NEW YORK STATE OF OPPORTUNITY. Department of Health

New York State Department of Health Statewide Steering Committee

January 29, 2018

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 - 10:45	Marcus Friedrich Susan Stuard
2	NYS PCMH ▪ NYS PCMH & NCQA Updates ▪ Medicaid Update ▪ PCMH & SHIN-NY	10:45 - 11:30	Marcus Friedrich Jeanne Alicandro Lori Kicinski Ron Bass Jim Kirkwood
3	Practice Transformation Progress ▪ Enrollment & TA Vendor Updates ▪ APC Scorecard feedback & summary ▪ DFS Support	11:30 - 12:00	Patrick Russell Scott Rader Paul Henfield/Anne Marie Audet John Powell
4	ROMC Progress & 2018 Goals	12:00 – 12:15	Susan Stuard Amy Tippett Stangler Thomas Mahoney
5	ROMC Vision ▪ Working Lunch	12:15 – 12:45	Gene Heslin
6	Consumer Engagement (3 proposals)	12:45 - 1:15	Marcus Friedrich Angella Timothy
7	Sustainability Planning ▪ Breakout Sessions (15-20 mins) ▪ Group Discussion	1:15 - 2:20	Marcus Friedrich Anne Schettine Susan Stuard
8	Closing Remarks and Next Meeting	2:20 - 2:30	Susan Stuard Marcus Friedrich

NYS PCMH

Developments: NYS PCMH 2017

Since August 2017, SIM team has been reviewing and aligning the NYS APC and NCQA PCMH guidance to define the NYS PCMH 2017 model.

SIM team goals were to:

(1) maximally align model to maintain key elements of NYS APC,
(2) strengthen existing APC model, and
(3) retain integrity of material evidence for NYS model.

Overview of material evidence alignment

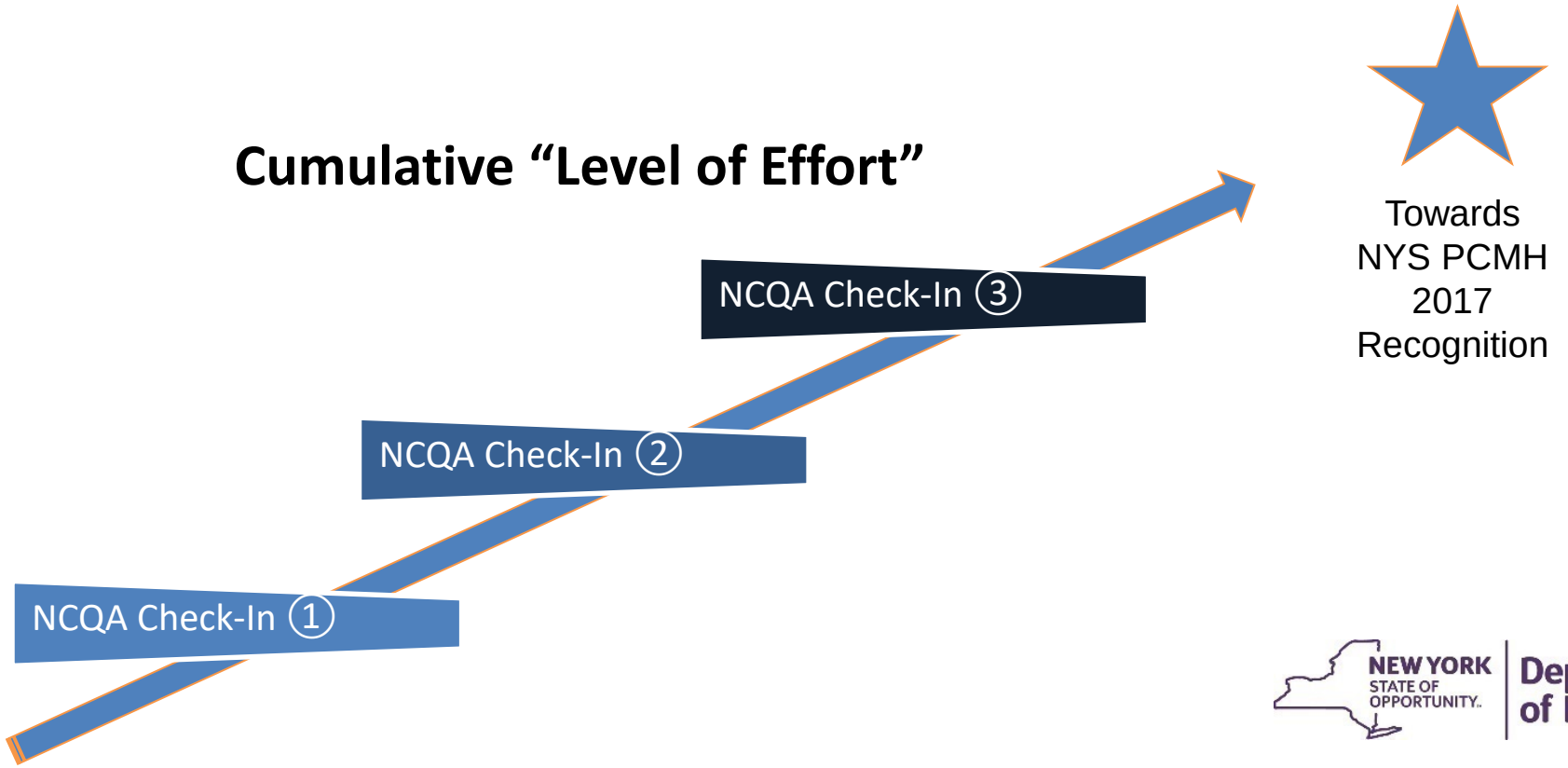
- Material evidence is how practice transformation progress is evaluated
- 50 items of material evidence are required for NYS APC
- 222 items of material evidence are required for NYS PCMH 2017
  - 150 of these items are for **core** elements
  - 77 of these items are for **elective** elements

Material Evidence: NYS PCMH 2017

Status	Units of Material Evidence
CORE	
Maintained original NYS APC Standards	63
Kept NYS APC Standards w/supplement	56
Integrate NCQA PCMH standards	31
ELECTIVE	
Maintained original NYS APC Standards	18
Kept NYS APC Standards w/supplement	24
Integrate NCQA PCMH standards	30
ALL NYS PCMH 2017	
Maintained original NYS APC Standards	81
Kept NYS APC Standards w/supplement	80
Integrate NCQA PCMH standards	61

PT TA Performance Roles in NYS PCMH 2017

- NCQA will conduct 3 Virtual Check-Ins with each Practice
- PT TA's will partner through the entire Check-In and Recognition process
- PT TA's will be required to ensure benchmarked progress for submitting documentation to NCQA



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NYS Medicaid PCMH Update

Ronald Bass - Director Bureau of Medical, Dental and Pharmacy Policy

Division of Program Development and Management

Office of Health Insurance Programs

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PCHM & SHIN-NY Support

NYS PCMH & SHIN-NY Services

- DOH is working with NYeC to clearly identify areas of alignment between NYS PCMH standards and SHIN-NY services available to providers
- NYS PCMH practices can leverage the services offered by the State Health Information Network for New York (SHIN-NY) to achieve their transformation goals
  - Core Services offered statewide* by all QEs
  - Value-added services offered regionally through Qualified Entities (QEs)* (availability varies by QE) NYS PCMH & SHIN-NY Services
- NYS PCMH success will require:
  - Access to patient data
  - Coordinated communication between care team providers
  - Timely notification of critical patient events
  - Ability to exchange patient information to support care coordination

*All information regarding the utilization of SHIN-NY services assumes providers have received written affirmative consent from patients to access data from the QE

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NYS PCMH & SHIN-NY Core Services

All QEs across the state provide several **Core Services** to their participants, including the following which both directly enable and indirectly support a practices' efforts to meet many of the NYS PCMH standards:

- **Patient Record Lookup** may be used to:
  - Access patient data, care plan information, and augment patient information contained in the practice EHR
  - Provide information on services obtained from other providers in the community or state including ED visits
  - Assess patients' adherence to medications where access to medication fill data exists
  - Assist with determining whether a patient fits criteria for care management
- **Statewide Secure Messaging (Direct)** can:
  - Enable communication between providers to support care transitions including requests for summaries of care, medication information, and additional patient information
  - Allow providers to share patient data with a hospital
  - Ensure a coordinated referral process
- **Notifications (Alerts / Subscribe and Notify) can be utilized to:**
  - Keep providers and other care team members aware of admissions, transfers, and discharges of patients
  - Signals providers of potential concerns or new diagnoses for patient(s)
- **Lab Results Delivery:**
  - Sends ordering providers and others designated lab results which supports clinical decision making and eliminates potential duplicative testing

