeast Region

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Saratoga Hospital	Saratoga	Saratoga Springs	$12,384
St Peters Hospital	Albany	Albany	$10,984
St. Mary's Hospital			
Samaritan Hospital			
St. Mary's Healthcare			

St Peters Hospital is in **Albany** in **Albany** County; part of the **Northeast** region.
In **2016**, the median cost for **Knee Joint Replacement** was **$10,984** and there were **590** discharges**.**

This facility is located at:
315 South Manning Blvd
Albany, NY 12208

For more information on this facility, **click on the Median Costs value** to visit the quality section of the NYS Health Profile.

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St Peters Hospital

Search County/Region

Overview | Quality | Maternity | Surgery | Inspections

St Peters Hospital

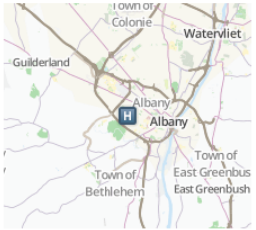
Quality in hospitals can be described as "doing the right thing, at the right time, in the right way—and having the best possible results." This report provides information on how well the hospitals in New York care for patients with a wide range of health problems. It can help you choose a hospital for yourself and provide useful information for your loved ones if they need hospital care. Read more about hospital quality.

Complications	○	0.79
Deaths - Cardiac Surgery	○	
Deaths - Other Conditions	△	0.88
Deaths - Stroke	○	
Emergency Department Timeliness	▽	43 mins
Hospital-Acquired Infections - Bloodstream	○	0.66
Hospital-Acquired Infections - Surgical Site	○	0.94 per 100
Patient Satisfaction	○	68.00%
Readmissions Within 30 Days	○	14.90%
Timely and Effective Care	○	

Legend more information

△ = High Performer
○ = Average Performer
▽ = Poor Performer
○ = No Comparison Available

Directions



My Providers compare these

To compare facilities, click on the icon next to each facility's name.

Print these clear

My Measures

To add measures here, click on the icon by the measure name on the measure compare page

clear

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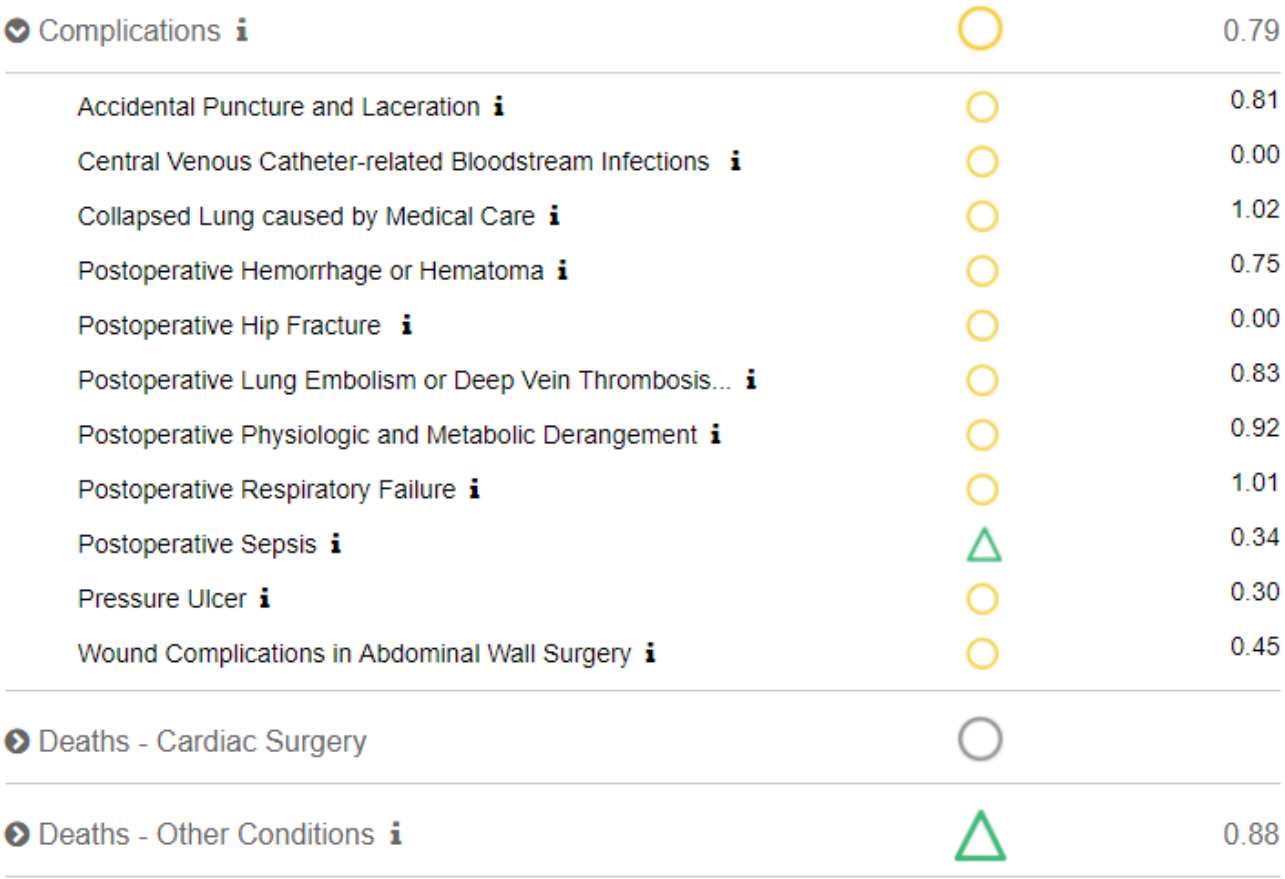

Complications	○	0.79
Accidental Puncture and Laceration	○	0.81
Central Venous Catheter-related Bloodstream Infections	○	0.00
Collapsed Lung caused by Medical Care	○	1.02
Postoperative Hemorrhage or Hematoma	○	0.75
Postoperative Hip Fracture	○	0.00
Postoperative Lung Embolism or Deep Vein Thrombosis...	○	0.83
Postoperative Physiologic and Metabolic Derangement	○	0.92
Postoperative Respiratory Failure	○	1.01
Postoperative Sepsis	△	0.34
Pressure Ulcer	○	0.30
Wound Complications in Abdominal Wall Surgery	○	0.45
Deaths - Cardiac Surgery	○	
Deaths - Other Conditions	△	0.88

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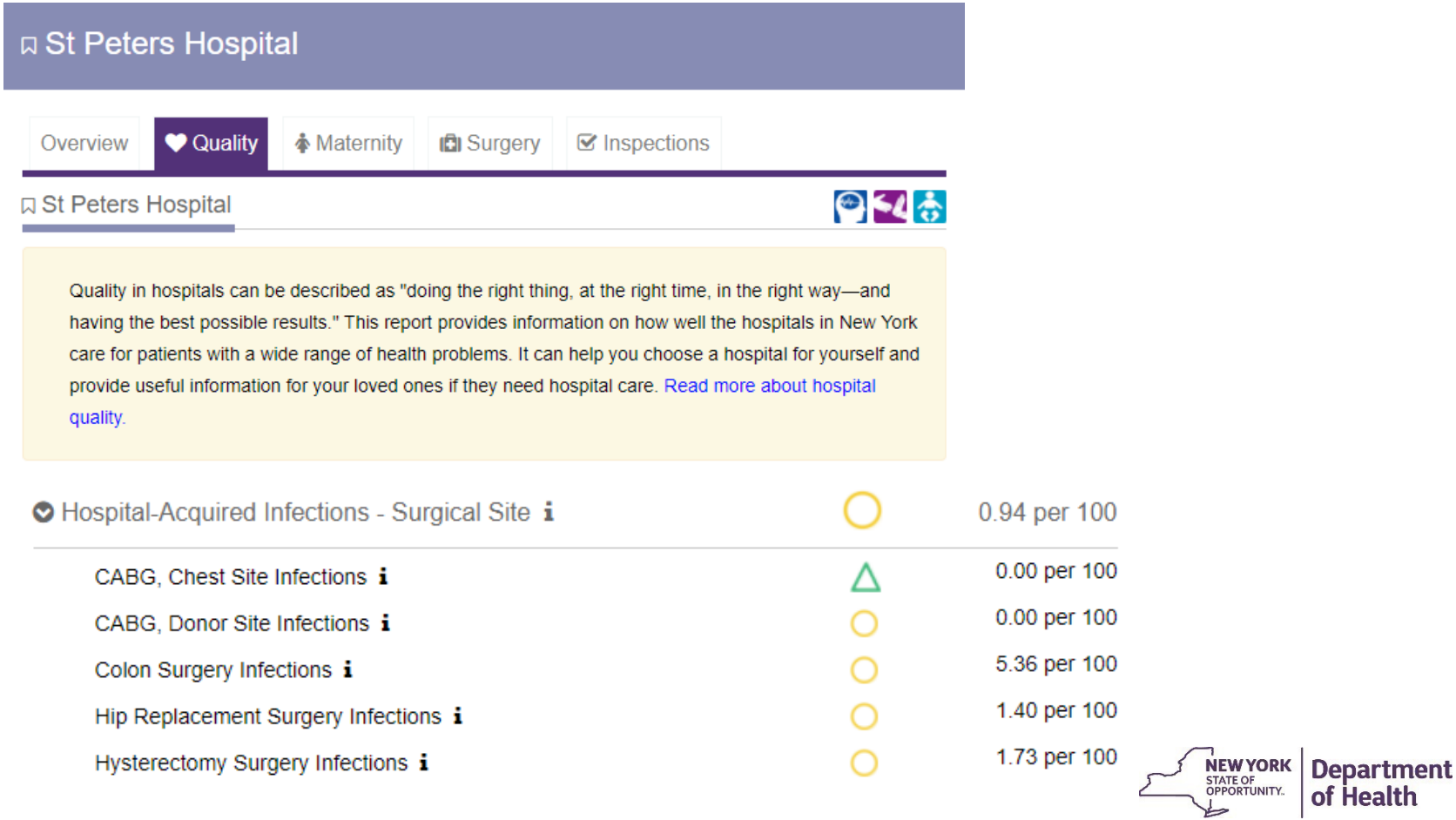

St Peters Hospital

Overview | Quality | Maternity | Surgery | Inspections

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Hospital-Acquired Infections - Surgical Site	○	0.94 per 100
CABG, Chest Site Infections	△	0.00 per 100
CABG, Donor Site Infections	○	0.00 per 100
Colon Surgery Infections	○	5.36 per 100
Hip Replacement Surgery Infections	○	1.40 per 100
Hysterectomy Surgery Infections	○	1.73 per 100

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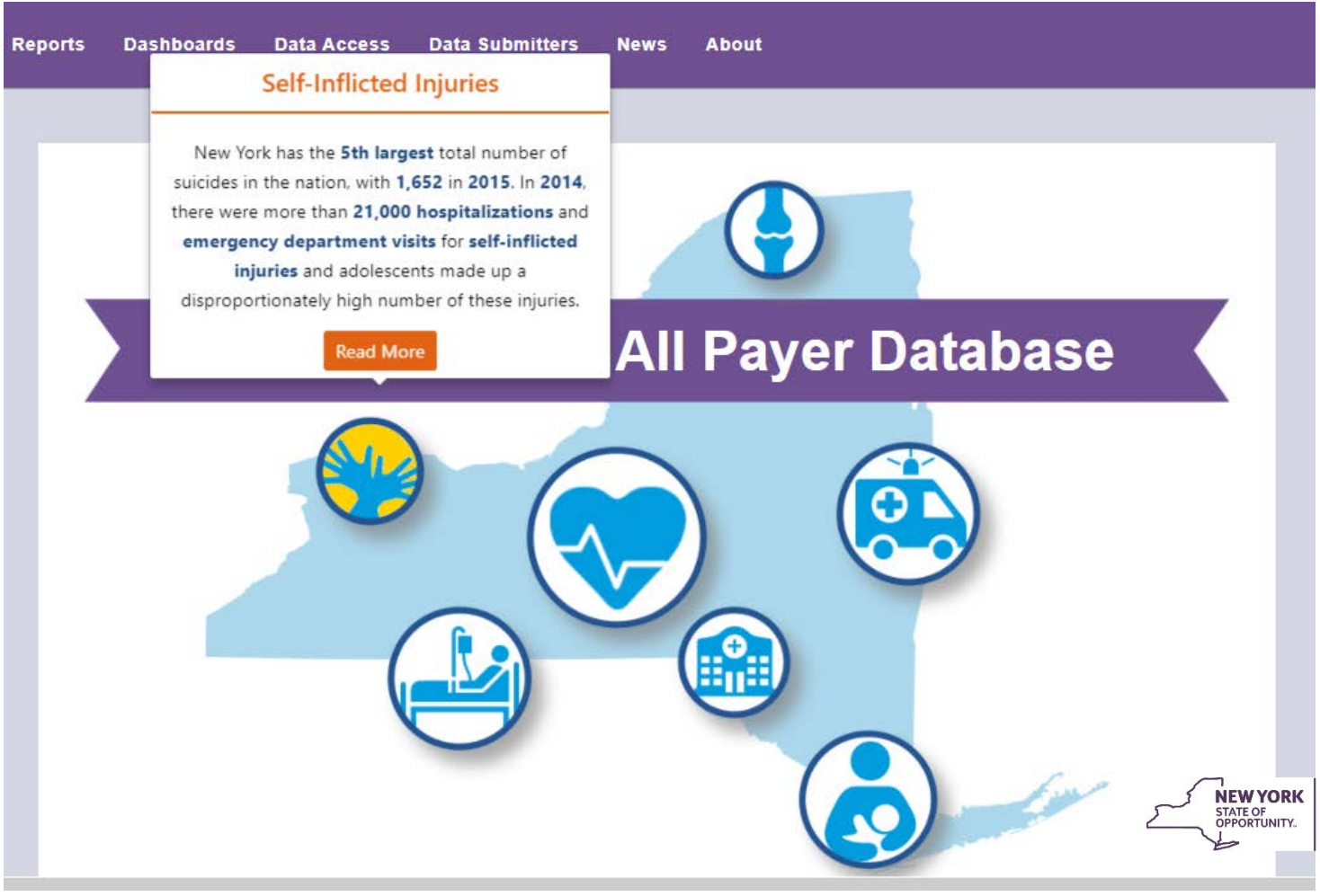
Reports
Dashboards
Data Access
Data Submitters
News
About
Self-Inflicted Injuries
New York has the 5th largest total number of suicides in the nation, with 1,652 in 2015. In 2014, there were more than 21,000 hospitalizations and emergency department visits for self-inflicted injuries and adolescents made up a disproportionately high number of these injuries.
Read More
All Payer Database
NEW YORK
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of Health

Suicides in New York State

Death by Suicide | Death by Suicide by County and Demographics

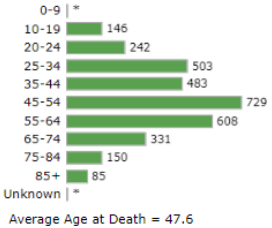
Deaths by Suicide

Hover over the "i" for Information

Death Rate per 100,000 vs Number of Deaths
- (•) Number of Deaths
- ( ) Death Rate per 100,000

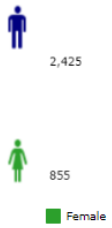
Number of Deaths			% Difference from 2014 to 2015
	2014	2015	
New York City	530	482	▼-9.1%
Rest of State	1,125	1,143	▲1.6%
Statewide	1,655	1,625	▼-1.8%

Suicide Deaths by Age Group

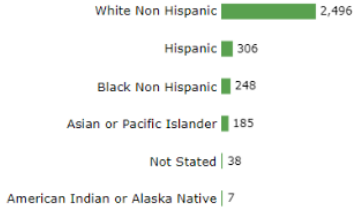


Average Age at Death = 47.6

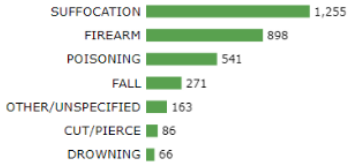
Suicide Deaths by Gender



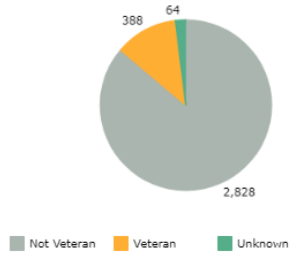
Suicide Deaths by Race



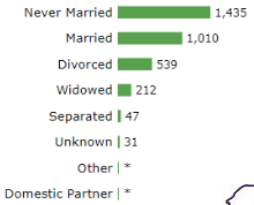
Suicide Deaths by Mechanism of Self-Harm



Suicide Deaths by Veteran Status



Suicide Deaths by Marital Status



*** Indicates that the number of deaths is less than 6**

NEW YORK STATE OF OPPORTUNITY. Department of Health

April 9, 2018

Suicides in New York State

Death by Suicide | Death by Suicide by County and Demographics

Deaths by Suicide

Hover over the "i" for Information

Death Rate per 100,000 vs Number of Deaths

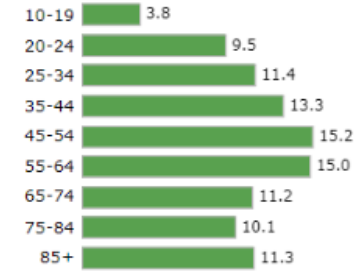
- Number of Deaths
- Death Rate per 100,000

Death Rate per 100,000			% Difference from 2014 to 2015
	2014	2015	
New York City	6.2	5.6	▼-9.7%
Rest of State	10.0	10.2	▲2.0%
Statewide	8.4		

Death Rate per 100,000: **10.2**
Year: **2015**
New York City or Rest of State: **Rest of State**

Numerator: **1,143**
Denominator: **11,227,200**

Suicide Deaths by Age Group

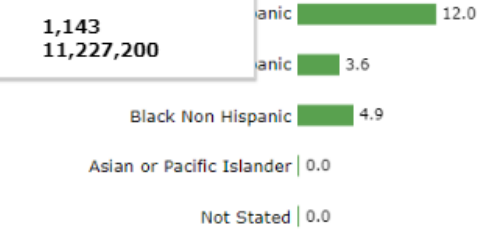


Average Age at Death = 48.3

Suicide Dea

Male | Female

hs by Race



NEW YORK STATE OF OPPORTUNITY. Department of Health

Suicides in New York State

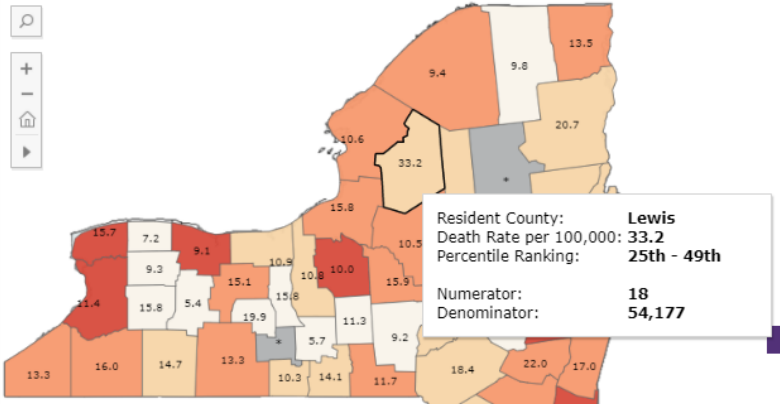
Death by Suicide | Death by Suicide by County and Demographics