NYS PCMH & QE Value-Added Services

- In addition to the Core Services offered statewide, each QE offers their own set of value-added services to their local participant community
- While these regionally available value-added services vary by QE, some include but are not limited to:
  - Advanced Alerts/ Clinical Event Notifications
  - Patients Portals
  - Analytics/ Population Health Insights
  - Image Exchange
  - Clinical Data Forwarding
  - Qualified Clinical Data Registry Services

HIT-Enabled Quality Measurement Leveraging Clinical Data

	Administrative/ Claims-Based	Hybrid	Proxy	eCQM
Numerator	Claims	Claims & Chart Review	EHR or CDR	EHR or CDR
Denominator	Claims, Member Data	Claims, Member Data	EHR or CDR	EHR or CDR
Additional Information	Supplemental data may be used to find numerator events & denominator exclusions	A sample of the population is targeted for chart review	Approximates spec using available electronic data May "loosen" the spec	Specification is used to build a query of the clinical data source
Uses/ Example	Health plan HEDIS reporting/APC/VBP	Health plan HEDIS reporting/APC/VBP	Frequent measures to drive pop health mgmt	Monitoring, Required Reporting

CLINICAL QUALITY MEASURES - METHODS

EHR – Electronic Health Record
CDR – Clinical Data Repository

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HIT-Enabled Quality Measurement Current Needs and Solutions

	Plans	Providers	NYSDOH
WHAT	• Produce HEDIS measures • Share measures with providers in P4P programs	• Close gaps in care to improve measures • Report measures or data for incentive programs	• Measure APC practices and VBP pilots
HOW	• Receive some EHR and lab data to supplement claims • Data comes from QE, aggregators, labs, practices, hospitals	• Use EHRs or aggregators to produce measures • Receive gaps in care reports from plans	• Leverage plans' HEDIS processes

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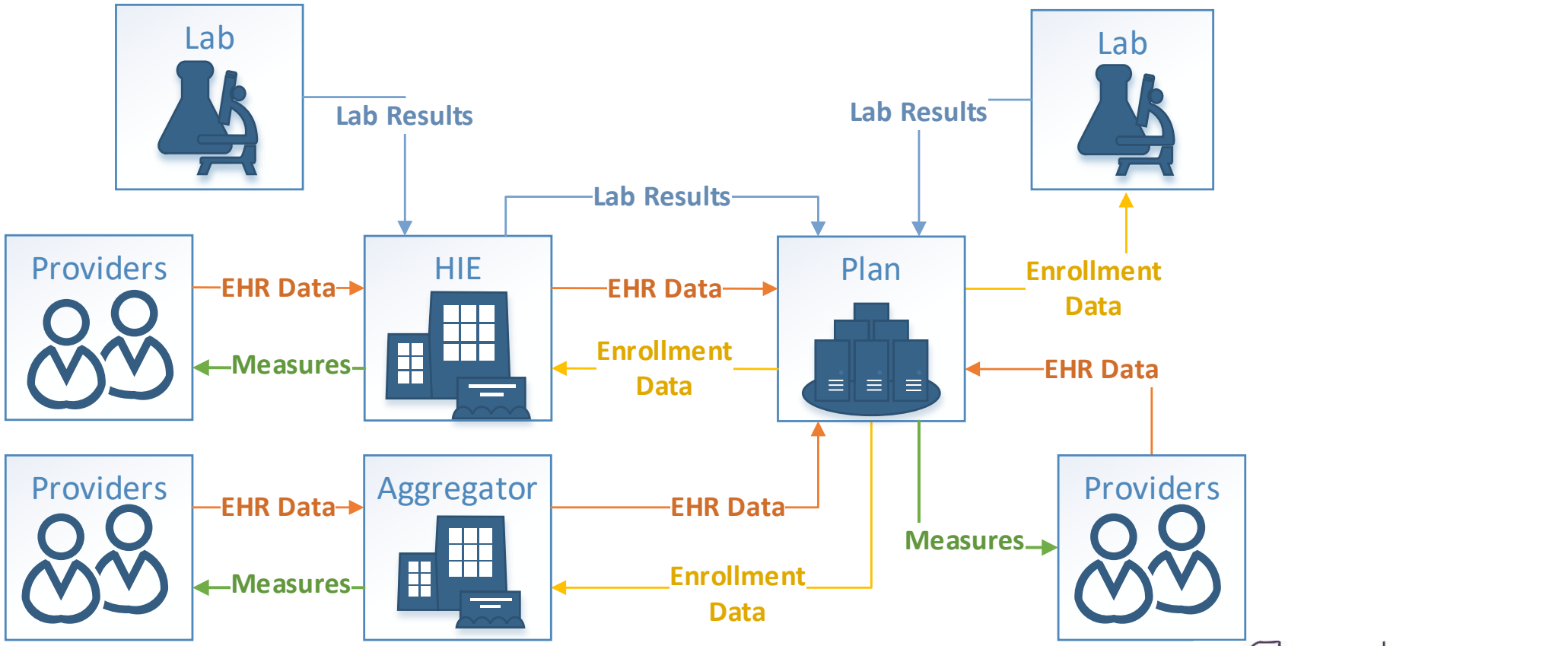
HIT-Enabled Quality Measurement
Current State



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HIT-Enabled Quality Measurement
Limitations of the Current State

Many solutions to a few problems

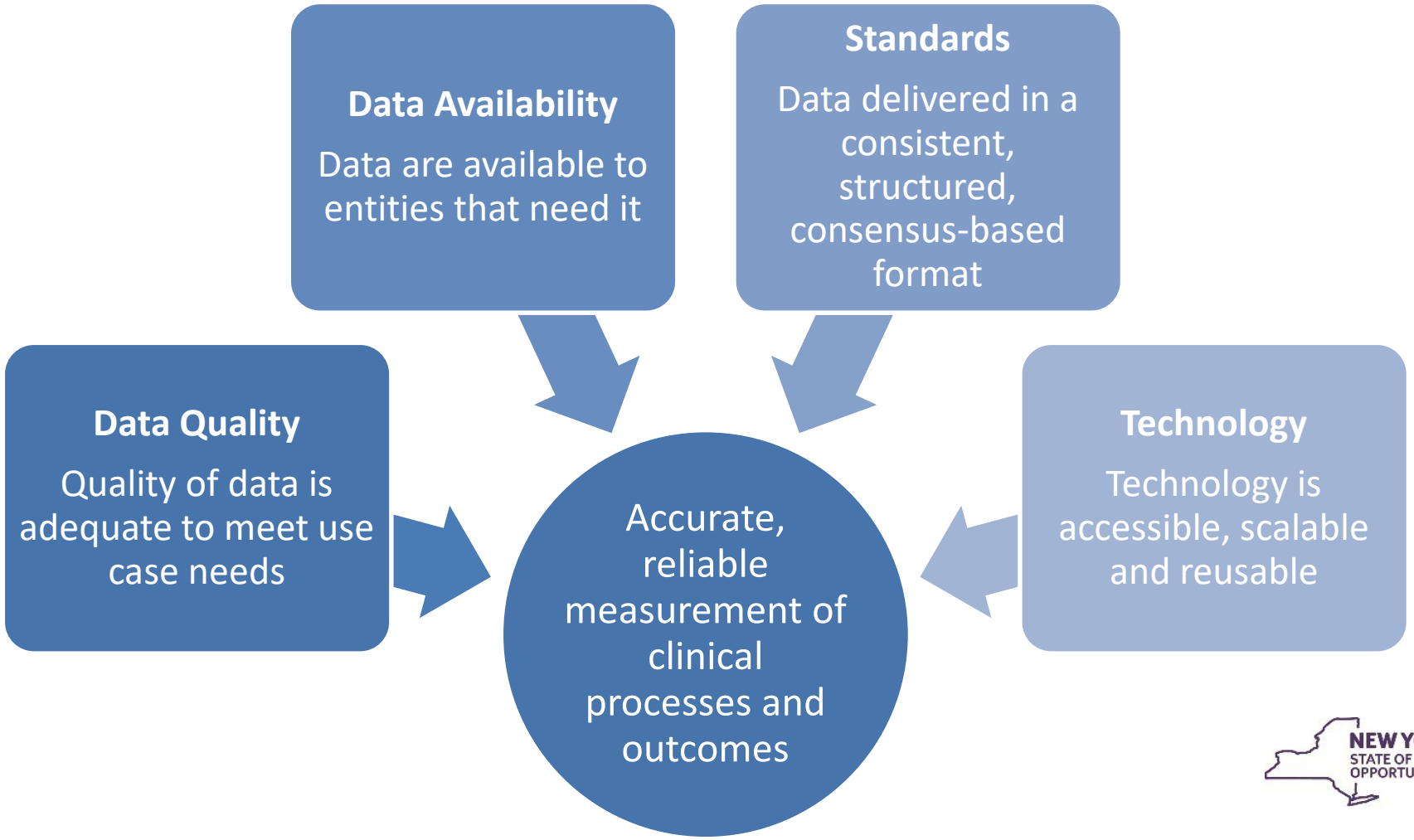
Many point-to-point connections, which are redundant and resource-intensive to manage….

….yet an inadequate amount of data, leaving both plans and providers with unmet needs

No agreed upon and consistently used standard

Inadequate data quality

HIT-Enabled Quality Measurement Characteristics of the Future State



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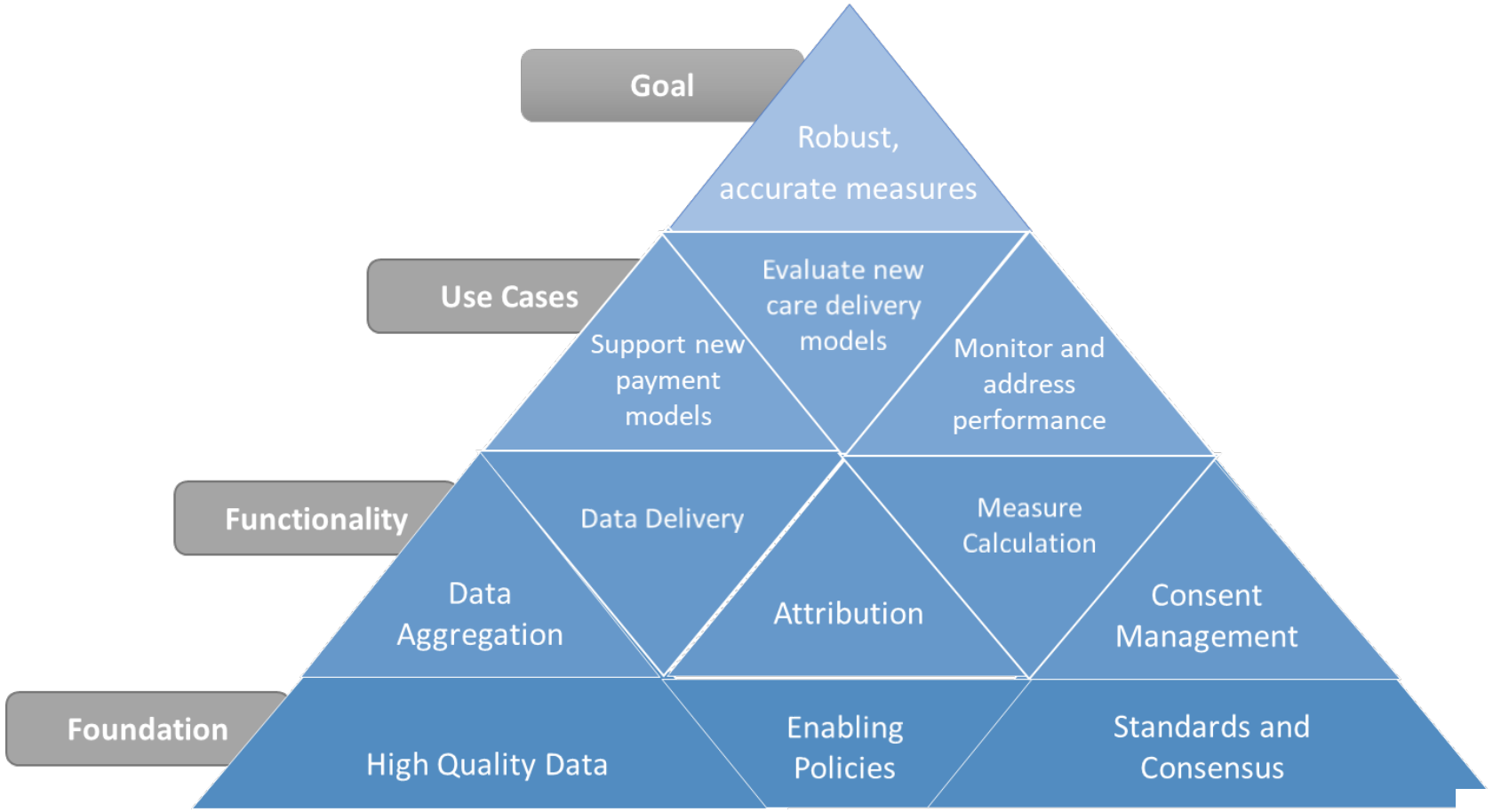
HIT-Enabled Quality Measurement
Future State Building Blocks



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HIT-Enabled Quality Measurement Path to the Future State

Activity	Description
Standards & Consensus Building	• ***Develop and disseminate standards*** for data needed to support quality measurement, ensuring alignment with ***national standards and initiatives*** • Communication channels to ensure a ***strategic & systematic approach*** to the future state
VBP Measure Testing Project	• ***Leverage clinical data*** to calculate the Controlling High Blood Pressure measure • ***Results and lessons learned will be scalable*** beyond VBP pilots and shared with NCQA and CMS
Strengthen QE Quality Measurement Capacity	• SIM project to fund QEs to ***improve data quality, assess current capacity and establish partnerships*** with plans and practices to enable measurement of APC practices
Quality Measurement Clearinghouse	• Determine requirements, explore technical options and develop solution to ***centralize, standardize and deliver data*** (starting with lab results) to plans and others for use in quality measurement and population health management