Deaths from Suicide from 2014 - 2015

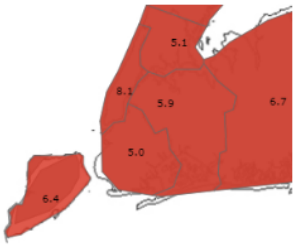
Hover over the "i" for Information

Death Rate per 100,000 vs Number of Deaths
- Number of Deaths
- Death Rate per 100,000

Suicide Deaths by County

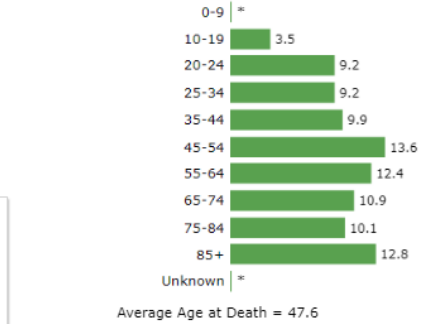


Suicide Deaths for New York City



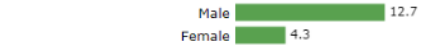
Percentiles
- 0-24th
- 25th - 49th
- 50th - 74th
- 75th - 100th
- Deaths less than 6

Suicide Deaths by Age Group

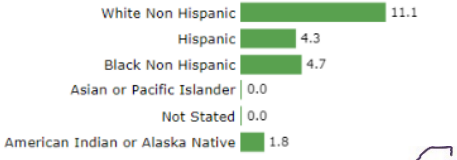


Average Age at Death = 47.6

Suicide Deaths by Gender



Suicide Deaths by Race



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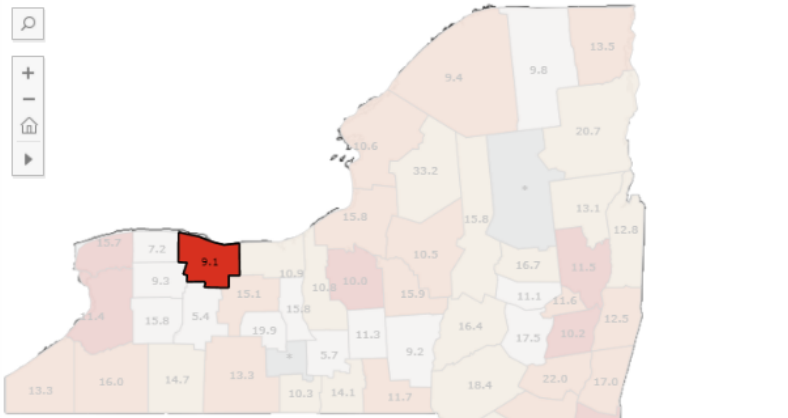

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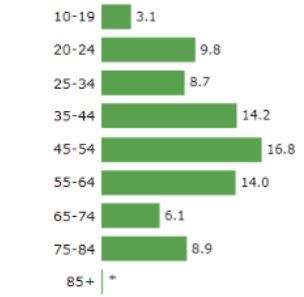
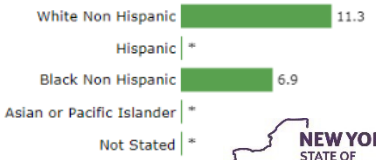


Average Age at Death = 46.1

Suicide Deaths by Gender

Suicide Deaths by Race



NEW YORK STATE OF OPPORTUNITY. Department of Health

Timeline

May 2018	Public Web Release
	1st Release of Analytic Portal (Sign-in) (SPARCS and Vital Statistics Mortality)
	1st Release Subject Matter Expert (SME) of APD ODS
	- Member, Provider, Claims, Issuer/Plan
	Stakeholder Meeting May 16th
June/July 2018	2nd Release of Analytic Portal (Sign-in)
	2nd Release of APD ODS
	- Member, Provider, Claims, Issuer/Plan

QUESTIONS?

FIND OUT MORE.

nysapd@health.ny.gov

NEW YORK STATE OF OPPORTUNITY. Department of Health

honesthealth

LEVERAGING THE APD FOR CONSUMERS

Emilio Galan, MSc
Chief Executive Officer
emiliogalan@honesthealth.org

ABOUT US

HonestHealth performs evaluation, design, and software development exclusively for health care transparency efforts.

BACKGROUND

New York has **invested in the data** to uniquely empower its residents for healthcare decisions with the APD, PNDS, and other resources.

LEVERAGING DATA TO SUPPORT CONSUMERS

One possibility to consider for NY is a **comprehensive tool** that leverages the robust data availability within New York across the Provider Network Data System (PNDS), upcoming All Payer Database (APD), and other resources.

- **Low Utilization**
  Health care transparency tools drastically vary in utilization and most have low use rates.

- **Design Matters**
  90% of State-based tools we evaluated for CPR performed poorly, because of functionality and user-friendliness, not data.

- **Hundreds of Tools**
  Consumers already use a number of tools to look-up information about their health care. Consider these as conduits for disseminating NY's unique data.

GUIDING PRINCIPLES

DESIGNS:
DATA AVAILABILITY

Quality, Price, and Network information

NEW YORK STATE Department of Health

Services News Government Local Location Translate

Department of Health Individuals/ Families Providers/Professionals Health Facilities Search

Sort by: Estimated Price

Distance

Languages

Network

Designations

Quality Rating

Price

Hospitals | Vaginal Birth | near | Manhattan, New York 10082

Showing hospitals for vaginal birth for MVP Liberty Plan

Viewmont Hospital Center

Hospital • 462 First Avenue (0.5 mi)

Quality

$6,450 Total Payment

How Much Will I Pay?

Updated 7/2017 ✓ In-Network ✓ SAFE Center of Excellence ✓ Perinatal Center

Is this information reliable? Learn more

Jacobson Hospital

Hospital • 3001 Haste St. (0.7 mi)

Quality

$6,450 Total Payment

Updated 7/2017 ✓ In-Network ✓ SAFE Center of Excellence ✓ Perinatal Center

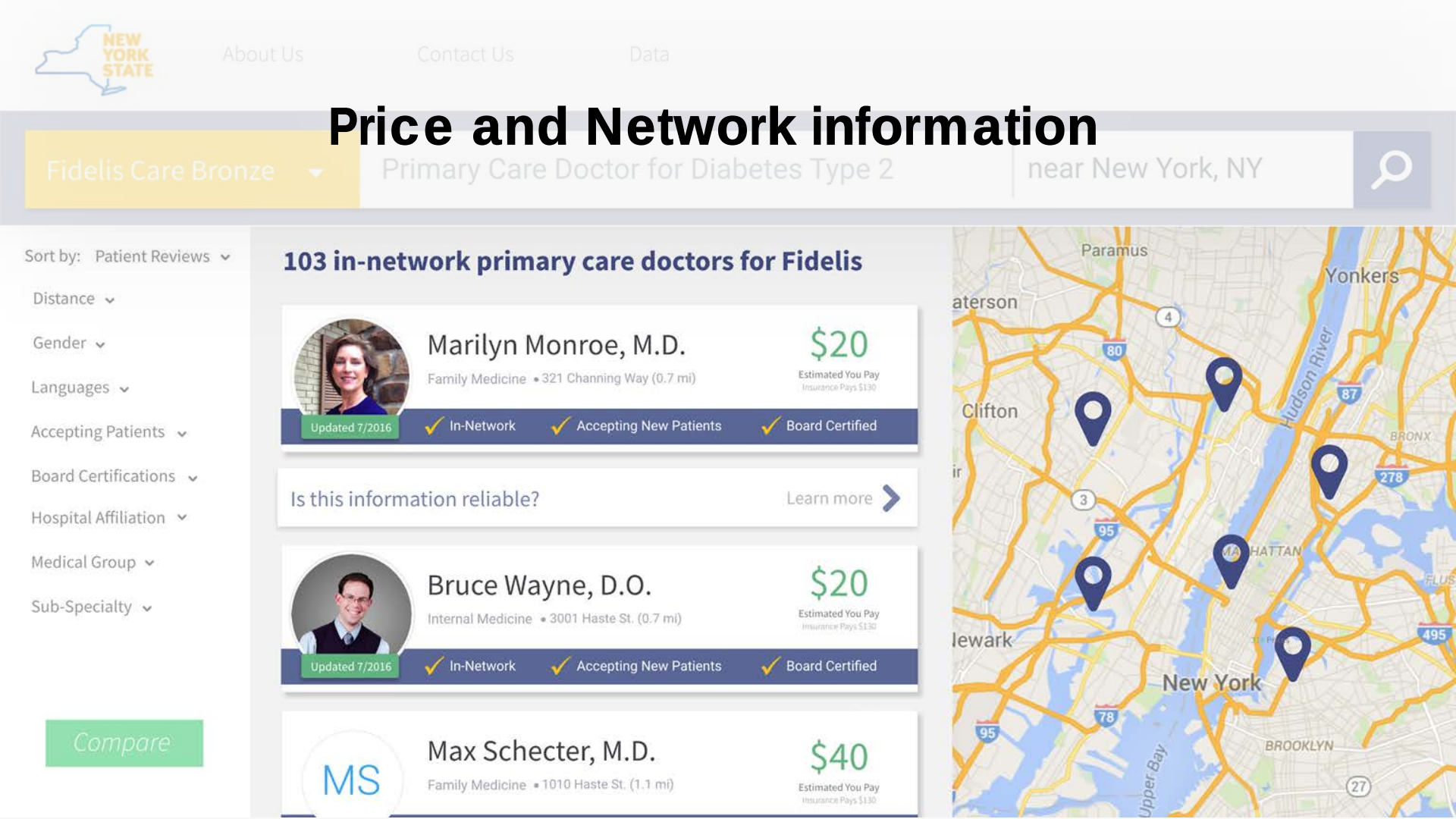
Berkeley Medical Center

Hospital • 1010 Haste St. (1.1 mi)

Quality

$6,450 Total Payment

Price and Network information



Quality and Network information

NEW YORK STATE | Department of Health

Services News Government Local Location Translate

Department of Health | Individuals/ Families | Providers/Professionals | Health Facilities | Search

Sort by: Estimated Price

Distance

Languages

Network

Designations

Quality Rating

Price

Compare

Hospitals | Childbirth | near | Manhattan, New York 10082

Viewmont Hospital Center

Hospital • 462 First Avenue (0.5 mi)

Quality

Updated 7/2016 | ✓ In-Network | ✓ SAFE Center of Excellence | ✓ Perinatal Center

Is this information reliable? Learn more

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Hospital • 3001 Haste St. (0.7 mi)

Quality

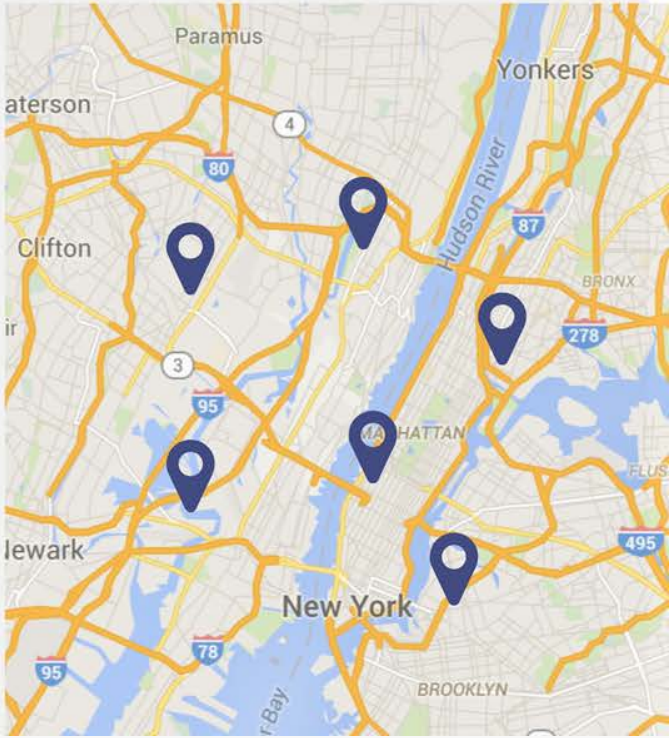
Updated 7/2016 | ✓ In-Network | ✓ SAFE Center of Excellence | ✓ Perinatal Center

Berkeley Medical Center

Hospital • 1010 Haste St. (1.1 mi)

Quality

Updated 7/2016 | ✗ Out-of-Network | ✓ SAFE Center of Excellence | ✓ Perinatal Center



Only Network information

NEW YORK STATE Department of Health

Services News Government Local Location Translate

Department of Health

Individuals/ Families Providers/Professionals Health Facilities Search

Sort by: Match

Distance

Gender

Languages

Accepting Patients

Board Certifications

Hospital Affiliation

Medical Group

Sub-Specialty

Doctors Childbirth

near Manhattan, New York 10082

Marilyn Monroe, M.D.

OBGYN • 321 Channing Way (0.7 mi)

Updated 7/2017 ✓ In-Network ✓ Accepting New Patients ✓ Board Certified

Is this information reliable? Learn more

Bruce Wayne, D.O.

OBGYN • 3001 Haste St. (0.7 mi)

Updated 7/2017 ✓ In-Network ✓ Accepting New Patients ✓ Board Certified

MS

Max Schecter, M.D.

OBGYN • 1010 Haste St. (1.1 mi)

Updated 7/2017 ✗ Out-of-Network ✗ Accepting New Patients ✓ Board Certified

PICKING PRICE DATA

PRICE SOURCE

Chargemasters

Contracts

Claims

PROVIDER SPECIFICITY*

Average for a geography (state, MSA, 3-digit zip)

Average for provider group

Average for an individual provider

PAYER SPECIFICITY

Average for Payer Type (e.g. all commercial carriers)

Average for a specific carrier (e.g Aetna)

Average for an individual plan (e.g. Aetna POS II)

PATIENT SPECIFICITY

Average total payment

Average out-of-pocket for patients

Specific out-of-pocket based on a benefit design and deductible status

*** Bundling**

About Us Contact Us Data

Geographic Average for Total Payment

Fidelis Care Bronze | Diabetes Type 2 | near New York, NY

Diabetes is a chronic disease due to high levels of sugar in the blood due to decreasing sensitivity to insulin, a hormone released by the pancrease to control blood sugar levels. More

$401 - $6,019

Average total paid by insurer and patient for Diabetes Type 2 medical care

Primary Care Doctor

Primary care doctors manage your medical conditions to keep keep you healthy.

$110

average spent by insurer and patient per visit

Search

Endocrinologist

Endocrinologist is a doctor that specializes in disorders of hormones.

$305

average spent by insurer and patient per visit

Search

Opthamologist

Opthamologist is a doctor who specializes in disorders of the eye.

$340

average spent by insurer and patient per visit

Search

Lab Services

Lab services include all blood tests that a doctor might order to monitor your condition.

$80

average spent by insurer and patient per visit

Search

Geographic Average for Total Payment

NEW YORK STATE

About Us Contact Us Data

Fidelis Care Bronze | Primary Care Doctor for Diabetes Type 2 | near New York, NY

Sort by: Patient Reviews

Distance

Gender

Languages

Accepting Patients

Board Certifications

Hospital Affiliation

Medical Group

Sub-Specialty

Compare

Total spent by insurance and patient ranges from: $180-$430

Marilyn Monroe, M.D.

Family Medicine • 321 Channing Way (0.7 mi)

Quality

Updated 7/2016 In-Network Accepting New Patients Board Certified

Is this information reliable? Learn more

Bruce Wayne, D.O.

Internal Medicine • 3001 Haste St. (0.7 mi)

Quality

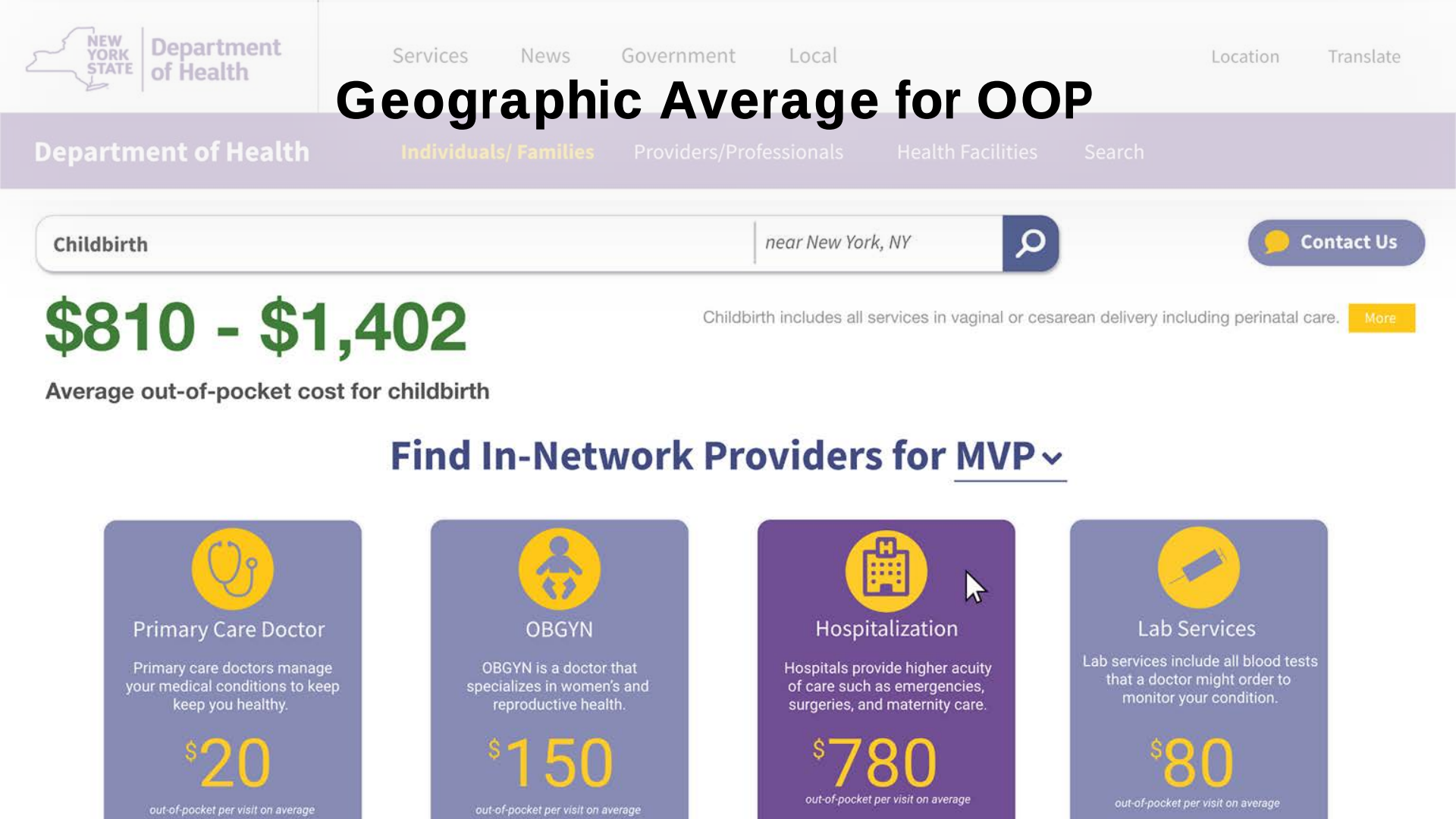
Updated 7/2016 In-Network Accepting New Patients Board Certified

MS

Max Schecter, M.D.