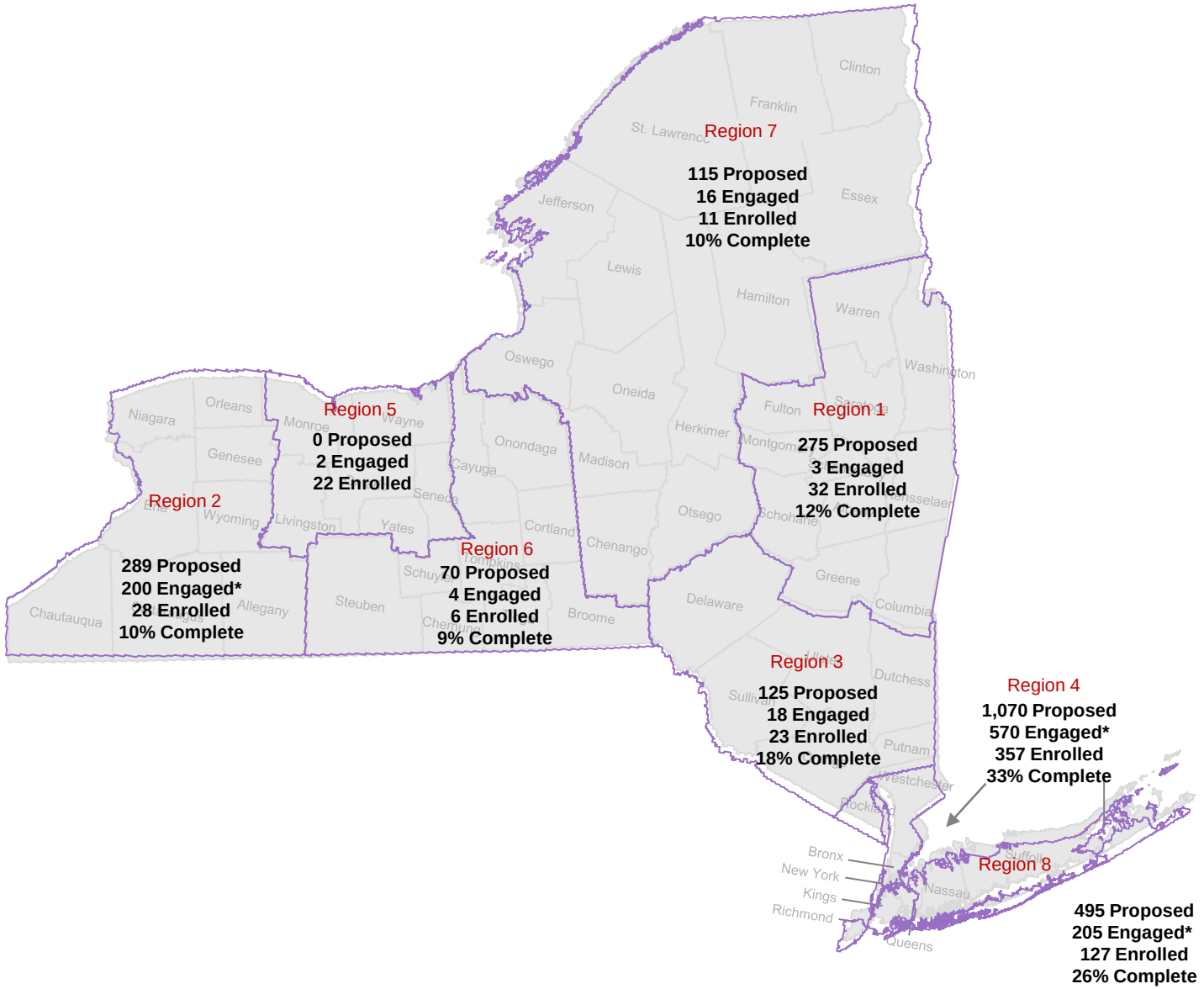
Practice Transformation Progress

NY State of Transformation – SIM/APC Facts

- The NYS SIM team held our second annual in person TA summit on 1/25/18
  - Over 100 attendees in person
  - Representation from all 15 TAs in NYS
- Practice Summary (as of 1/25/18)
  - 633 Enrolled Practices
  - 75% of enrolled practices fall into the small category of 1-4 providers.
    - Small (1-4) – 75%
    - Medium (5-10) – 18%
    - Large (>10) – 7%
  - Estimated 2,400+ individual providers receiving direct TA support on APC practice transformation (based on projections using available data in our PTTS system)

APC Recruitment Status – 01/22/18

2,439 Proposed
1018 Engaged
633 Enrolled
25.50 % Complete
Statewide



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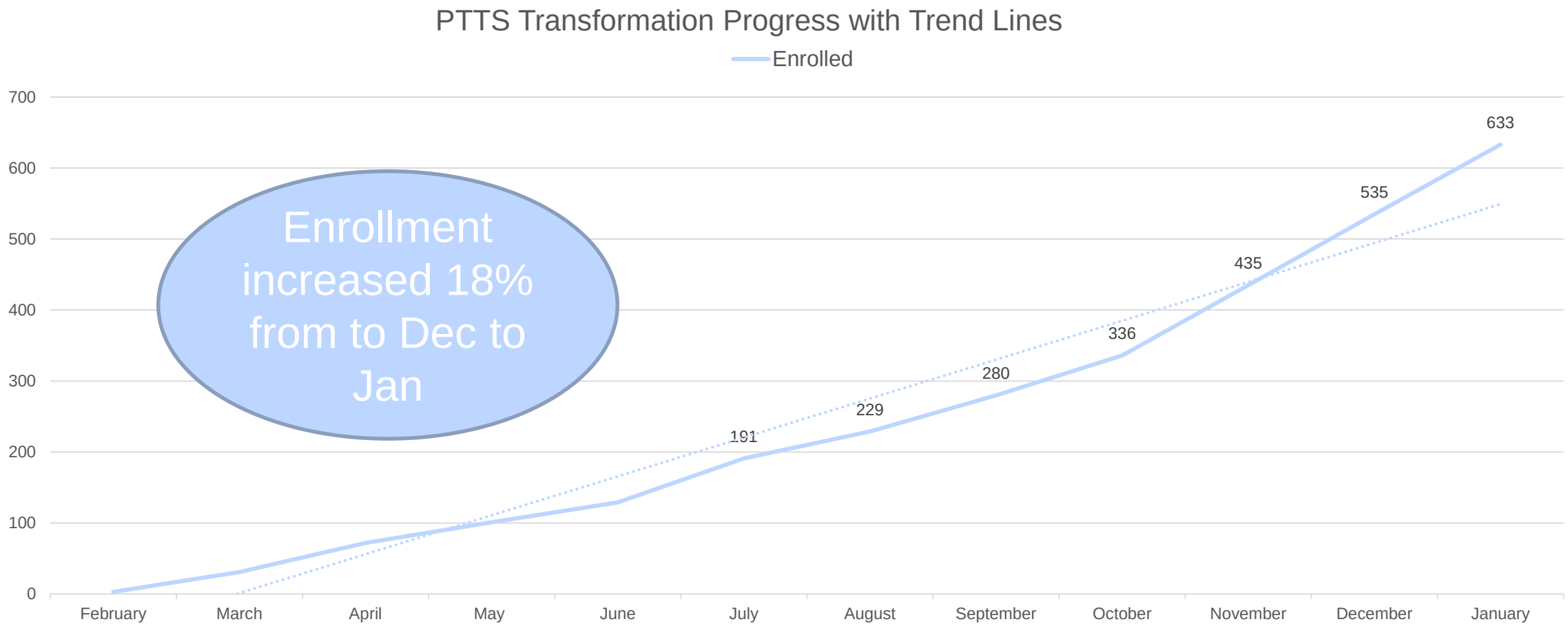
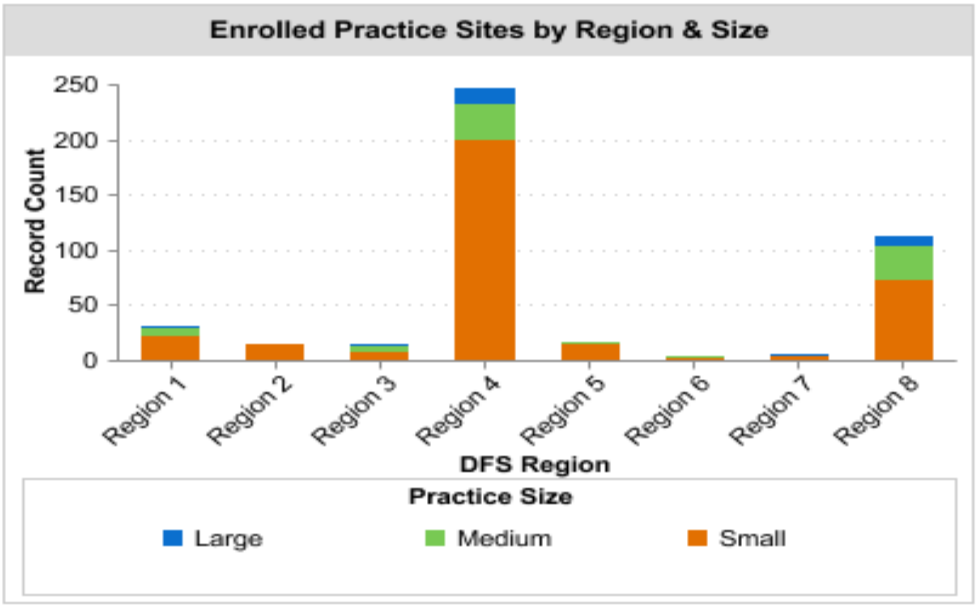
Enrolled Practices Progress



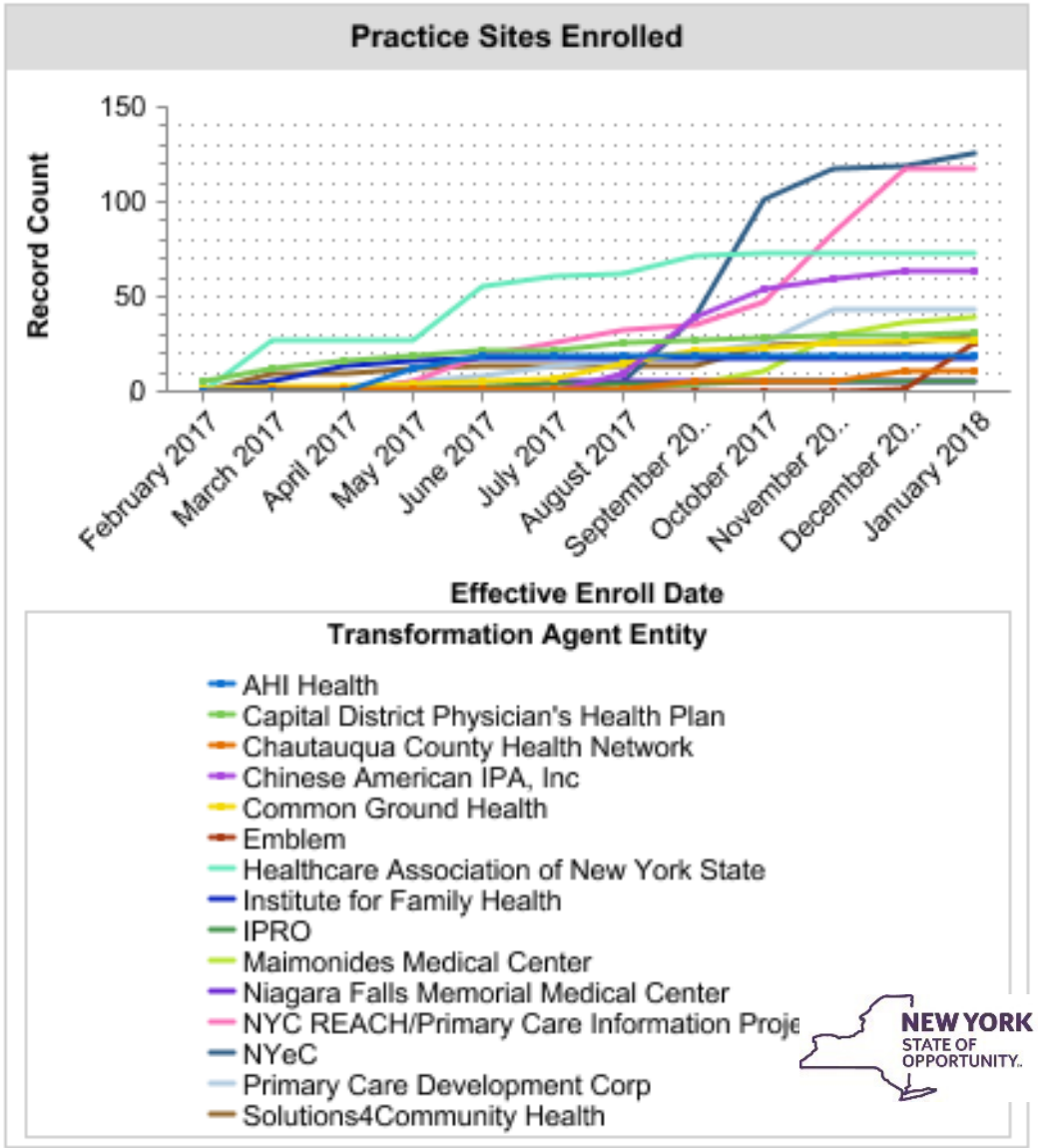
NY State of Transformation – SIM/APC Facts

Enrolled Practice Sites by Region

DFS Region	Record Count
Region 1	32
Region 2	28
Region 3	23
Region 4	384
Region 5	21
Region 6	6
Region 7	11
Region 8	128



Small = 1-4 primary care physician and mid-level providers; medium = 5-10; large = 11+



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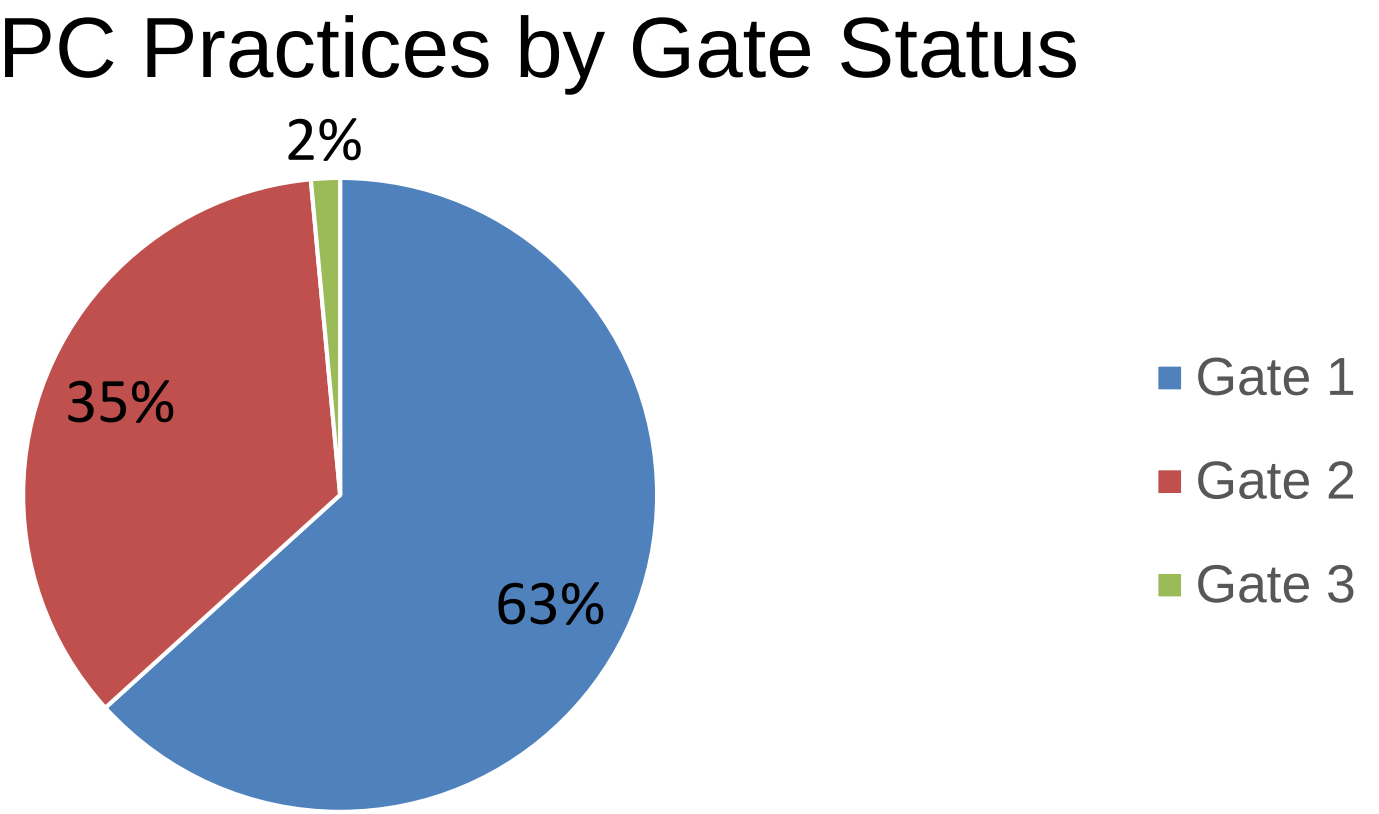
Gate 1 Practices – Length of Time Since Enrollment as of 1/26/18



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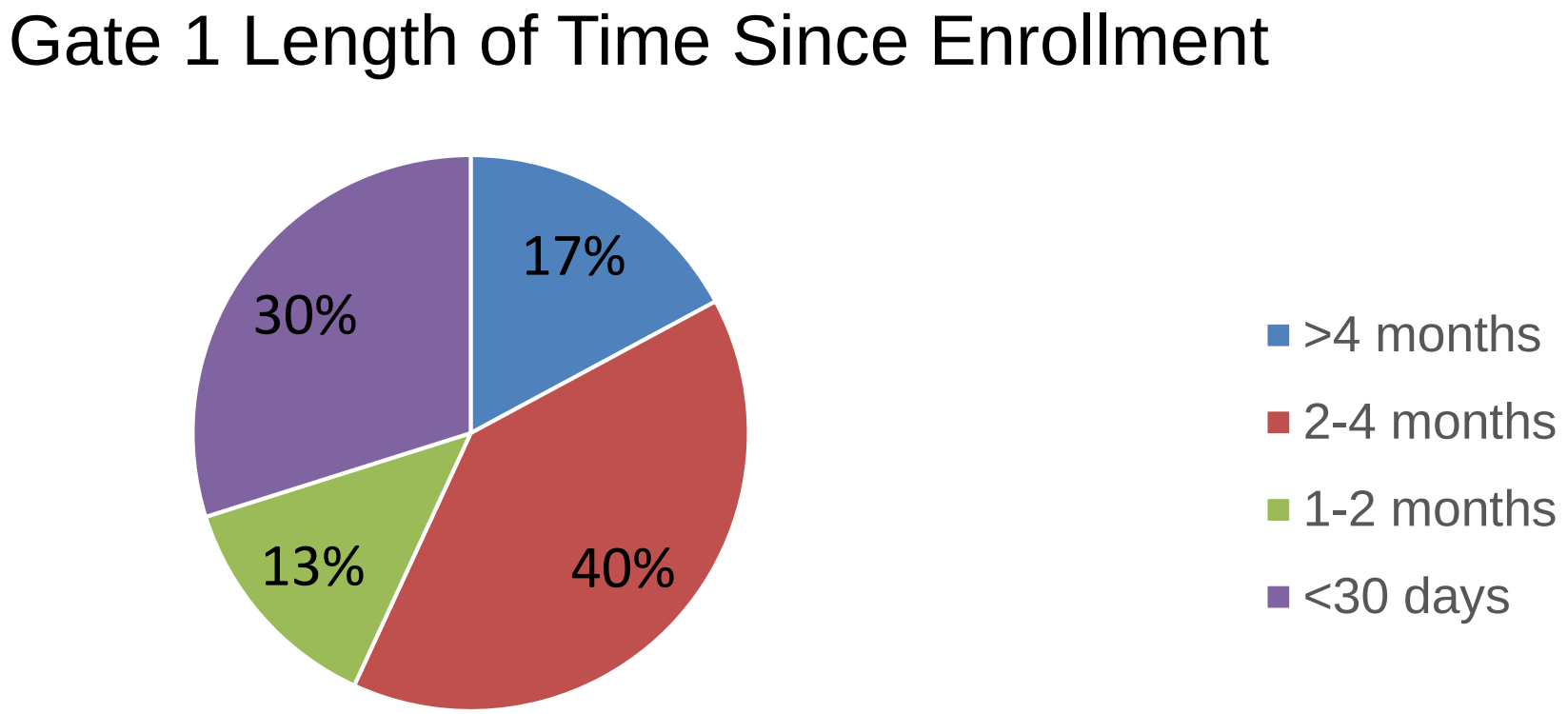