Family Medicine • 1010 Haste St. (1.1 mi)

Quality


NEW YORK STATE
Department of Health
Services
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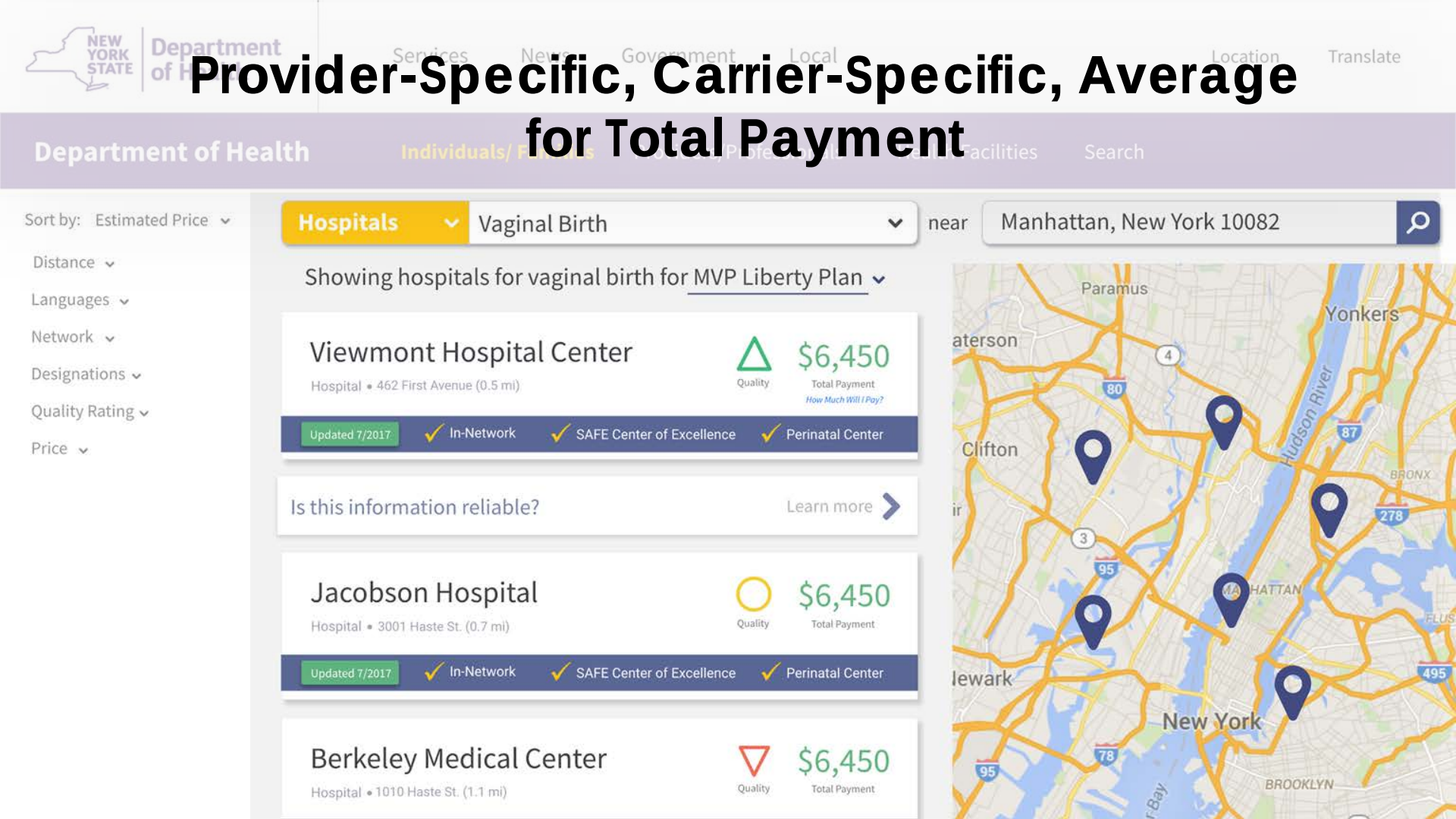
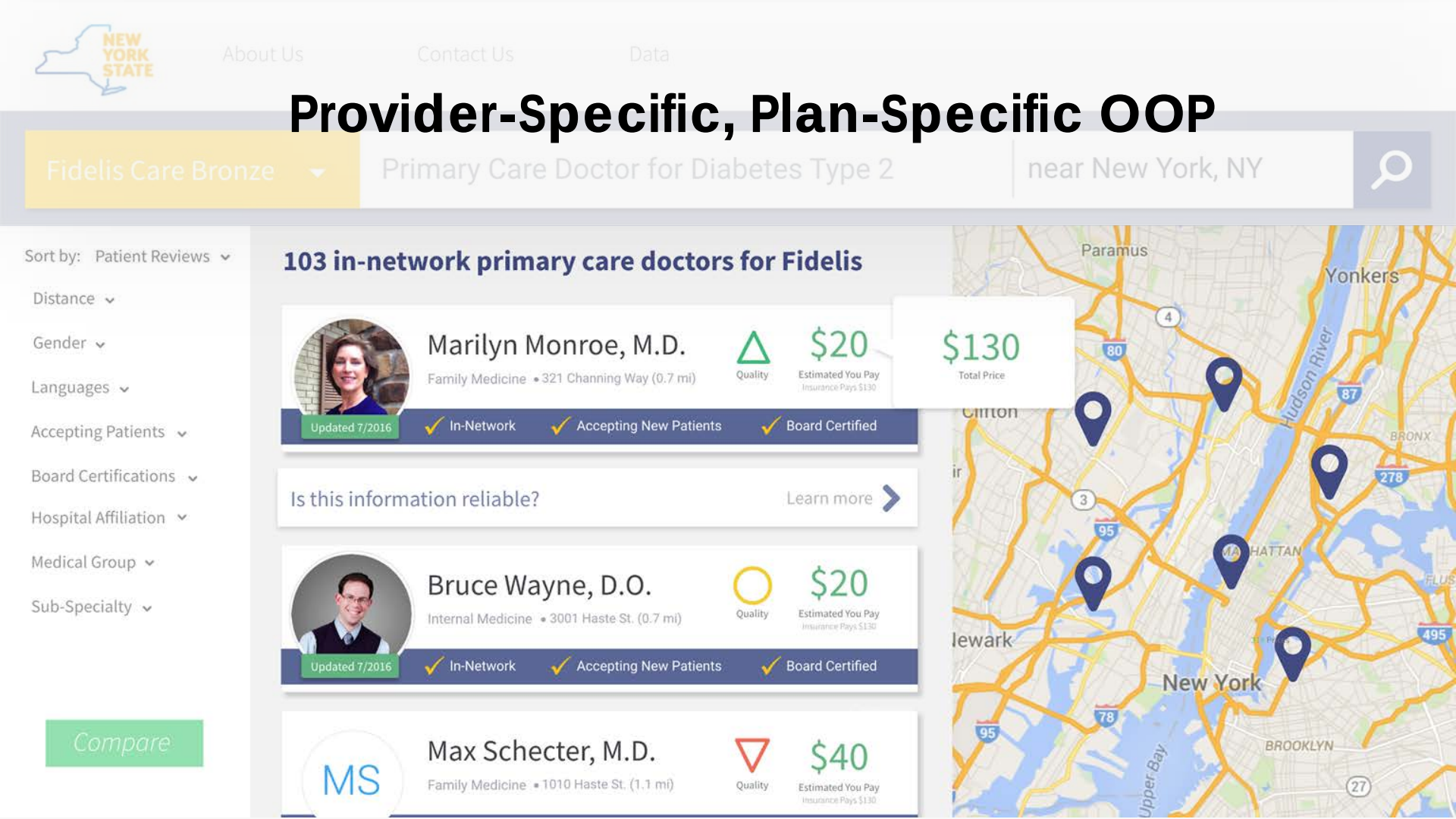
Location
Translate
Geographic Average for OOP
Department of Health
Individuals/ Families
Providers/Professionals
Health Facilities
Search
Childbirth
near New York, NY
Contact Us
$810 - $1,402
Average out-of-pocket cost for childbirth
Childbirth includes all services in vaginal or cesarean delivery including perinatal care.
More
Find In-Network Providers for MVP
Primary Care Doctor
Primary care doctors manage your medical conditions to keep keep you healthy.
$20
out-of-pocket per visit on average
OBGYN
OBGYN is a doctor that specializes in women's and reproductive health.
$150
out-of-pocket per visit on average
Hospitalization
Hospitals provide higher acuity of care such as emergencies, surgeries, and maternity care.
$780
out-of-pocket per visit on average
Lab Services
Lab services include all blood tests that a doctor might order to monitor your condition.
$80
out-of-pocket per visit on average

Provider-Specific, Carrier-Specific, Average for Total Payment

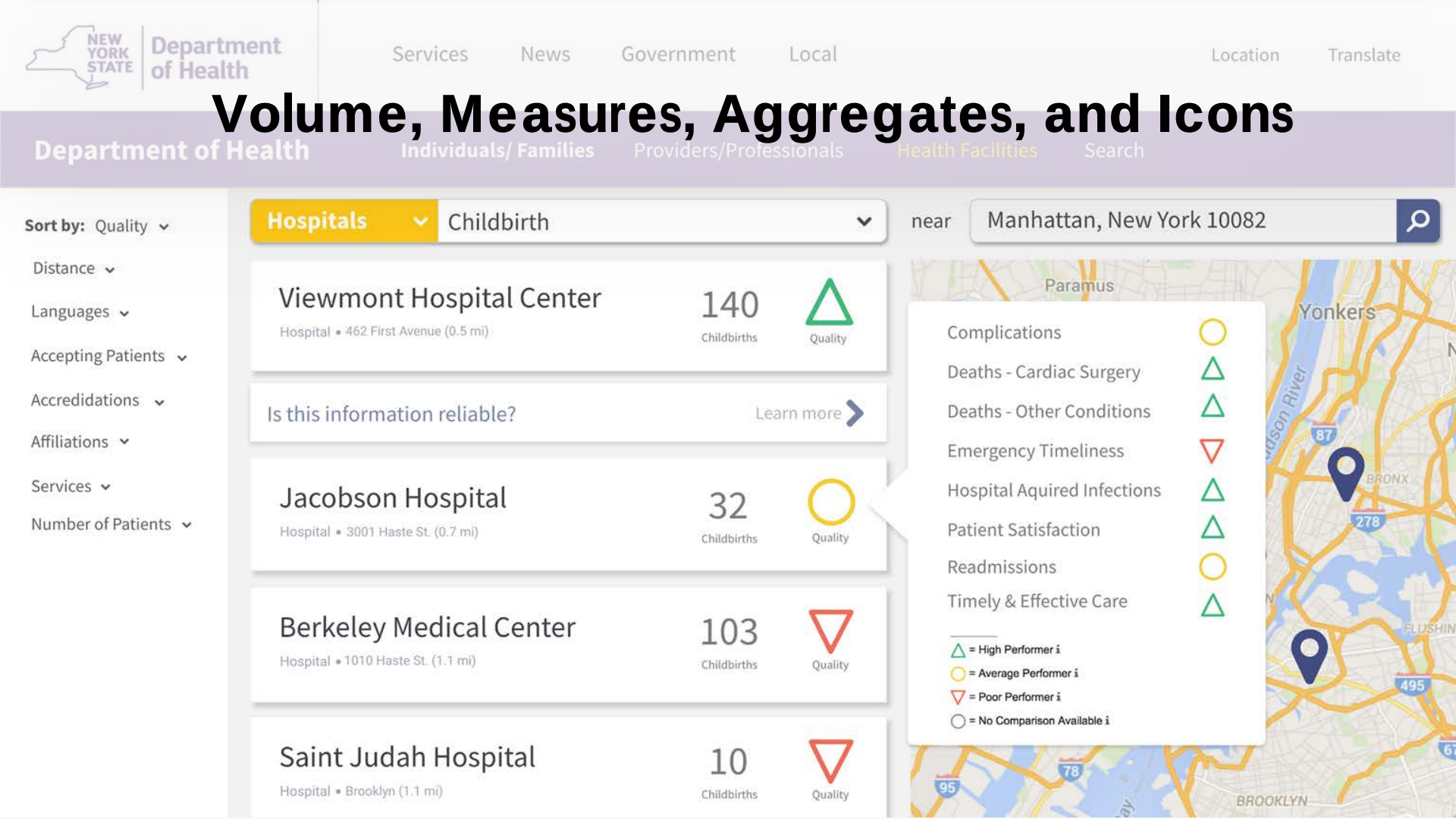


Provider-Specific, Plan-Specific OOP



DESIGNS:
BRIEFLY ON QUALITY

Volume, Measures, Aggregates, and Icons



NEXT STEPS

Review the Consumer needs in NY

Determine data availability such as price specificity

After inventorying best practices, decide to partner or develop

THANK YOU!

Emilio Galan, MSc

Chief Executive Officer

emiliogalan@honesthealth.org

A Cancer Screening Clinical Information System and Quality Improvement Project for NYS Federally Qualified Health Centers

Today's Presenters

Heather Dacus, DO, MPH

Bureau of Cancer Prevention and Control

NYS Department of Health / Office of Public Health

Lisa Perry, MPP, MBA

Sr. Vice President, Quality & Technology Initiatives

Community Health Care Association of NYS (CHCANYS)

NEW YORK STATE OF OPPORTUNITY. Department of Health

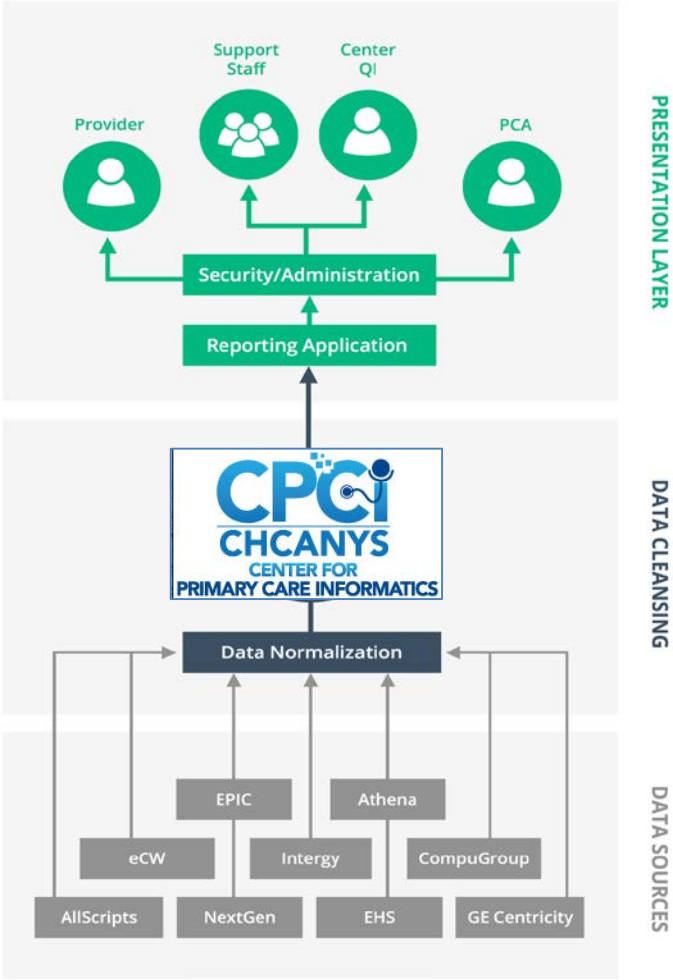
Develop and use a clinical information system within the CHCANYS Center for Primary Care Informatics to provide quality improvement support around improving breast, cervical and colorectal cancer screening rates in NYS FQHCs. July 2012 – June 2018

NEW YORK STATE | Department of Health

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

IPRO

NEW YORK STATE OF OPPORTUNITY. | Department of Health



Data System = CHCANYS Center for Primary Care Informatics (CPCI)

- Extracts data from EHRs
- Calculates performance results
- Displays performance dashboards
- Provides clinical workflow tools
- Add'l functionalities (to be mentioned later)

NEW YORK STATE OF OPPORTUNITY. Department of Health

Key Project Activities

Recruitment & Connections

Data Validation

Data & Clinical Quality Improvement Support

Evaluation

NEW YORK STATE OF OPPORTUNITY. Department of Health

FQHC Recruitment & CPCI Connections

Connect at least 75% of NYS FQHCs to system	80% of NY FQHCs connected to CPCI as of January 2018

- 52 FQHCs connected to the CPCI
- 9 different EHRs mapped to the CPCI
- 3 Cohorts of 11-12 FQHCs participated in QI work

Cohort 1	Cohort 2	Cohort 3
Anthony L. Jordan*	Access CHC*	APICHA
CHC North Country	Betances Health Center	Bedford Stuyvesant
Community HCN	Brownsville Family CHC	Boriken
Cornerstone	CHC Richmond	CHC Buffalo
Hometown Health	Damian*	Family Health Network
Hudson River HC	Ezras Cholim	Harlem United
Institute for Family Health	Finger Lakes	Housing Works
Morris Heights	Lutheran/Sunset	ICL Healthcare Choices
Oak Orchard	Project Renewal	North Country Family Hlth.
Open Door	Settlement	NOCHSI
Regional Primary Care Network	William F. Ryan	Urban Health Center
Whitney M. Young		

NEW YORK STATE OF OPPORTUNITY. Department of Health

Data Validation

Validate data between CPCI and FQHC EHRs

- Sample of CPCI patient data compared to data from clinic EHRs
  - Calculated agreement statistics for each measure
- Practice-specific feedback → actionable results shared with FQHCs

Quality Improvement Support

12-months of data & clinical QI support to FQHCs	3 cohorts representing 34 FQHCs participated in 12-month interventions

- Kick-Off Meetings, webinars, emails, coaching calls and in-person meeting with QI Teams

- Mapping support, training on use of EHR structured fields, self-validation training

The Pre-Visit Planning Report

Gunther, Eric — 1 Scheduled Appointment

Export this Provider to PDF

1:00 PM | Wednesday, October 11, 2017 — **Visit Reason: Annual Visit**

RUNYAN, WILLENE	Sex at Birth: F	Phone: 781-705-1682	Last Phys:	PCP: Black, Ronda
MRN: 9849397	Gender Identity: Female	Language: Spanish	Portal Access: N	Payer: Coventry
DOB: 4/13/1994 (23 years)	Sexual Orientation: Bisexual	Risk: High		Care Manager: MARDELL KERNODLE

Diagnoses (12)

ASD	CNMP	IVD
ASM	COPD	Pre-DM
CAD	DM	SCZ
CAD/No MI	HIV	SMI

Risk Factors (1)

TOB

SDOH (10)

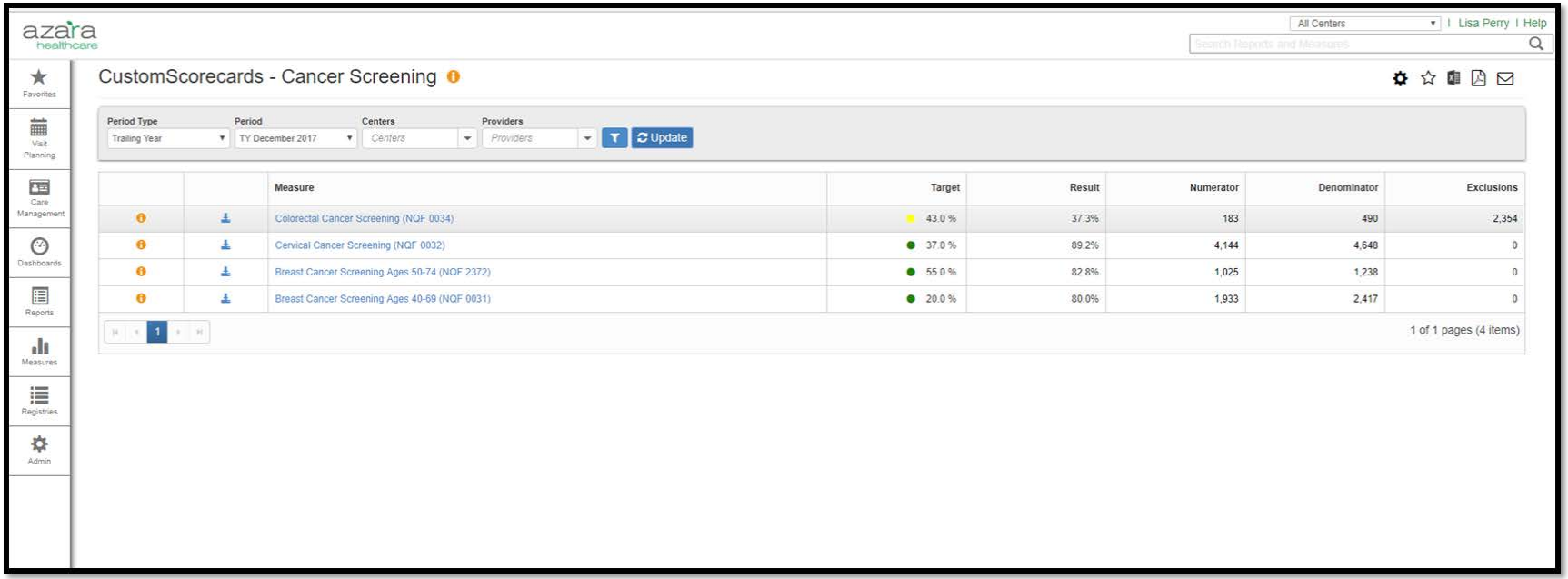
HOMELESS	MED/CARE	RACE
HOUSING	CHILDCARE	MIGRANT
FPL<200%	CLOTHING	
UTILITY	STRESS	

DEMO DATA

Alert	Message	Most Recent Date	Most Recent Result
Pap	Overdue		
Pap HPV	Overdue		
Gonorrhea	Overdue		
Hep C	Missing	9/18/2015	
BMI	Missing Follow-up	6/23/2017	18.00
Violence Scr	Overdue		
Flu	Missing		
HPV	Missing		
Tetanus	Overdue		
Eye	Overdue		
Foot	Overdue		
Statin Rx	Overdue		

Open Referral w/o Result	Specialist/Location	Ordered Date	Appt. Date

Scorecards – Clinical Measures



Outcomes To-Date

Clinic Screening Rates

Did cancer screening rates improve among participating FQHCs?

CPCI Data Quality

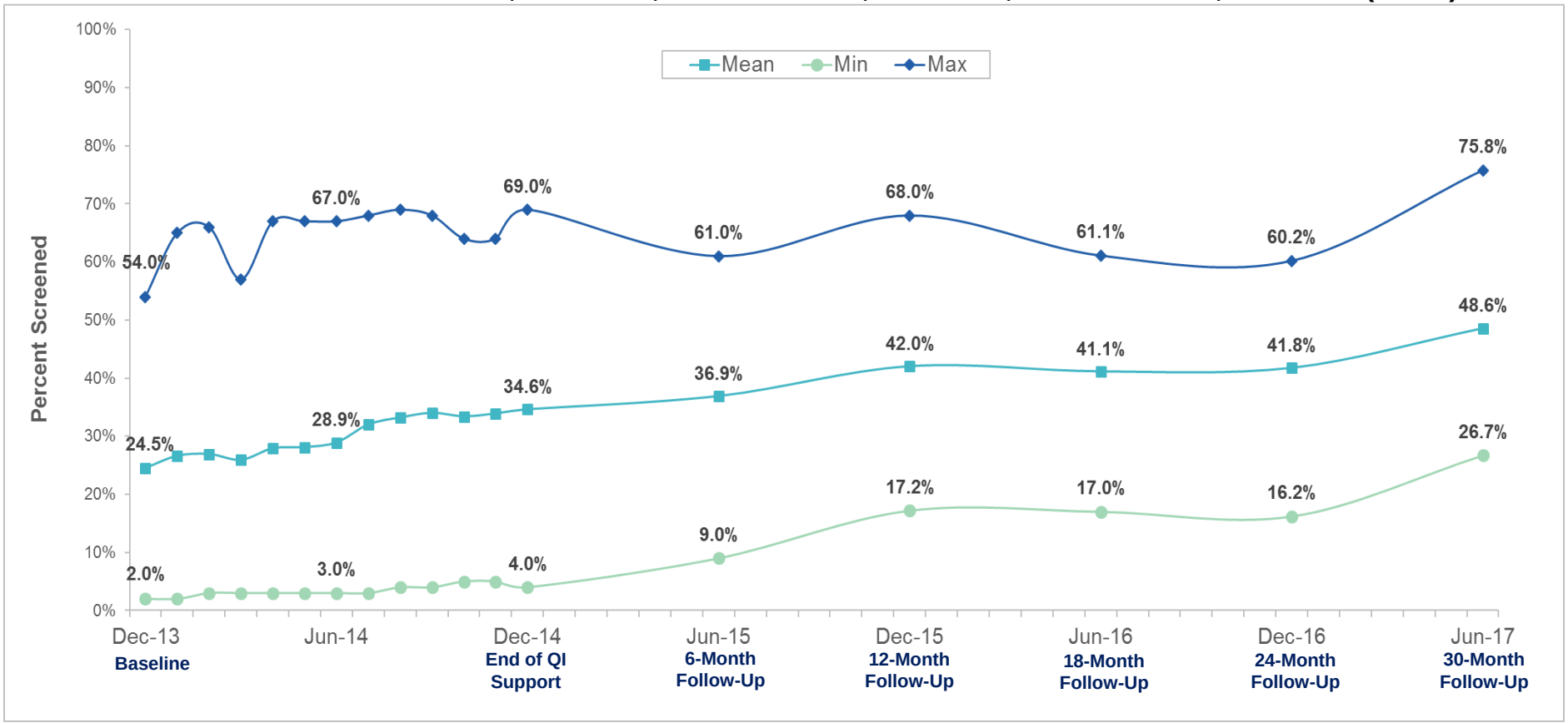
Is there evidence that quality of cancer screening data in CPCI improved?

Key Informant Interviews

How do staff at participating FQHCs perceive the project?

Cohort 1 TY Monthly Colorectal Cancer Screening Rates,

December 2013-December 2014, June 2015, December 2015, June 2016, December 2016, June 2017 (N=14*)



* 14 Health care settings (5 practices and 9 practice sites) participated in Cohort 1; As of TY June 2016 N=13 (missing data from 1 practice site due to site closure); As of TY June 2017 N=12 (missing data from 1 practice)

Did Data Quality Improve?

- **Repeated data validation process with Cohort 1 post-QI**
- Compared pre/post validation to assess improvements in CPCI's ability to accurately capture a patient's screening status

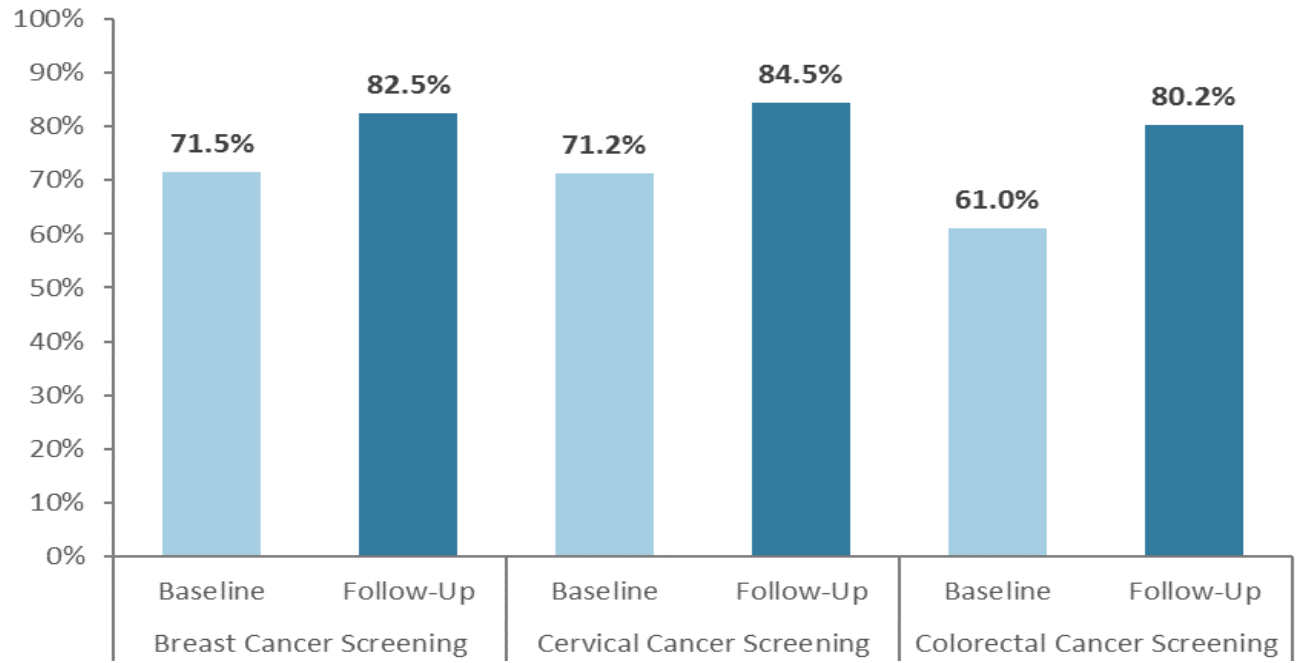
Sensitivity = ability of CPCI to correctly identify patients that had a screening test

Specificity = ability of CPCI to accurately rule out patients that did not have a screening test

Sensitivity improved for all three screening metrics between baseline and follow-up

Sensitivity

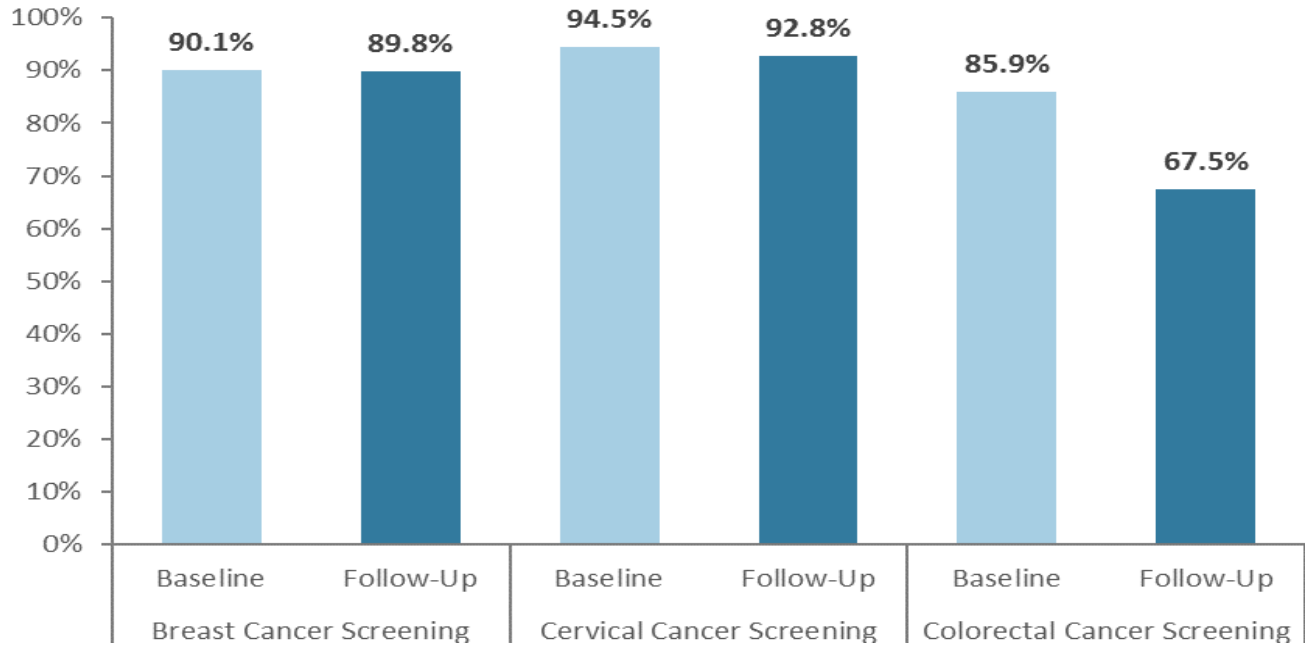
of the CPCI by Cancer Screening Type, Baseline (Pre-QI) and Follow-up (Post-QI)



Specificity for breast and cervical cancer screening was 90%+ at both data collection points but decreased to 68% for colorectal cancer screening at follow-up

Specificity

of the CPCI by Cancer Screening Test, Baseline (Pre-QI) and Follow-up (Post-QI)



How Do FQHC Staff Using the CPCI Perceive Its Utility?

Methods:

- April to June 2017: Qualitative, semi-structured, key informant phone interviews
- Administrative and clinical staff at 17 FQHCs
- 28 FQHC staff were interviewed
  - Response rate: 75.7%

Perceived Utility of CPCI

The CPCI **provides actionable data** that supports clinical quality improvement

The CPCI is perceived as more **user-friendly** than other tools and **fills a gap in reporting capabilities of EHRs**

Degree of **usefulness depends on staffing capacity**

Suggestions for New Users

Devote time to **carefully map and validate** the CPCI data

Take advantage of the CPCI functionalities **sooner and more often**

Devote time to **communicate the purpose** of CPCI and **provide staff training** to support use

Allocate sufficient **staff support**

Project Summary to-date

Results suggest that a combination of data quality activities and quality improvement support has led to:

1. Adoption of improved workflows by FQHCs

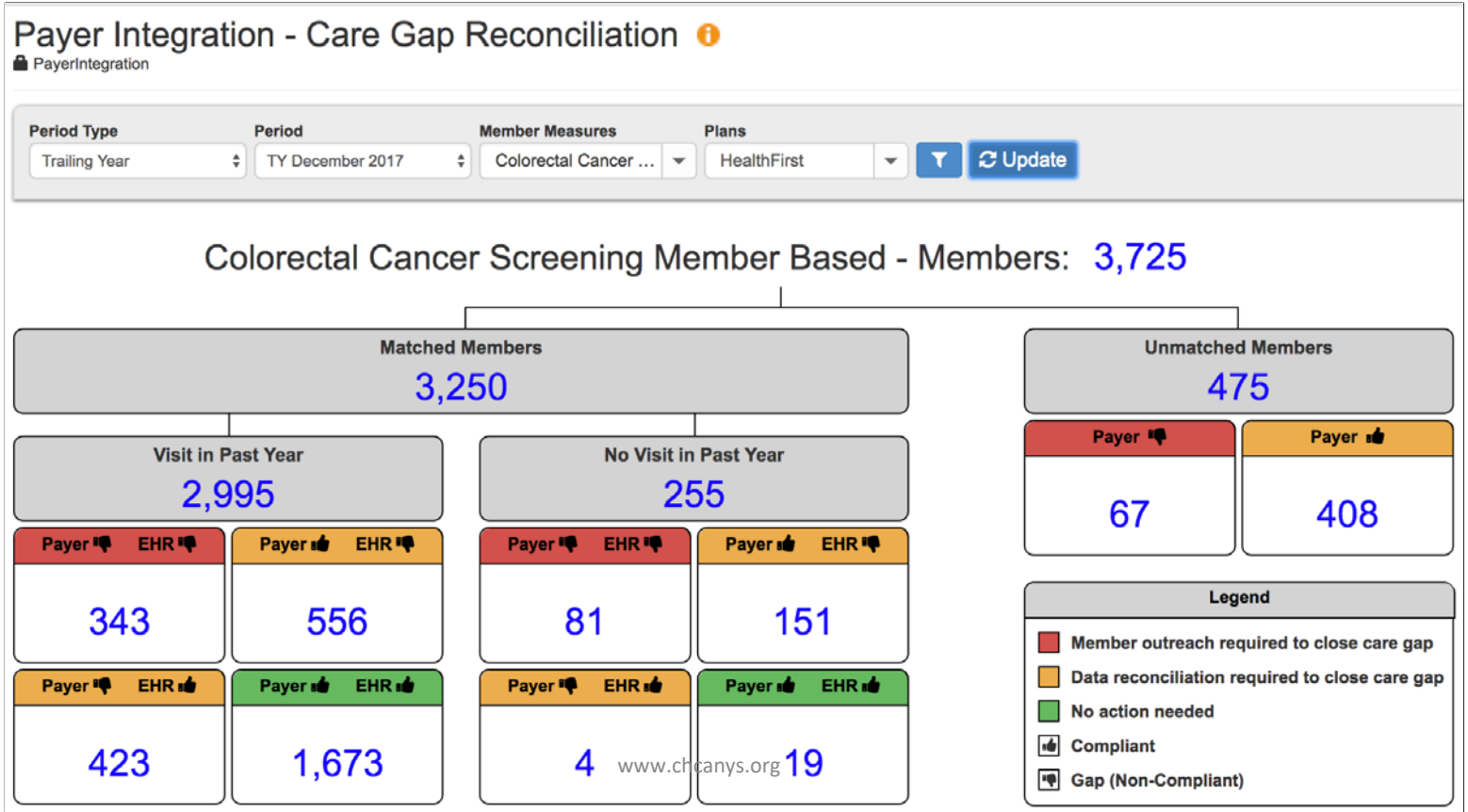
2. Improved data quality and use of a clinical information system to support QI
   - *Data quality must be an ongoing focus*

3. Sustained and/or promising improvements in cancer screening rates

Any questions for me?