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APC Scorecard Year 1 Update

Background and Overview

- 23 Payers reported 13 HEDIS Measures
  - 2016 HEDIS was reported
  - Reported at the patient level with service provider information
  - Practice results were aggregated at a TIN (tax id) level.
  - All relevant LOBs were reported when available (i.e., commercial, Medicaid, Medicare)
- 3,191,030 unique members were reported (i.e., members in at least one measure)
- Reports for 18,623 unique practices were generated (both APC and non-APC)
  - Report was generated for any practice with at least 20 attributed patients for one measure
- Reports were issued to practices in the APC initiative

Background and Overview (Cont.)

Measures Included in the Scorecard:

- Childhood Immunization Combo 3
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Medication Management for People with Asthma
- Persistent Beta Blocker Treatment After Heart Attack
- Comprehensive Diabetes Care: HbA1c Testing, Eye Exam, Nephropathy
- Antidepressant Medication Management
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Imaging Studies for Low Back Pain
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- **23 payers in total submitted data:**
  - Affinity -- United HealthCare
  - Amida Care -- United Community
  - CDPHP -- Univera
  - Empire -- VNS
  - Empire BCBS -- WellCare
  - Excellus -- YourCare
  - Fidelis
  - GHI
  - HIP (EmblemHealth
  - HealthNow NY
  - HealthFirst
  - Independent Health
  - MetroPlus
  - MVP
  - Oscar
  - Oxford
  - Total Care

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Aggregation Process

- Practices were aggregated across payers using the Practice TIN
  - 973,666 records with missing/incorrect Practice TINs
    - 973,092 unique members with missing/incorrect Practice TINs
- Payers reported by LOB and LOB benchmarks were calculated
- Measure results were checked for reasonability by payer/LOB and outliers were flagged for correction

Aggregation Process

- IPRO conducted the analysis, which was replicated by the OQPS for accuracy

Practice Report

- Report grouped measure results by domain (Prevention, Chronic Disease, Behavioral Health/Substance Abuse, Appropriate) with benchmarks by product line (Commercial, Medicaid, Medicare).

- Bar graph with practice measure results compared to the statewide benchmark.

- Written sections with technical notes, data definitions, available resources (UHF, IPRO, PT agents) and appendix to guide use of the report.

Summary Statistics

Measure	Subcategory	Commercial Rate	Medicare Rate	Medicaid Rate	Total Rate
Childhood Immunization		63.7%	.	67.0%	66.0%
Breast Cancer Screening		71.7%	76.8%	71.0%	72.7%
Cervical Cancer Screening		77.6%	44.1%	69.4%	73.7%
Chlamydia Screening	16-20 yrs	59.9%	.	72.7%	67.5%
Chlamydia Screening	21-24 yrs	68.5%	66.7%	74.7%	71.2%
Spirometry Testing COPD		48.3%	44.7%	51.9%	47.9%
Med Mgmt. for people with Asthma	5-18 yrs (50%)	58.3%	.	53.6%	54.2%
Med Mgmt. for people with Asthma	19-50 yrs (50%)	66.2%	78.2%	64.0%	65.1%
Med Mgmt. for people with Asthma	51-85 yrs (50%)	74.3%	82.0%	77.2%	77.8%
Med Mgmt. for people with Asthma	Total (50%)	67.9%	81.8%	61.5%	65.4%
Med Mgmt. for people with Asthma	5-18 yrs (75%)	34.2%	.	26.4%	27.5%
Med Mgmt. for people with Asthma	19-50 yrs (75%)	43.3%	59.6%	37.8%	40.2%
Med Mgmt. for people with Asthma	51-85 yrs (75%)	55.2%	62.1%	53.9%	56.9%
Med Mgmt. for people with Asthma	Total (75%)	46.3%	61.9%	35.4%	41.2%

Summary Statistics (Cont.)

Measure	Subcategory	Commercial Rate	Medicare Rate	Medicaid Rate	Total Rate
Persistent Beta Blocker		83.9%	92.8%	86.4%	88.7%
Statin Therapy for Patients w Cardiovascular disease	Males 21-75 yrs - Received	82.7%	81.5%	76.7%	80.4%
Statin Therapy for Patients w Cardiovascular disease	Males 21-75 yrs - Adherence	63.2%	76.6%	67.1%	70.8%
Statin Therapy for Patients w Cardiovascular disease	Females 40-75 yrs - Received	72.3%	75.3%	68.7%	72.6%
Statin Therapy for Patients w Cardiovascular disease	Females 40-75 yrs - Adherence	58.4%	71.1%	61.7%	66.3%
Comprehensive Diabetes Care	HbA1c Test	89.5%	93.5%	90.3%	90.9%
Comprehensive Diabetes Care	Eye Exam	46.4%	69.4%	56.6%	56.2%
Comprehensive Diabetes Care	Nephropathy	87.0%	95.3%	92.2%	91.1%
Statin Therapy for Patients w Diabetes	Received	61.4%	71.6%	64.4%	66.1%
Statin Therapy for Patients w Diabetes	Adherence	68.5%	75.3%	60.3%	67.2%

Summary Statistics (Cont.)

Measure	Subcategory	Commercial Rate	Medicare Rate	Medicaid Rate	Total Rate
Antidepressant Medication Management	Acute Phase	67.2%	68.6%	51.5%	59.0%
Antidepressant Medication Management	Continuation Phase	51.9%	54.6%	36.7%	44.3%
Diabetes Screening for People w Schizophrenia		81.6%	98.2%	82.1%	82.1%
Avoidance of Antibiotic Treatment in Adults w Acute Bronchitis		25.9%	20.3%	31.2%	28.2%
Use of Imaging Studies for Low Back Pain		74.6%	81.1%	77.6%	75.9%
Initiation and Engagement of Alcohol	13-17 yrs - Initiation	39.0%	.	40.2%	39.8%
Initiation and Engagement of Alcohol	18+ yrs - Initiation	39.0%	44.1%	53.0%	48.0%
Initiation and Engagement of Alcohol	Total - Initiation	39.0%	44.1%	52.6%	47.8%
Initiation and Engagement of Alcohol	13-17 yrs - Engagement	19.3%	.	14.1%	15.8%
Initiation and Engagement of Alcohol	18+ yrs - Engagement	15.7%	6.6%	24.1%	19.7%
Initiation and Engagement of Alcohol	Total - Engagement	15.8%	6.6%	23.8%	19.6%

Members by LOB and Tax IDs

Total	Attributed to Tax ID	Commercial	Medicare	Medicaid
3,192,905*		1,549,022	379,532	1,264,351
	2,219,239	698,595	302,968	1,217,676

- Number of Unique Tax IDs (practices) = **18,623**

* Some members are in more than one LOB

Potential sources of error

- Data Completeness
  - Managed Care services only
  - Most but not all payers reported and some could not report entire book of business
  - Missing TINs
  - Continuous enrollment requirements