I'll turn it over to Lisa Perry from CHCANYS

Additional CPCI Functionality


Payer Integration - Care Gap Reconciliation
PayerIntegration
Period Type
Trailing Year
Period
TY December 2017
Member Measures
Colorectal Cancer ...
Plans
HealthFirst
Update
Colorectal Cancer Screening Member Based - Members: 3,725
Matched Members
3,250
Unmatched Members
475
Visit in Past Year
2,995
No Visit in Past Year
255
Payer EHR
343
Payer EHR
556
Payer EHR
81
Payer EHR
151
Payer EHR
423
Payer EHR
1,673
Payer EHR
4
Payer EHR
19
Payer
67
Payer
408
Legend
Member outreach required to close care gap
Data reconciliation required to close care gap
No action needed
Compliant
Gap (Non-Compliant)

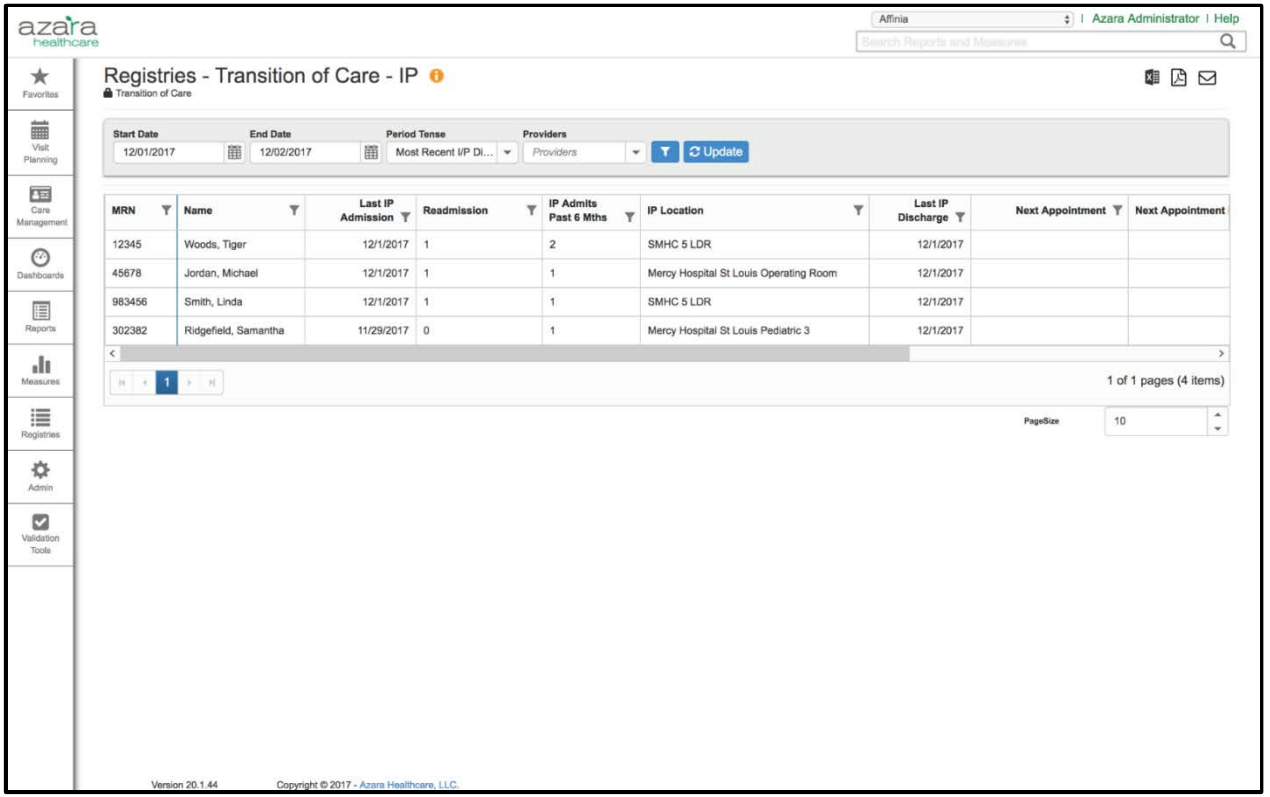
Member Details: Cost

Detail includes: Total Medical Expense & Categorized Cost Breakdown (per patient)

Total Cost	Cost Group	Payer Risk	Behavioral Health	Dental	Home Health	Inpatient Care	Labs/Diagnostic	Medical Devices
$78,288	$50k-100k				$3,256.59	$36,270.11		
$99,738	$50k-100k		$349.18		$3,338.51	$46,549.65		$3,623.92
$10,780	$10k-25k		$658.24				$79.55	
$68,128	$50k-100k		$803.73		$5,135.07	$27,965.78		

Distinguish Primary Care in/outside Health Center

Other	Outpatient Hospital Care	Pharmaceutical	Primary Care	Primary Care - Community Health	Special Needs Facility	Specialty	Support Services	Transportation	Unmapped	Vision
	$3,874.03	$32,096.68	$2,459.93					$330.68		
	$6,356.44	$5,560.36	$12,072.03	$600.40			$17,544.82	$3,742.59		
	$3,557.60	$3,665.82	$566.72	$1,339.02				$913.21		
$223.57	$11,046.83	$2,632.22	$6,899.03	$2,841.81	$4,025.75			$6,554.18		


azara healthcare
Affinia
Azara Administrator
Help
Search Reports and Measures
Favorites
Visit Planning
Care Management
Dashboards
Reports
Measures
Registries
Admin
Validation Tools
Registries - Transition of Care - IP
Transition of Care
Start Date
12/01/2017
End Date
12/02/2017
Period Tense
Most Recent I/P Di...
Providers
Update
MRN
Name
Last IP Admission
Readmission
IP Admits Past 6 Mths
IP Location
Last IP Discharge
Next Appointment
Next Appointment
12345 Woods, Tiger 12/1/2017 1 2 SMHC 5 LDR 12/1/2017
45678 Jordan, Michael 12/1/2017 1 1 Mercy Hospital St Louis Operating Room 12/1/2017
983456 Smith, Linda 12/1/2017 1 1 SMHC 5 LDR 12/1/2017
302382 Ridgefield, Samantha 11/29/2017 0 1 Mercy Hospital St Louis Pediatric 3 12/1/2017
1
1 of 1 pages (4 items)
PageSize
10
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Data Integration with Health Plans & RHIOs

		Medical Claims		Pharmacy Claims			
Health Plan	Enrollment	Cost	Utilization	Rx Cost	Rx Utilization	Care Gaps	Risk
HealthFirst	●		Q2[1]		Q2[1]	●	
HealthPlus[2]	●		Q2[3]		Q2[3]		
Affinity	●	●	●	●	●		
United	●	●		●	●		●
Capital District (CDPHP)							
MetroPlus							
Fidelis[4]	●		●	●	●	●	●

Integrating with CPCI?	RHIO	Count of HCs impacted
In Discussion	Bronx RHIO	11
✓	HealtheConnections	7
	HEALTHeLINK	5
✓	HealthLinkNY	6
✓	Healthix	22
	Hixny	3
	NYCIG	TBD
✓	Rochester RHIO	5

Thank you!

Heather Dacus
heather.dacus@health.ny.gov

Lisa Perry
lperry@chcanys.org

NEW YORK STATE OF OPPORTUNITY. Department of Health

Provider Directory Project

Provider Data Strategic Planning

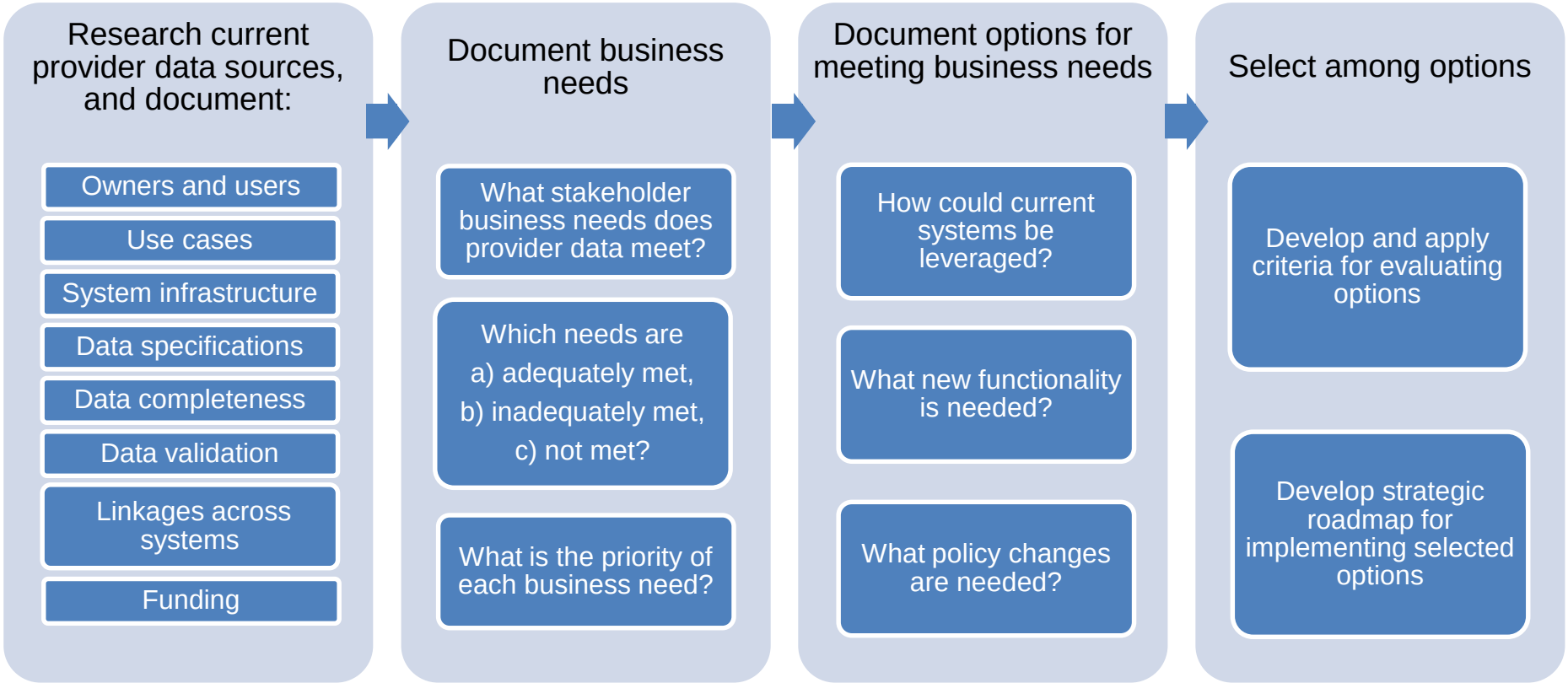
Issue:

- Currently, a number of disparate sources of provider data are in use across the New York State Department of Health (NYSDOH), managed by separate program areas that intake, house, and manage the data.

The Provider Data Strategic Planning Project Aims To:

- Understand current provider data sources and systems, and document their characteristics including accuracy and reliability.
- Understand and document New York State's existing and future needs as relates to provider data, especially as they relate to supporting value-based payment initiatives.
- Develop a strategic implementation roadmap for options to meet priority business needs for provider data.

Provider Data Strategic Planning



Lunch Break

National Landscape for Interoperability

- TEFCA

NYeC
NEW YORK eHEALTH COLLABORATIVE

NEW YORK STATE Department of Health

DOH HIT Committee

Performance Based Contracting Update & TEFCA Overview

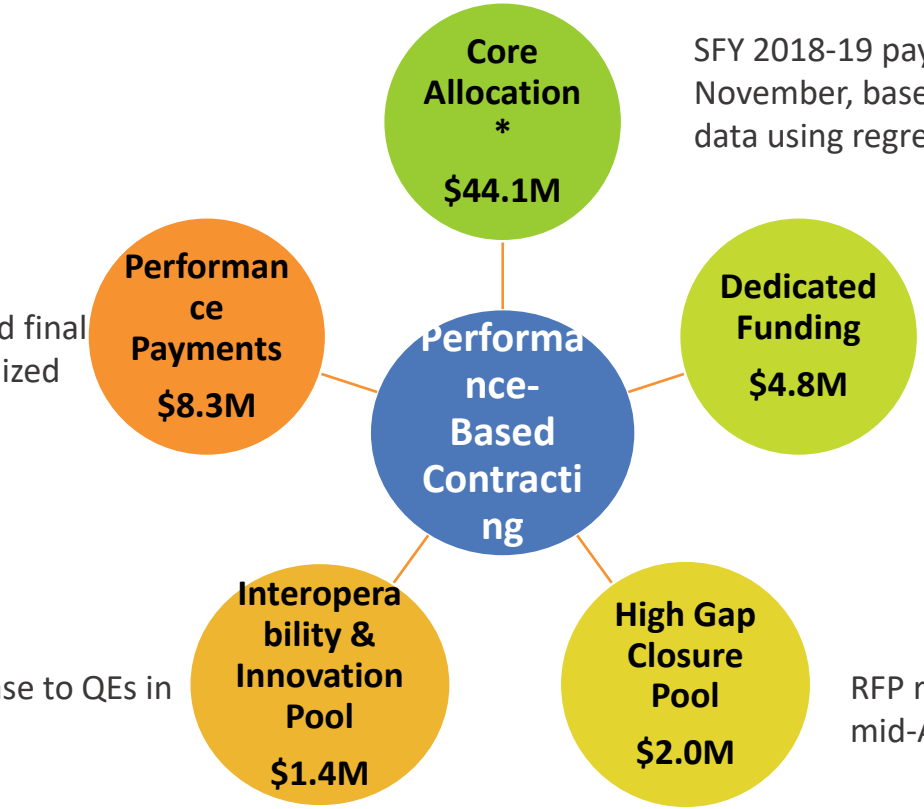
Valerie Grey

April 9, 2018

Performance Based Contracting Update

Since January 2018 Meeting

2018-19 NYeC Performance-Based Contracts with QEs



SFY 2018-19 payments were finalized in November, based on October 31, 2017 data using regression model ✓

✓ Performance methodology and final calculations finalized

SFY 2018-19 payments were finalized in November ✓
(security and quality measurement)

RFP release to QEs in mid-April

RFP release to QEs in mid-April

* Including a set-aside for Bronx for Somos related to material data changes post 10/31/17 baseline data for core allocation finalized

SHIN-NY: Current Statistics

Metrics	2020 Goal	Statewide Estimate	QE Average (of 8 QEs)	Low (of 8 QEs)	High (of 8 QEs)
Participating hospitals	100%	100%	100%	98%	100%
Participating skilled D&TCs, FQHCs, nursing facilities, home care, hospice	70%	64%	71%	62%	85%
Participating physicians	70%	61%	63%	51%	81%
Unique patient consent for at least one provider	85%	55%	78%	41%	112%~
New higher-level data completeness & quality* for hospitals	100%	20%	17%	0%	64%
New higher-level data completeness & quality* for other regulated entities (ORE)**	70%	5%	5%	0%	22%
New higher-level data completeness & quality* for physicians	70%	14%	11%	0%	19%

~QE consent rates may exceed 100% if the consent rate exceeds their market share of participants

Performance Payments

- NYeC will provide quarterly reports to QEs on progress against Gap to Goal to help with early warning systems and provide assistance
- Partial credit for performance will be allowed using the following 3 tiers:
  - If meet 50% of gap to goal then 15% of full allocation
  - If meet 75% of gap to goal then 50% of full allocation
  - If meet 100% of gap to goal then 100% of full allocation
- Unearned performance funds will be allocated to high performing QEs based on a methodology TBD

The Out Years …

- Learn from Year 1, improve data and develop additional metrics
  - Customer satisfaction
  - Meaningful SHIN-NY usage
  - System reliability
- Stay true to overall strategy and outline of PBC originally presented to the NYeC Board and contained in the DOH & NYeC approved Roadmap report and slides
  - Significantly increase proportion associated with performance and achieving goals and deliverables
  - I & I increases
  - Core allocation decreases
- Work on Sustainability Plans

Trusted Exchange Framework Common Agreement (TEFCA)

Health Information Technology Advisory Committee

What is HITAC?

- The Health Information Technology Advisory Committee (HITAC) was established in the 21st Century Cures
- HITAC will recommend to ONC policies, standards, implementation specifications, and certification criteria, relating to the implementation of a health information technology infrastructure, nationally and locally
- HITAC unifies the roles of, and replaces, the HIT Policy Committee and the HIT Standards Committee

Priority Target Areas?

- Achieving a health information technology infrastructure that allows for the electronic access, exchange, and use of health information
- The promotion and protection of privacy and security of health information in HIT
- The facilitation of secure access by an individual to such individual's protected health information
- Any other target area that the HITAC identifies as an appropriate target area to be considered

NYeC

HITAC 2018 Charges

Throughout 2018, ONC plans to request feedback on the topics below that align with the priority target areas:

- Trusted Exchange Framework and Common Agreement (TEFCA)
- U.S. Core Data for Interoperability (USCDI) Glide Path
- Standards Use Cases
- ONC's upcoming rule to implement Cures Act provisions

TEFCA Big Picture Goals

Planned Timeline

Draft TEFCA Structure Core Takeaways

All about creating a national network by leveraging public & private infrastructure that is already built

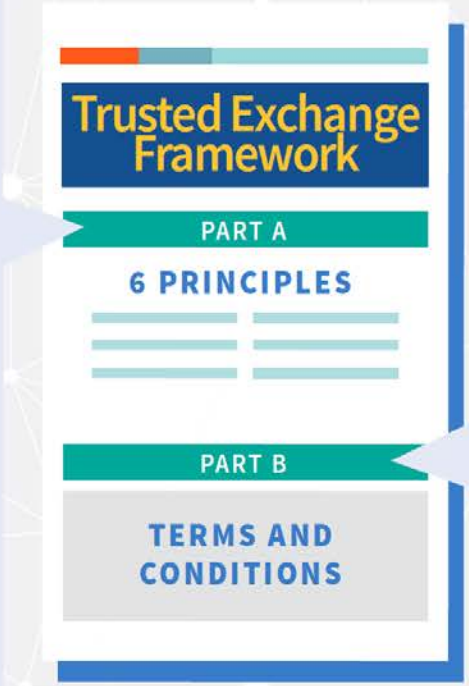
- Voluntary & not mandatory
  - Value proposition for joining will be important
- No new government funding support
  - Some new fees would be allowed
- Resembles NYS SHIN-NY structure but not fully aligned
  - Permitted uses, services, etc.
- Ambitious & aggressive timeline

Draft TEFCA Basics

Part A—Principles for Trusted Exchange

General principles that provide guardrails to engender trust between Health Information Networks (HINs). Six (6) categories:

- **Principle 1 - Standardization:** Adhere to industry and federally recognized standards, policies, best practices, and procedures.
- **Principle 2 - Transparency:** Conduct all exchange openly and transparently.
- **Principle 3 - Cooperation and Non-Discrimination:** Collaborate with stakeholders across the continuum of care to exchange electronic health information, even when a stakeholder may be a business competitor.
- **Principle 4 - Security and Patient Safety:** Exchange electronic health information securely and in a manner that promotes patient safety and ensures data integrity.
- **Principle 5 - Access:** Ensure that patients and their caregivers have easy access to their electronic health information.
- **Principle 6 - Data-driven Accountability:** Exchange multiple records at one time to enable identification and trending of data to lower the cost of care and improve the health of the population.



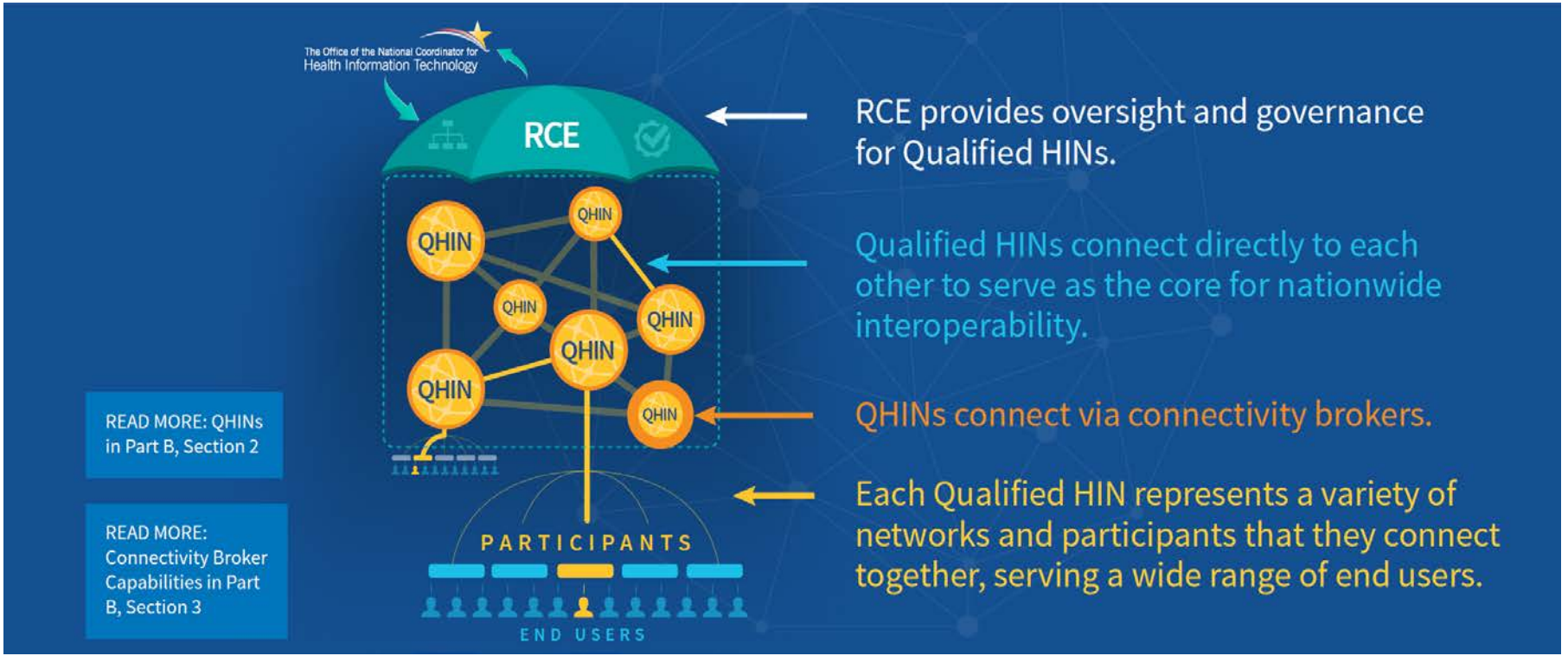
Part B—Minimum Required Terms and Conditions for Trusted Exchange

A minimum set of terms and conditions for the purpose of ensuring that common practices are in place and required of all participants who participate in the Trusted Exchange Framework, including:

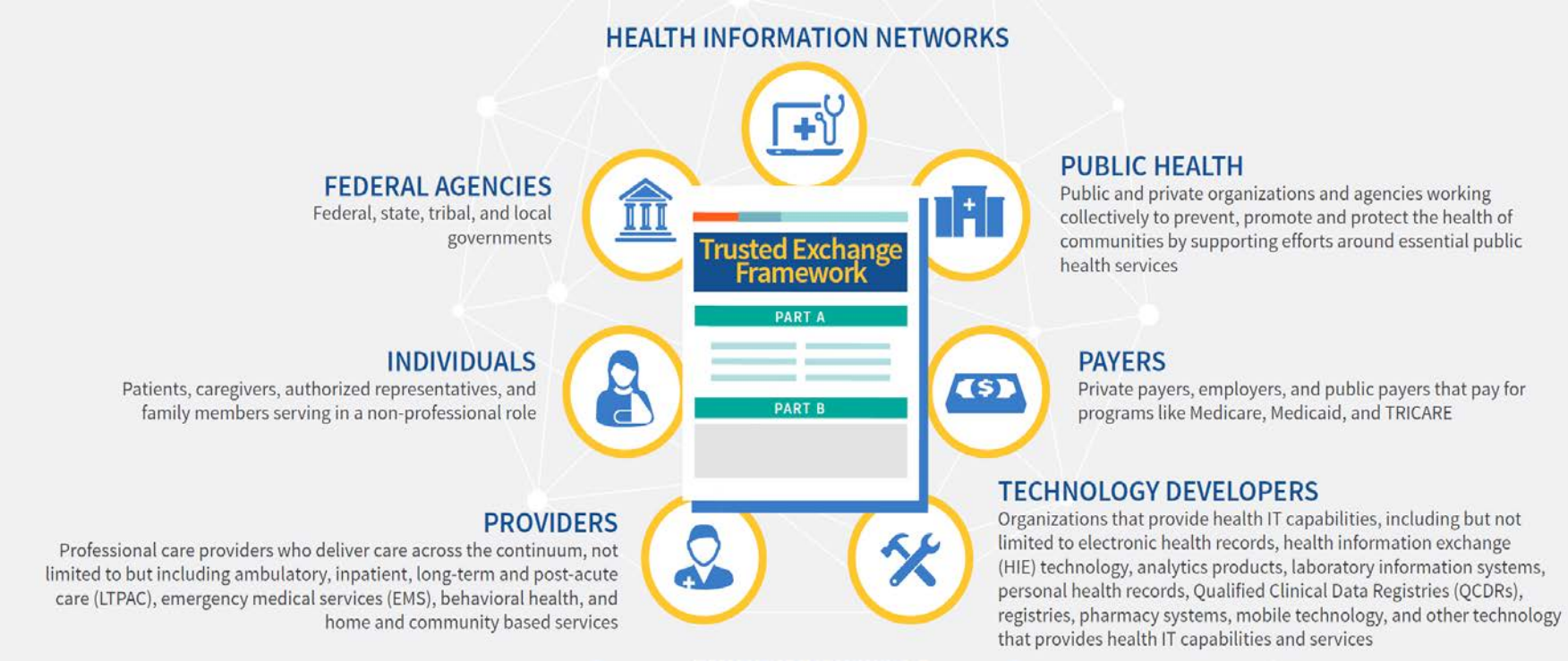
- Common authentication processes of trusted health information network participants;
- A common set of rules for trusted exchange;
- A minimum core set of organizational and operational policies to enable the exchange of electronic health information among networks.

NYeC

Draft TEFCA Vision



Who Could Use It?



What Uses?


PUBLIC HEALTH
BENEFITS DETERMINATION
INDIVIDUAL ACCESS
Permitted Purposes
TREATMENT
PAYMENT
HEALTHCARE OPERATIONS
READ MORE: Part B, Section 1

What Services?

Broadcast Query

Sending a request for a patient's Electronic Health Information (EHI) to all Qualified HINs to have data returned from all organizations who have it.

Supports situations where it is unknown who may have Electronic Health Information about a patient.

Directed Query

Sending a targeted request for a patient's Electronic Health Information to a specific organization(s).

Supports situations where you want specific Electronic Health Information about a patient, for example data from a particular specialist.

Population Level Data

Querying and retrieving Electronic Health Information about multiple patients in a single query.

Supports population health services, such as quality measurement, risk analysis, and other analytics.

Allowable Fees?

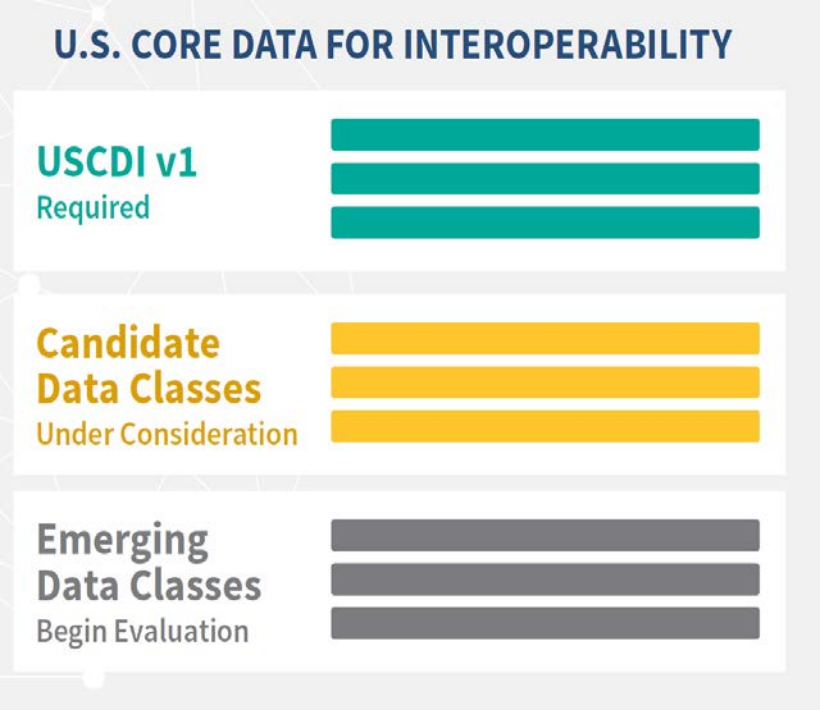
Qualified HINs may, though they are not required to, charge attributable service costs to other Qualified HINs, provided they are reasonable and non-discriminatory.

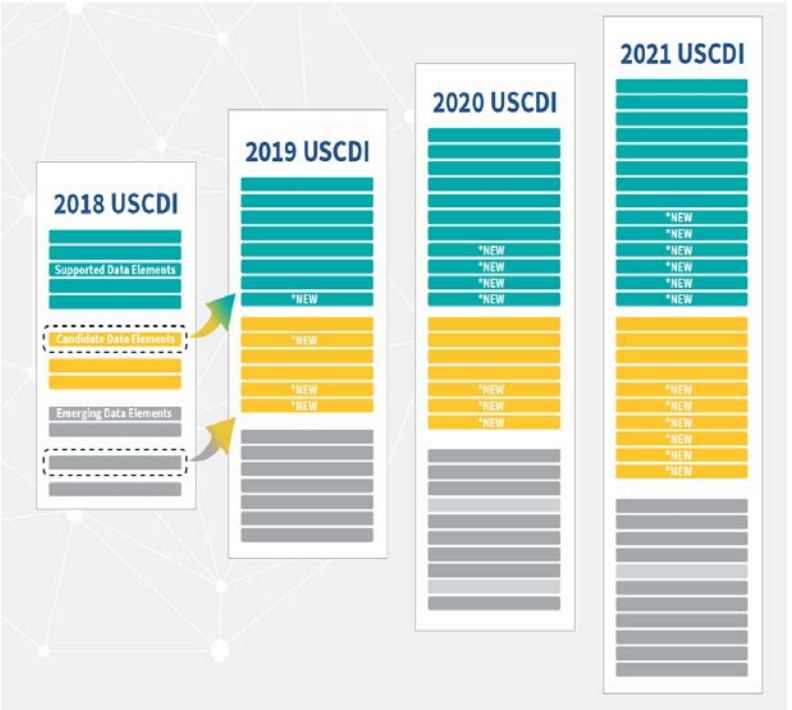
Reasonable Allowable Costs: are costs that were actually incurred; are a direct cost or a reasonable allocation of indirect costs for the attributable services below; are based on objective and verifiable criteria; and are not variable depending on which Qualified HIN is being charged

Attributable Services may include:

- Developing or modifying interfaces or APIs to be able to exchange data in the USCDI;
- Developing or revising the Connectivity Broker required in the Trusted Exchange Framework; and
- Employing legal services necessary to review the Trusted Exchange Framework and amend participation and Business Associate agreements to meet the requirements of the Trusted Exchange Framework.

USCDI Draft


U.S. CORE DATA FOR INTEROPERABILITY
USCDI v1
Required
Candidate
Data Classes
Under Consideration
Emerging
Data Classes
Begin Evaluation


2018 USCDI
Supported Data Elements
Candidate Data Elements
Emerging Data Elements
2019 USCDI
2020 USCDI
2021 USCDI
*NEW

Proposed Required USCDI v1 for 2018

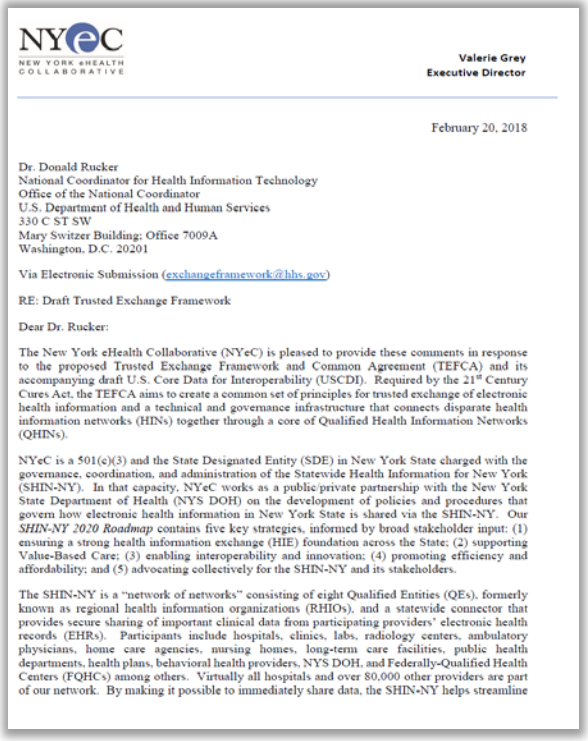
Draft USCDI Version 1 Data Classes	
1. Patient name	2. Sex (birth sex)
3. Date of Birth	4. Preferred Language
5. Race	6. Ethnicity
7. Smoking Status	8. Laboratory tests
9. Laboratory values/results	10. Vital signs
11. Problems	12. Medications
13. Medication Allergies	14. Health concerns
15. Care Team members	16. Assessment and plan of treatment
17. Immunizations	18. Procedures
19. Unique device identifier(s) for a patient's implantable device(s)	20. Goals
21. Provenance	22. Clinical Notes

Same data classes referenced by the 2015 Edition CCDS definition and also includes clinical notes and provenance

- Clinical notes is composed of structured (pick-list and/or check the box) and unstructured (free text) data – free text portion may include the assessment, diagnosis, plan of care and evaluation of plan, patient teaching and other relevant data points
- Provenance describes the metadata, or extra information about data, that can help answer questions such as when & who created the data

NYeC Public Comments

Public Comment Period went through February 20



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NEW YORK eHEALTH COLLABORATIVE

Valerie Grey
Executive Director

February 20, 2018

Dr. Donald Rucker
National Coordinator for Health Information Technology
Office of the National Coordinator
U.S. Department of Health and Human Services
330 C ST SW
Mary Switzer Building; Office 7009A
Washington, D.C. 20201

Via Electronic Submission (exchangeframework@hhs.gov)

RE: Draft Trusted Exchange Framework

Dear Dr. Rucker:

The New York eHealth Collaborative (NYeC) is pleased to provide these comments in response to the proposed Trusted Exchange Framework and Common Agreement (TEFCA) and its accompanying draft U.S. Core Data for Interoperability (USCDI). Required by the 21st Century Cures Act, the TEFCA aims to create a common set of principles for trusted exchange of electronic health information and a technical and governance infrastructure that connects disparate health information networks (HINs) together through a core of Qualified Health Information Networks (QHINs).

NYeC is a 501(c)(3) and the State Designated Entity (SDE) in New York State charged with the governance, coordination, and administration of the Statewide Health Information for New York (SHIN-NY). In that capacity, NYeC works as a public/private partnership with the New York State Department of Health (NYS DOH) on the development of policies and procedures that govern how electronic health information in New York State is shared via the SHIN-NY. Our *SHIN-NY 2020 Roadmap* contains five key strategies, informed by broad stakeholder input: (1) ensuring a strong health information exchange (HIE) foundation across the State; (2) supporting Value-Based Care; (3) enabling interoperability and innovation; (4) promoting efficiency and affordability; and (5) advocating collectively for the SHIN-NY and its stakeholders.