- Attribution Process
  - Member >>> Service Provider
  - Provider >>> Practice
  - Practice Aggregation Across Payers

Lessons Learned

- Reporting at the Practice Site may be most actionable
- TIN format issues (all numeric characters and length should equal 9)
- Duplicate members in measures (2 or more LOBs)
- Need for payers to review data before submitting (e.g., denominator/numerator for EOC measures should be ‘0’ or ‘1’, checking rates for reasonability)

Year 2 Next Steps

- File Request to be sent to payers in February, 2018
  - Attempt to collect practice site information
  - Two HEDIS Utilization measures added: AMB and IPU
  - Four new VPB measures added for Medicaid only (CDC HbA1c Poor Control (>9.0%), Initiation of Pharmacotherapy upon New Episode of Opioid Dependence, Weight Assessment and Counseling for Nutrition and Physical Activity
- Conference call/webinar to be held in February/March 2018 with payers
- Deadline for submitting data – August 17, 2018
- Reports Issued in November, 2018

YOUR PRACTICE REPORT

Reporting Period: January 1 - December 31, 2016

		Your Practice			Benchmark by Product		
Domain	Measure	*Numerator*	*Denominator*	*Result*	*Commercial*	*Medicaid*	*Medicare*
Prevention	**Cervical Cancer Screening**	18	21	86	78	65	57
	Breast Cancer Screening	4,706	5,668	83	74	73	79
	Chlamydia Screening						
	Patients of age 16 - 20 years	864	1,027	84	64	75	NA
	Patients of age 21 - 24 years	486	606	80	70	76	50
	Total	1,350	1,633	83	67	76	40
	Childhood Immunization Status - Combo 3	30	33	91	76	76	NA
Chronic Disease	**Comprehensive Diabetes Care: HbA1C Testing**	112	115	97	91	89	94
	Comprehensive Diabetes Care: Eye Exam	76	115	66	49	58	72
	Comprehensive Diabetes Care: Medical Attention for Nephropathy	109	115	95	89	91	95
	Persistent Beta Blocker Treatment after Heart Attack	72	80	90	88	86	94
	Medication Management for People with Asthma						
	On medication for at least 50% of treatment period	445	777	57	69	58	81
	On medication for at least 75% of treatment period	256	777	33	47	34	59
Behavioral Health/ Substance Use	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**						
	Initiation of treatment within 14 days of diagnosis	212	427	50	38	52	40
	Engagement of treatment (two/more services) within 30 days of initiation	46	427	11	14	24	5
	Antidepressant Medication Management						
	Acute Phase: on medication for at least 12 weeks	419	722	58	65	53	66
	Continuation Phase: on medication for at least 6 months	328	722	45	51	38	50
Appropriate Use	**Use of Imaging Studies for Low Back Pain**	92	351	74	77	77	77
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	47	77	39	28	31	24

SS: Suppressed for denominator values < 20

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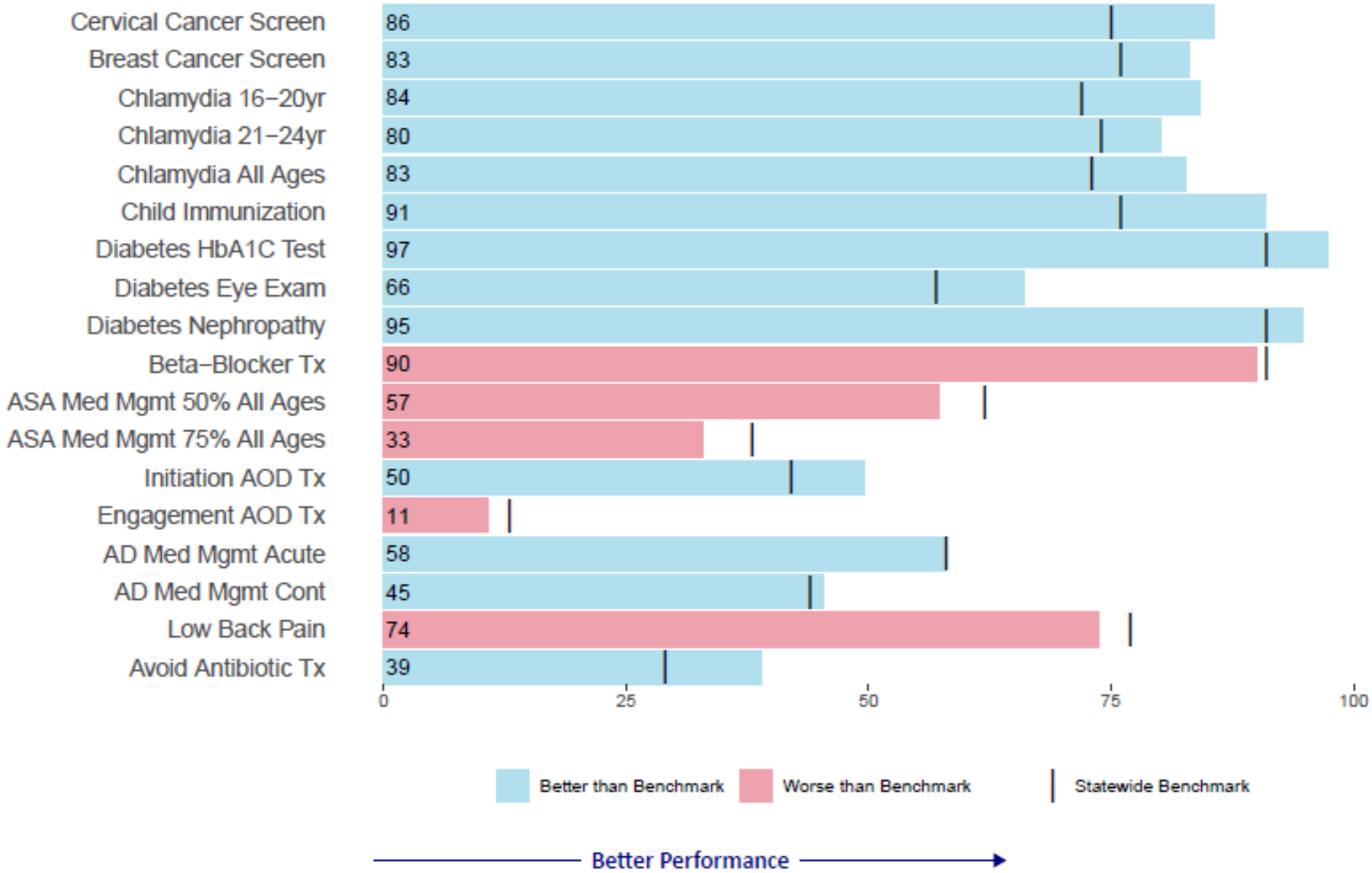
Your Practice Compared with Statewide



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UHF Quality Institute

Statewide Steering Committee

Feedback on the APC Scorecard Narrative Report

Anne-Marie J. Audet, Senior Medical Officer
Lynn Rogut, Director, Quality Measurement and Care Transformation
Roopa Mahadevan, Policy and Program Manager

January 29, 2017

United Hospital Fund

UHF's Approach for Obtaining Feedback

- Aims:
  - ❑ Seek input from stakeholders on:
    - Scorecard report content, format, and usefulness.
    - How the Scorecard can support QI and complement broader primary care transformation in regions and statewide.
  - ❑ Develop a brief report summarizing the feedback with recommendations.
  - ❑ Inform the development of the next (2018) Scorecard based on feedback.

- Stakeholders include:
  - APC-enrolled practices that received the scorecard
  - PT TA Agents who shared the scorecard with practices
  - Payers that provided data for the Scorecard
  - ROMCs
  - SSC

Audience	Mode	Content	Timing
PT TA agents	▪ In-person PT TA Summit in Albany on Jan 25 ▪ Follow-up conversations	▪ One hour informational session with Q&A co-hosted with IPRO and DOH	Jan - Feb
Practices	▪ Survey Monkey (web survey) to all practices that received a scorecard	▪ 10 minute survey ▪ 20 questions – mostly multiple choice	Feb
Payers	▪ Group discussion at payer-only ROMC meetings	▪ Dedicated time slot on agenda ▪ Will share results of practice and PT TA agent feedback	Mar - Apr
ROMCs	▪ Group discussion at ROMC meetings and ROMC synchronization calls	▪ Dedicated time slot on agenda ▪ Will share results of practice and PT TA feedback	Mar - Apr
SSC	▪ Presentation at regular meeting	▪ Dedicated time slot on agenda ▪ Will share results of practice, PT TA, and payer/ROMC feedback	Spring Meeting

Sample Questions:
Discussion with PT TA Agents

- Which aspects of the scorecard were of **most interest** to the practices? Of less interest?
- How **familiar** are the practices with the scorecard **measures and their definitions**?
- What reactions did you receive around the state and product (Commercial/Medicaid/Medicare) **benchmarks**?
- Did **practices agree with their specific results**? Did the results match up with their own expectations or existing quality data?
- Will practices be able to use the scorecard for **quality improvement**, or will they need to collect more data? As PT TA agents, **how will you help them** as they use the scorecard for quality improvement?