The SHIN-NY is a "network of networks" consisting of eight Qualified Entities (QEs), formerly known as regional health information organizations (RHIOs), and a statewide connector that provides secure sharing of important clinical data from participating providers' electronic health records (EHRs). Participants include hospitals, clinics, labs, radiology centers, ambulatory physicians, home care agencies, nursing homes, long-term care facilities, public health departments, health plans, behavioral health providers, NYS DOH, and Federally-Qualified Health Centers (FQHCs) among others. Virtually all hospitals and over 80,000 other providers are part of our network. By making it possible to immediately share data, the SHIN-NY helps streamline

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http://www.nyehealth.org/nyec16/wp-content/uploads/2018/03/02-20-18-NYeC-TEFCA-Comment-Letter-Details.pdf

Significant Potential Opportunity

- Single on-ramp can help participants & encourage use
- Work of both public HIEs & private industry solutions get leveraged
- More standardization, improved & expanded data being shared
- Strong consumer focus
- Spur national policy changes
  - Alignment between various programs
  - Modernization of Part 2 data
  - Others
- Accelerate needed state policy changes
  - Closer alignment to HIPAA
  - Others
- Reduced costs & increased system efficiency
- Better healthcare

NYeC

Major Themes: Some General Concerns

- Not fully leveraging & maximizing current infrastructure
- Overly ambitious & unachievable timelines
  - New data sharing agreements, use of open APIs, use of CCDAs & FHIR, minimum data set requirements
- Pull-only approach – no push services like alerts
- Differing consent & privacy laws are not being realistically addressed
- Some components may result in unintended consequences
- Lack of government funding for a lot of work by many
- Allowable fee methodology that is inefficient & inadequate
- Selection of RCE and independence & mission

Major Themes: Recommendations

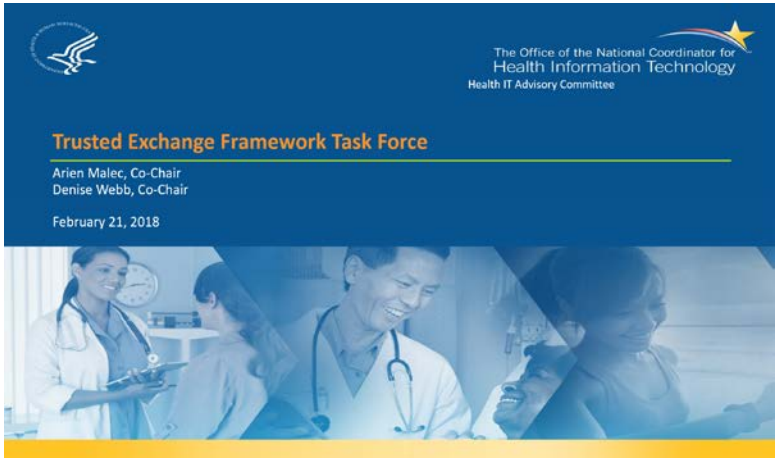
- Fully leverage current infrastructure, HIE lessons learned, pressure on vendors
- Recognize current market & industry capacity & adjust timelines appropriately
- Help resolve & sort through consent and privacy laws
- Remove federal barriers to existing data exchange
- Some components may result in unintended consequences
  - Multiple sets of agreements, impact on participation, etc.
- Ensure RCE is independent, mission-driven & inclusive of all stakeholders
- Provide government funding & support in creative ways
- Revisit & revise allowable fee methodology
- Continue to focus on patient access & engagement & transparent process

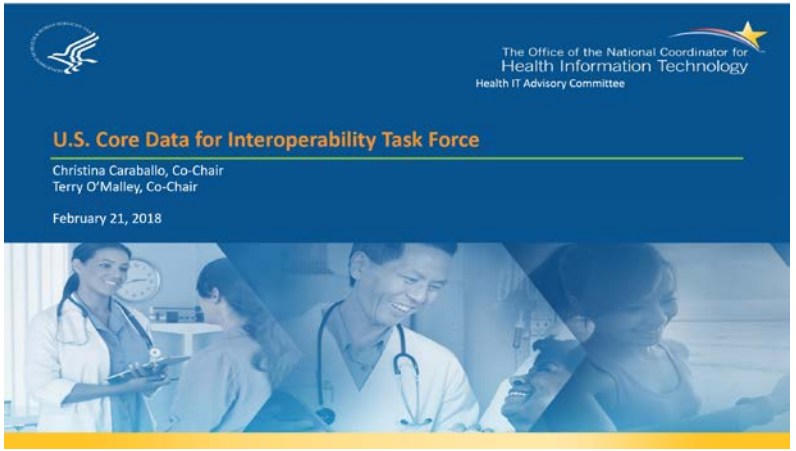
Questions in a Number of Areas

- “Participant Neutral”
- API standards
- QHIN eligibility
- Allowable fees
- Security framework
- Others

ONC Reflection and Input

Public Comments available at:
https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement





Task Force Updates:

https://www.healthit.gov/hitac/health-information-technology-advisory-committee-hitac/hitac-task-forces

TEFCA & USCDI Will Evolve

- Changes to Drafts coming
- ONC trying to build support
- Federal government will try to use all levers
- Could be a positive force
- But picture will become clearer over time

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Sign up for our newsletter, follow us on Facebook and Twitter, and join our LinkedIn group.

40 Worth Street, 5th Floor / New York, New York 10013
99 Washington Avenue, Suite 1750 / Albany, New York 12260

HIT Enabled Quality Measurement – Vision Document

HIT-Enabled Quality Measurement
Current State Recap

Business Needs

- Clinical data for use by plans as HEDIS supplemental data
- Clinical data for use by provider organizations in their analytics systems
- Population-level measures

Current State Limitations

- Data delivered in inconsistent, non-standard formats
- Multiple point-to-point connections
- Poor data quality
- Reliance on claims and medical record review = outcome measures calculated infrequently on a sample of the population

Future State Characteristics

- Availability of high-quality electronic clinical data for plans and providers
- Consensus-based solutions and specifications
- Reusable and scalable technology
- Population-level outcome measurement

NEW YORK STATE OF OPPORTUNITY. Department of Health

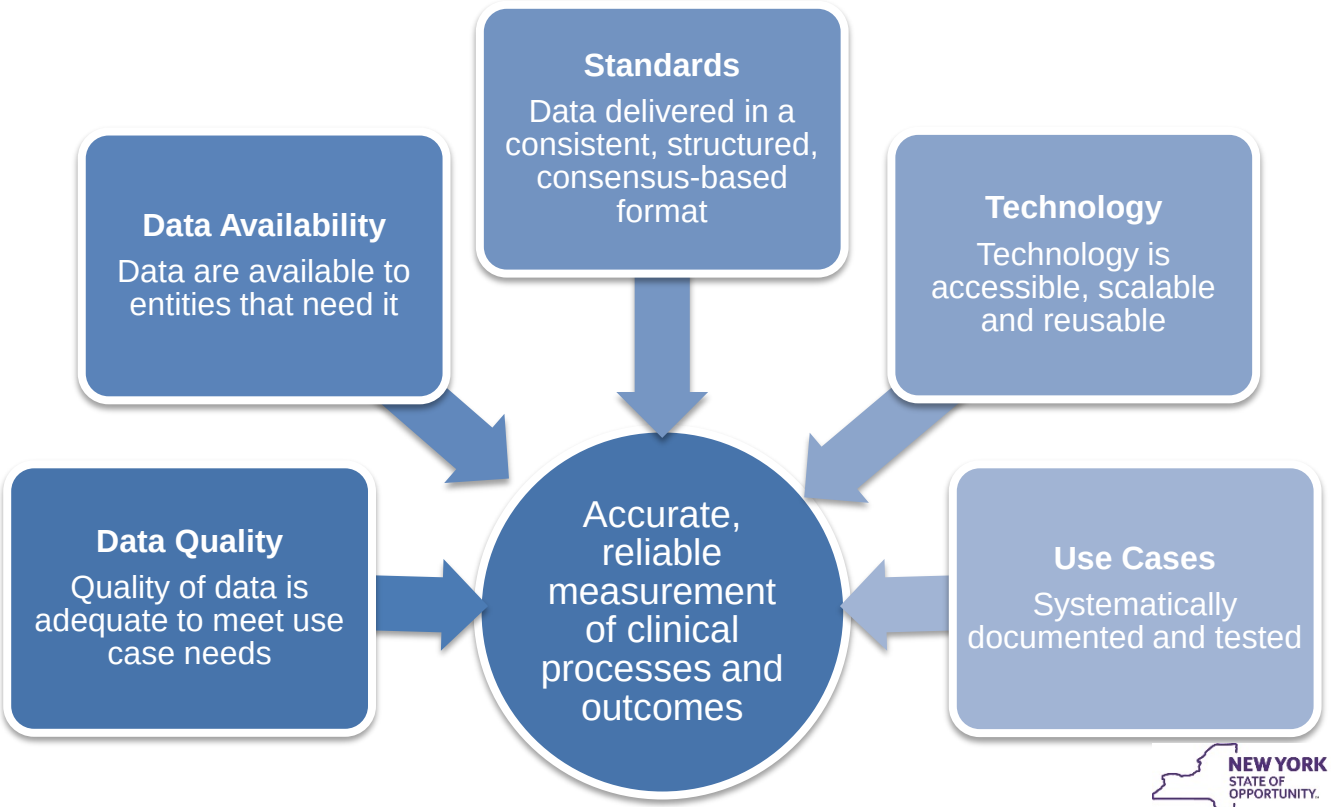
The Problem

- Quality measurement is a critical component of healthcare system transformation
  - NYSDOH initiatives like DSRIP, SIM and VBP all rely on quality measures to assess and compare performance and to inform payment decisions
- Measuring outcomes requires clinical data
- Electronic clinical data is not well integrated into current quality measurement processes

Vision for HIT-Enabled Measurement

An infrastructure of ***technology and policies*** that allow ***multiple stakeholders*** to access ***high-quality data*** that represents a ***complete picture of the care*** delivered to a patient and enables ***measurement*** of the ***health outcomes of a population***

Vision for HIT-Enabled Measurement



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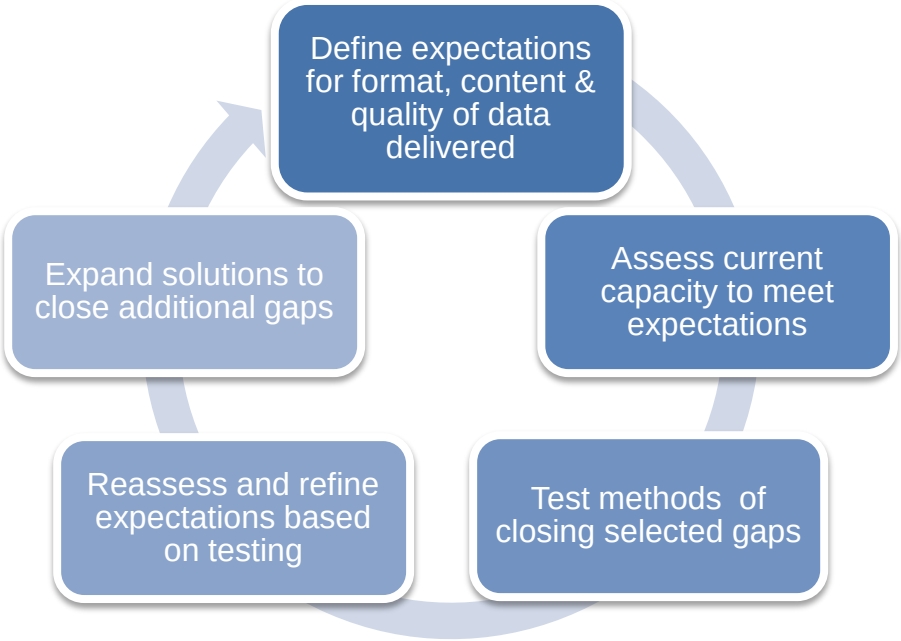
Vision for HIT-Enabled Measurement

Foundational components and functionality are needed to support new use cases and reach the goal of robust, accurate outcome measurement

NEW YORK STATE OF OPPORTUNITY. Department of Health

Achieving the Vision

- NYSDOH will pursue a ***multi-pronged approach*** to build the capacity to ***meet unmet needs*** and ***realize the desired characteristics*** of the future state
- The approach will emphasize a process of ***continuous learning*** to answer key questions



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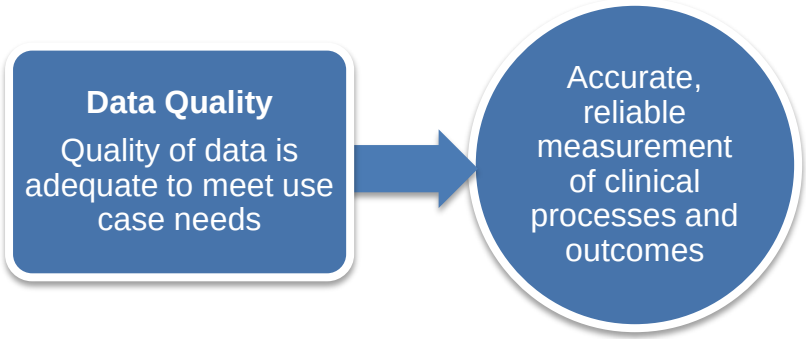
Future State Objectives

Objective 1

The ***quality of available data is high enough*** to satisfy quality measurement needs.



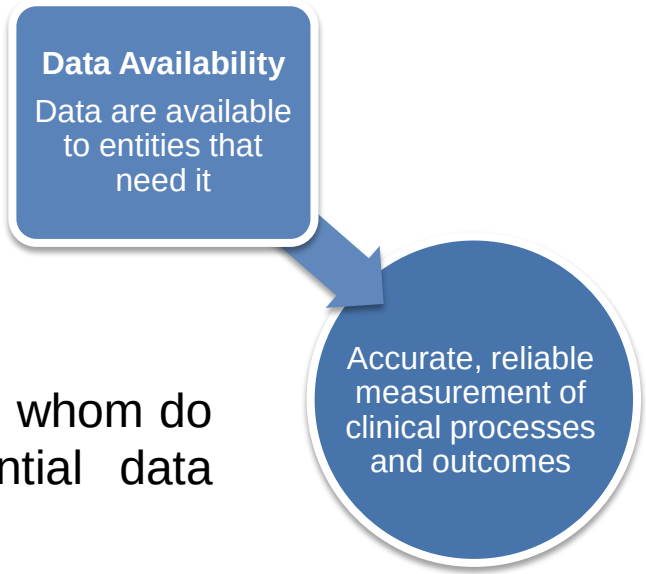
Questions

1. Where in data flows are data quality issues being introduced?
2. How can each of these “failure points” be addressed?
3. What procedures and policies are in place to monitor and address data quality issues?
4. Can gaps in these procedures and policies be closed?
5. Can available data satisfy the requirements of measure specifications?

Future State Objectives

Objective 2

Ensure that the needed ***data are available to stakeholders*** including health plans, providers, and NYSDOH



Questions

1. What data are needed, from what entities, and to whom do they need to be delivered? Are there potential data consumers beyond health plans and providers?
2. Are policies in place to enable data sharing between data contributors and data consumers? If not, what are the policy barriers and how may they be overcome?

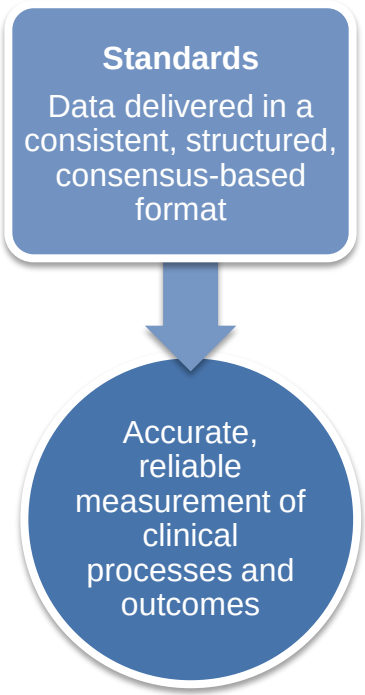
Future State Objectives

Objective 3

Develop and promote ***consensus-based standards*** for data contribution and data delivery

Questions

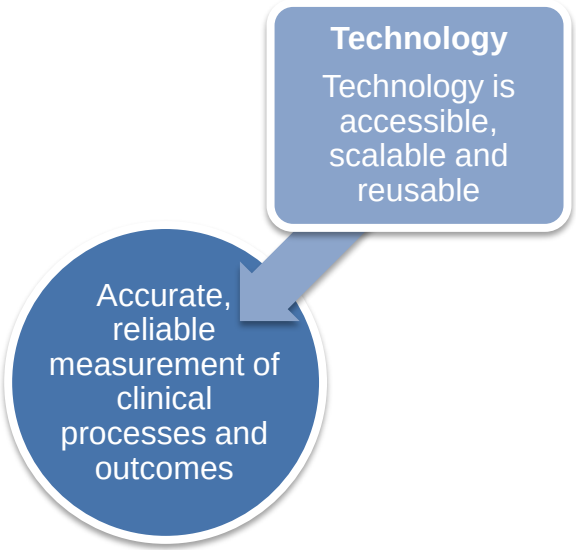
1. What national standards are applicable to the use cases being addressed?
2. What requirements would a file need to meet to be considered a standard supplemental data source by a HEDIS auditor?
3. What are the barriers to adoption of a standard file format?



Future State Objectives

Objective 4

Reuse or implement technology solutions that can be used ***by multiple stakeholders*** and scaled for broader utility



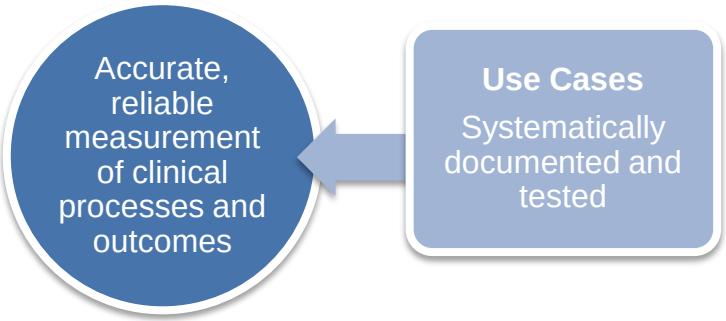
Questions

1. What functions are needed to aggregate, process, and deliver data?
2. What technology is in place to aggregate data from the necessary entities? How well are these working? Can they be reused? What changes would need to be made?
3. Do new solutions need to be developed?
4. What capabilities do entities have for taking in data?

Future State Objectives

Objective 5

Systematically ***define and test use cases*** and ***incorporate lessons learned*** for strategic decision making.



Questions

1. Who are the key stakeholders that will use a solution?
2. What are their key business needs, i.e. what are they measuring and for what purpose?
3. What are the specific requirements?
4. How can we test solutions?
5. Which solutions should be scaled?

Initiatives to Support the Future State

Project Description	Expected Outcome
Establish reporting and communication channels to ensure a strategic and systematic approach to the future state	✓A ***shared understanding of NYSDOH's vision*** for HIT-enabled quality measurement and of related initiatives. ✓Continued ***strategic alignment*** among stakeholders

Communication and Strategic Alignment

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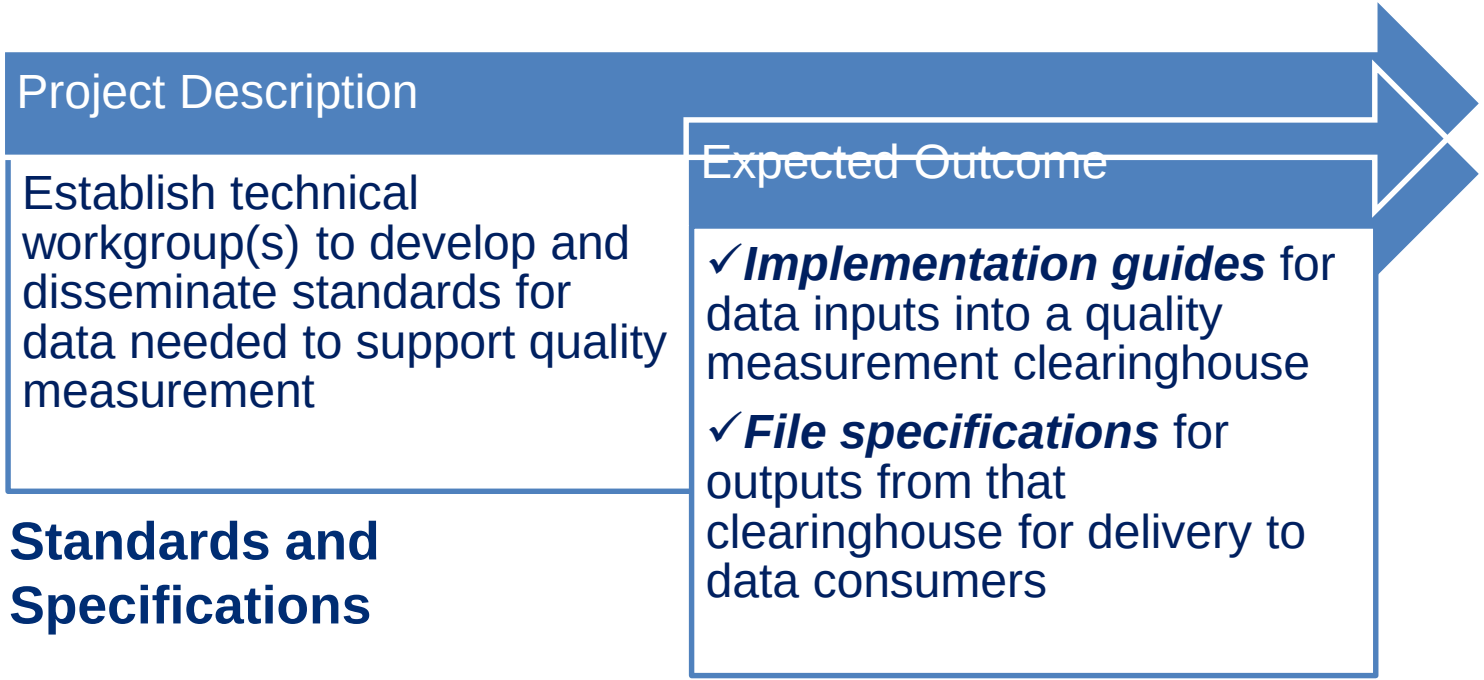
Initiatives to Support the Future State



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Initiatives to Support the Future State

Project Description	Expected Outcome
Fund QEs to implement use cases to support quality measurement for the APC scorecard	✓Understand the ***measurement needs*** of APC practices, health plans and NYSDOH ✓Understand ***data quality issues*** at the APC level ✓Understand ***data exchange capabilities*** and ***barriers*** among practices, QEs and health plans ✓Understand ***requirements and specifications for measures*** in the APC scorecard

Qualified Entity Quality Measurement Pilots

NEW YORK STATE OF OPPORTUNITY. Department of Health

Initiatives to Support the Future State

Project Description	Expected Outcome
Pilot participants collaborate to share data to produce the Controlling High Blood Pressure Measure at a population level	✓Enhanced understanding of ***the quality of EHR-sourced data*** for measures that are ***not reportable at a population level*** based on administrative specifications ✓Understanding of provider and plan ***data exchange capabilities*** ✓Lessons learned regarding ***data delivery*** methods, ***data quality***, and means of improving quality

VBP Pilots Measure Testing Projects

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Initiatives to Support the Future State

Project Description	Expected Outcome
Design and develop solution to centralize, standardize and deliver data to plans and others to support APC and VBP measures	✓Documented ***business and technical requirements*** ✓Analysis of ***policy barriers and enablers*** ✓Current state ***analysis of existing systems*** that may meet needs ✓***Identification and assessment of options*** for solutions to meet requirements

Quality Measurement Clearinghouse (Phase 1: Lab Data)

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Initiatives to Support the Future State

Project Description	Expected Outcome
Develop and implement model to assist APC practices in improving data quality	✓***Systematic review of existing models*** for improving data quality at the practice/EHR level ✓***Assess needs and develop a model*** to meet those needs based on review of existing models ✓***Pilot methodology*** for data quality improvement activities

Practice Data Quality Improvement

Initiatives to Support the Future State

Project Description	Expected Outcome
Quantitative and qualitative assessment of QE data quality	✓Identify potential ***data quality barriers*** to quality measurement ✓Identify ***opportunities*** for improvement

SHIN-NY Data Quality Assessment

NYS PMP
PRESCRIPTION MONITORING PROGRAM REGISTRY

Bureau of Narcotic Enforcement Prescription Monitoring Program – EHR Integration

NEW YORK STATE OF OPPORTUNITY. Department of Health

What Is the PMP?

- A statewide electronic database which collects designated data on the dispensing and distribution of controlled substances.

- The registry includes patient-specific information on dispensed controlled substances.

What Is the PMP?

- Patient data is derived from pharmacy dispensing information.
- Accurate pharmacy data entry is a must!
- 1 year of patient history is displayed.
- Data is visible within 24 hours of submission.

Uses of PMP Data

1. Inform prescribers and pharmacists of patient's recent controlled substance prescription activity via the PMP Registry for better evaluation of treatment;
2. Decrease Multiple Provider Episodes (Dr Shoppers);
3. Enforcement activities; and
4. Present aggregate data to inform public health initiatives.

History of the NYS PMP

1972: pharmacies required to report dispensed controlled substance prescription information (Schedule II drugs only).

June 2005: pharmacies required to report dispensed CS prescription records (Schedules II-V, monthly).

April 2006: all prescriptions required to be written on the New York State serialized and forge-proof Official Prescription Form (with limited exceptions).

Basis for data collected for inclusion on the PMP registry.

History of the NYS PMP

- **February, 2010:** On-Line PMP is available to prescribers.
- **August 27, 2013:** The updated PMP goes live.
- Pharmacies and dispensing practitioners required to report all controlled substance prescription data daily.
- Prescribers are required to access the PMP prior to writing a controlled substance prescription.
- Pharmacists are allowed to view the PMP Registry prior to dispensing a controlled substance prescription.

Who Can Access the PMP?

- On August 27, 2013, the updated PMP and the mandatory duty to consult for practitioners was officially implemented.
- Practitioners do not need to include a reference that they checked the PMP on the prescription, but do need to note it in the patient's medical record.
- Pharmacists are encouraged but not mandated to consult the PMP Registry.

PMP Duty to Consult -- Practitioners

- Practitioners must consider their patient's information presented in the PMP Registry prior to prescribing or dispensing any controlled substance listed in Schedule II, III, or IV.

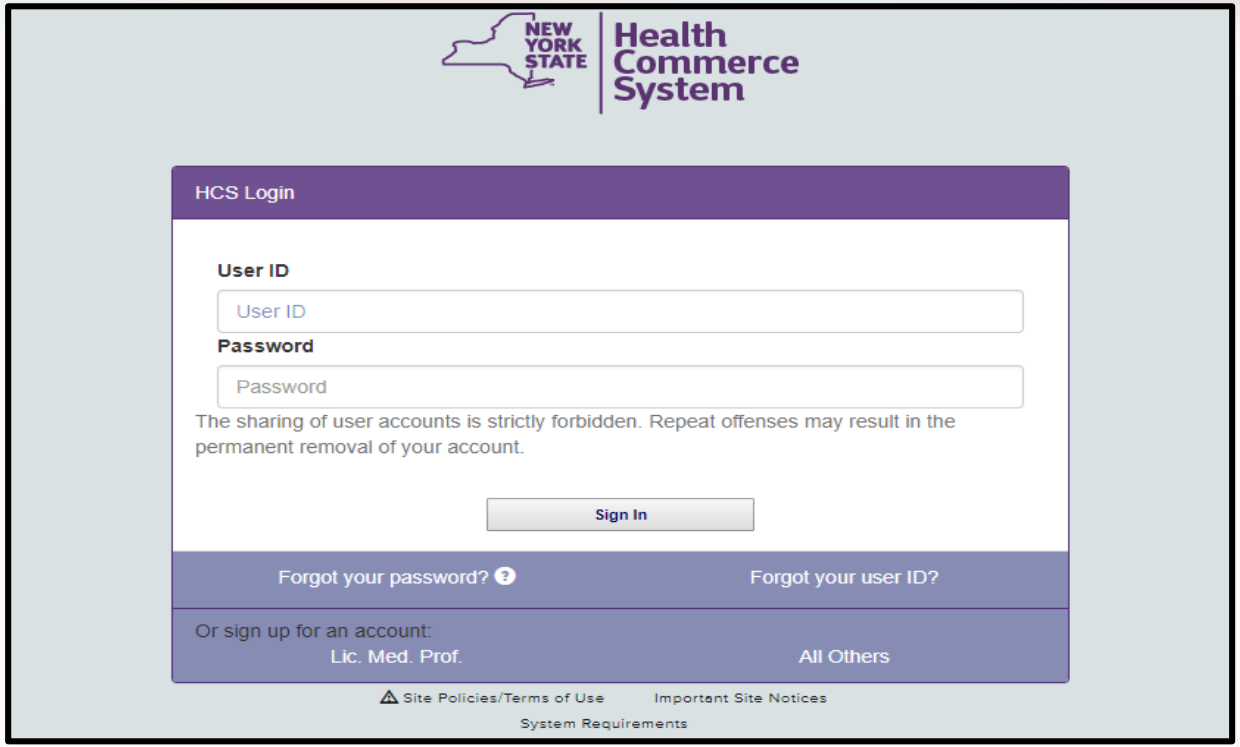
- The data considered by the practitioner must be obtained from the PMP Registry no more than 24 hours before the prescription is issued.

PMP Duty to Consult—Practitioners

- Law allows for the use of designees
- Practitioner must train designee on appropriate use of the PMP
- Practitioner is responsible for their activities

Pharmacist Access to PMP Registry

- Pharmacists may designate another pharmacist or pharmacy intern.
- Pharmacy technicians and other pharmacy employees are PROHIBITED from access to the PMP Registry.
- Pharmacists are PROHIBITED from providing a PMP report, upon request, for any law enforcement official, including a DEA agent.
- Pharmacist may NOT access the PMP Registry for someone for whom they do NOT have a prescription.



How to Access the PMP

It is necessary to obtain a Health Commerce System (HCS) account, to provide secure online access to an individual's recent controlled substance prescription history.

2017 Reporting Statistics

- Over 4,700 pharmacies are currently reporting;
- Average of 80,728 dispensed prescription records sent each day; and
- Just under 23 million unique dispensed controlled substance prescription records reported in 2017.
  - Just under 8 million opioid prescriptions reported in 2017.

New York PMP Usage

2/16/10 through 8/26/13: 19,000 users

- performed 950,000 searches
- for 202,714 patients

8/27/13 through 2/28/18: 114,197 unique users

- performed over 80.6 million searches
- for over 15 million unique patients
- 18,739,213 searches occurred in 2017 alone
- Over 47 searches have been handled per second

EHR Integration

- In NYS, practitioners are required to consult the PMP prior to writing a Schedule II, III or IV controlled substance.

- The Bureau of Narcotic Enforcement, within the New York State Department of Health, is continually assessing ways to make the PMP more easily accessible to practitioners.

EHR Integration

- Another strategy to ease access to the PMP is full EHR integration. This simplifies access and does not require a practitioner to leave one application and log into a separate PMP application.

- Under the CDC grant, the Department of Health proposes an optional pilot to provide a cost-free alternative (other than implementation costs on the side of the health system) to integration. The state will not charge monthly or maintenance fees to health systems connected to the EHR.

- The Department of Health is exploring how to deploy the integration.

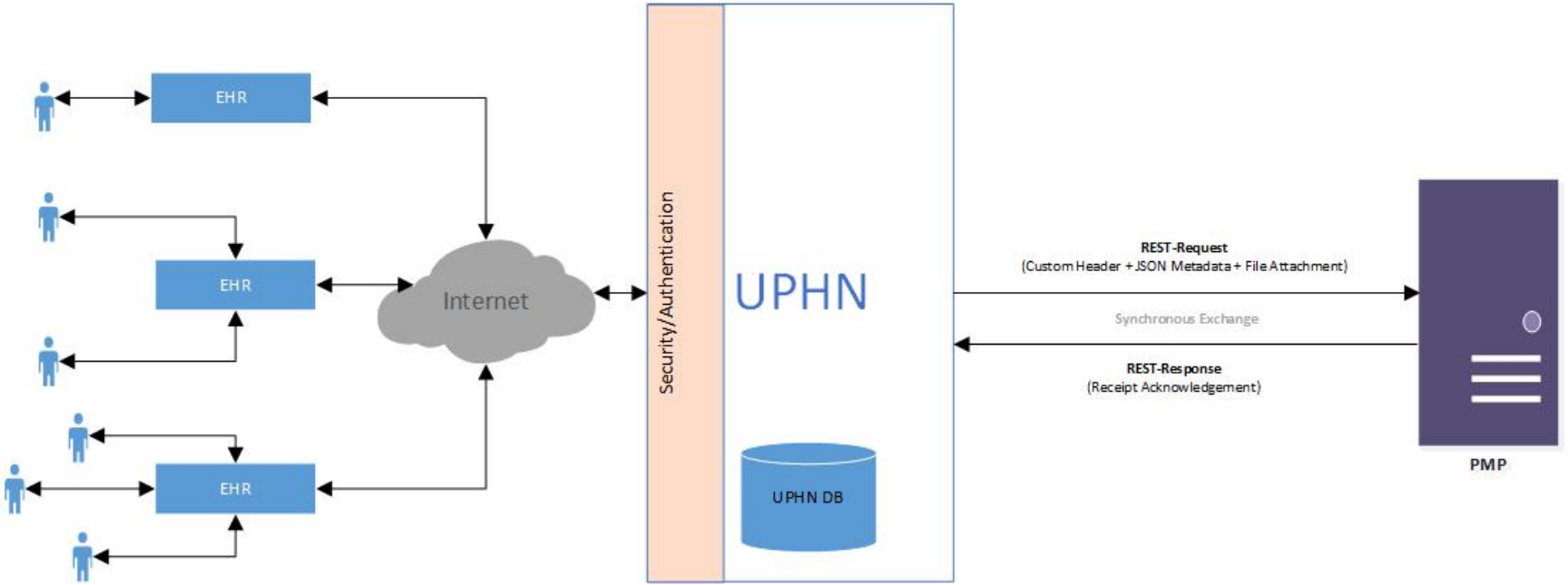
EHR Integration

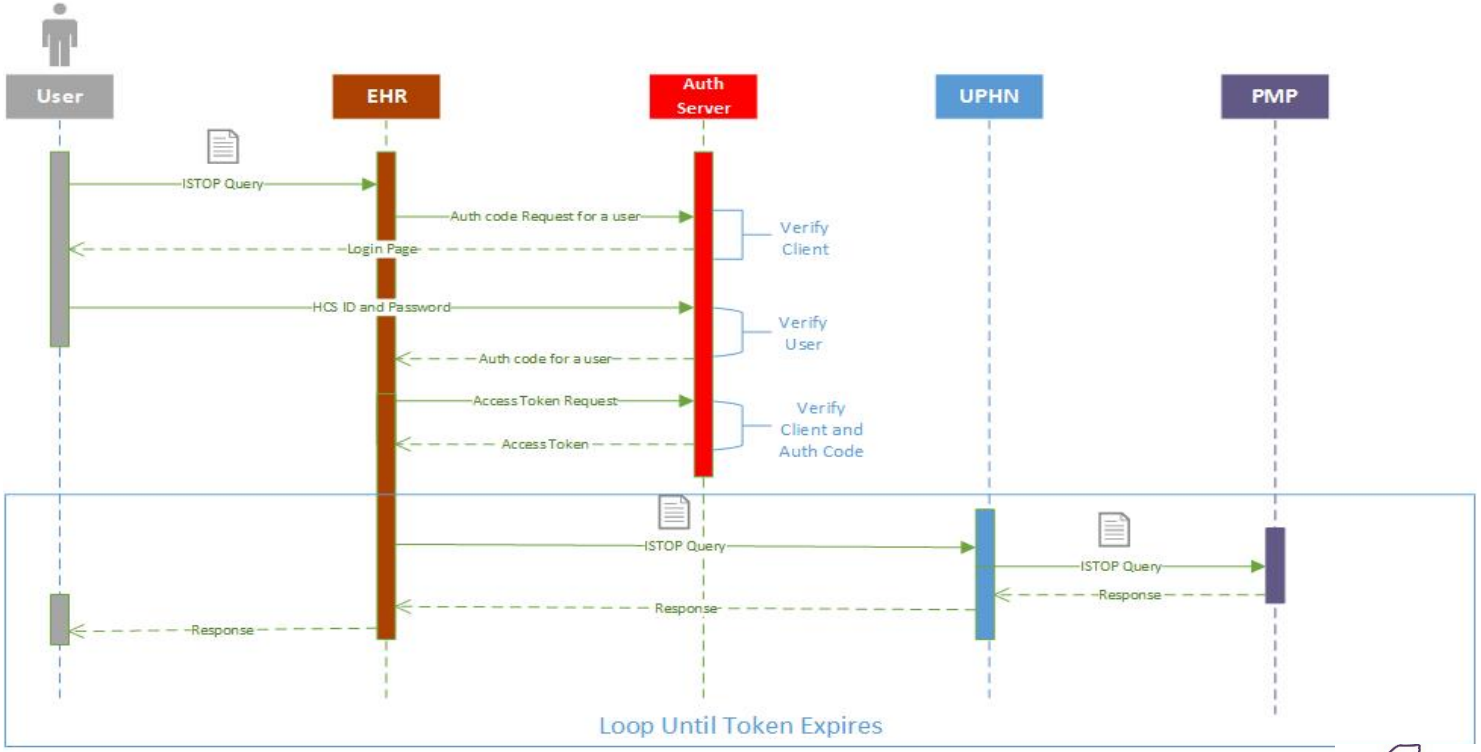
- The Health Commerce System, the current access point, will continue to be maintained.

- The Single Sign-On solution developed under a different grant will also continue.

EHR Integration—Lessons Learned (so far)

- Sustainability—Concerns with grant funding decreases or elimination, staffing, upgrades and maintenance to the system.
- PMP data sharing with other states using the State provide IT solution may not be available, which could be problematic with high density areas sharing borders with multiple states. (NYC and PA, NJ, CT and MA)
- MOUs will be needed. Still exploring how and at what level these are required.


EHR
EHR
EHR
Internet
Security/Authentication
UPHN
UPHN DB
REST-Request
(Custom Header + JSON Metadata + File Attachment)
Synchronous Exchange
REST-Response
(Receipt Acknowledgement)
PMP


User
EHR
Auth Server
UPHN
PMP
ISTOP Query
Auth code Request for a user
Verify Client
Login Page
HCS ID and Password
Verify User
Auth code for a user
Access Token Request
Verify Client and Auth Code
Access Token
ISTOP Query
ISTOP Query
Response
Response
Response
Loop Until Token Expires

Discussion and Next Steps