DFS SIM Support

DFS has been working with the SIM team throughout the entire process:

- Integrated Care Workgroup
- Developing ideas for “regulatory levers” to incentivize VBP
- Working with DOH/DSRIP on guidelines regarding risk-sharing provider contracts
- Working with APD team to coordinate data collection and use cases with insurance regulatory oversight
- Collecting data for survey of insurers’ overall percentage of VBP business
- Collecting data on insurers’ quality improvement expenses for rate review
- Participating in the NYC ROMC and other ROMCs as needed.

ROMC Progress & 2018 Goals

ROMC progress & successes

- Detailed how local ACO's support PCPs within their arrangements.
- Consumer focus groups pointed toward relationship matters. Need for more consumer measures.
- Exposed the committee to the Milbank Memorial Fund's approach to multipayer collaboration

Key learnings working on SIM

- Great regional variation in approach and style.
- Difficulties engaging payers that have plans across multiple regions.

Payer engagement & VBP progress

- High penetration of providers in VBP arrangements in our area, greater than 80%.
- Difficult to engage payers when dealing with small numbers.

ROMC plans for 2018

- Expand use of the Quality Report
- Expose our State Steering Committee to RI and Oregon experience to gain sustainability beyond the 4th year

New York's State Innovation Model and Advanced Primary Care Initiative:

Capital-Hudson Regional Oversight and Management Committee (ROMC)

NORTHEAST BUSINESS GROUP ON HEALTH

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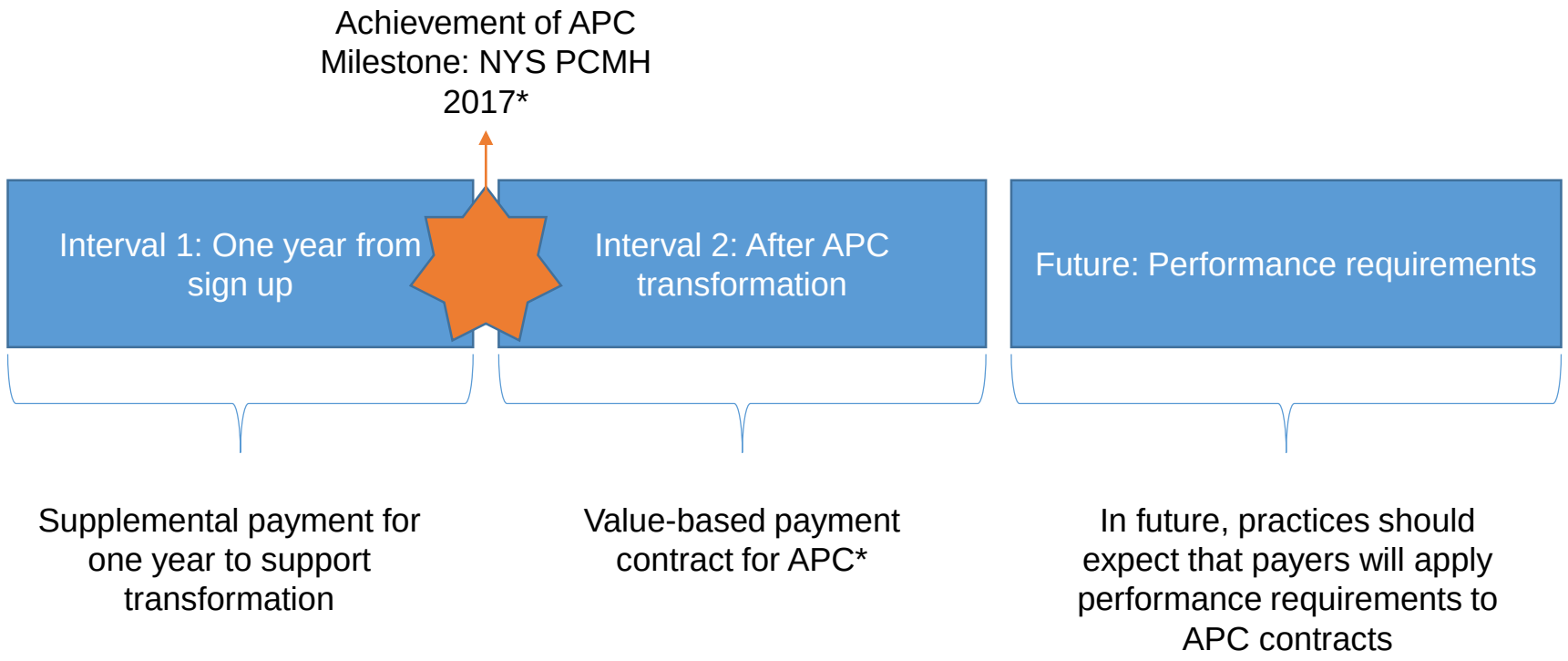
Discussion of Multi-Payer Model

To support primary care practices efforts achieve transformation and improve outcomes, Capital-Hudson region payers are exploring a voluntary multi-payer collaboration to achieve high-level alignment on an APC payment model.

Key attributes:

- Voluntary multi-payer effort
- Targeting smaller primary care practices
- Focus on high-level alignment of payment model, but not requiring uniformity
- Anti-trust protection with state supervision

Draft: Small Practice Payment Model



**Note: There is some variability among health plans. Some may not require NYS PCMH for existing contracts. Some may start VBP prior to NYS PCMH recognition.*

Current Activities

- Discussing timing for a possible launch of multi-payer model in early 2018
  - Completing an analysis of primary care practices and members attributed by the four health plans
  - Identified an initial cohort of target practices; assessment of budget impact for health plans underway
- A joint payer communication document has just started review by health plan legal and marketing departments
  - Will be a multi-week process and may need to navigate multi-party comment process

NORTHEAST BUSINESS GROUP ON HEALTH

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DRAFT

MULTI-PAYER PRIMARY CARE PRACTICE MODEL

The New York State Advanced Primary Care initiative, sponsored by the New York State Department of Health, seeks to support practices' efforts to achieve NYS Patient Centered Medical Home (NYS PCMH) designation with technical assistance and coaching support for practices. In support of this initiative, four Capital Region-Hudson Valley health plans,

initiating a voluntary, multi-payer collaboration. This collaboration targets small and medium size practices with an aligned payment model that facilitates both transformation to advanced primary care and ongoing efforts to improve patient outcomes. To qualify for this model, a practice must have a primary care focus and a

NYC ROMC Update

- Since last update to APC Steering Committee we have held
  - Three health plan meetings
  - Completed two rounds of one-on-one health plan discussions
  - Three Multi-stakeholders meetings
  - December 2017 ROMC included presentations by three PT TA agents and started a good discussion regarding the over all approach to engaging and enrolling practices including suggestions for improvement

Moving from Discussion to Implementation

- Practice path to transformation
  - NYS PCMH will be the pathway to payment and recognition
    - *Plans have requested the NYS PCMH model crosswalk and summary*
- Quality Measures
  - Health plans have agreed to a subset of APC core measures to use as part of payment model
    - *10/14 measures that represent the most common measures among payers and/or identified as priority from the quality/primary care perspective*
- Payment Models
  - Concentrate on PCPs who currently don't have "accountable payment" contracts
  - Allow plans to follow an individual approach to payment
  - Existing payer VBP contracts could be offered to practices
    - *Payers sharing primary care practice lists to target for support in enhancing their performance*
    - *Data received from two of the six national/regional plans*

Still Ahead

- APC/NYS PCMH Payment Parameters
  - Agree on payment model for each plan
    - Eligibility criteria
    - Membership threshold to qualify
    - Quality measures application to payment
    - Payment terms
    - Attribution criteria
- Complete Practice Analysis and Targets
    - Who is eligible
    - Where do plans want to focus?
- Establish Timeline for Deliverables

ROMC Vision

Dr. Gene Heslin – NYSDOH First Deputy Commissioner

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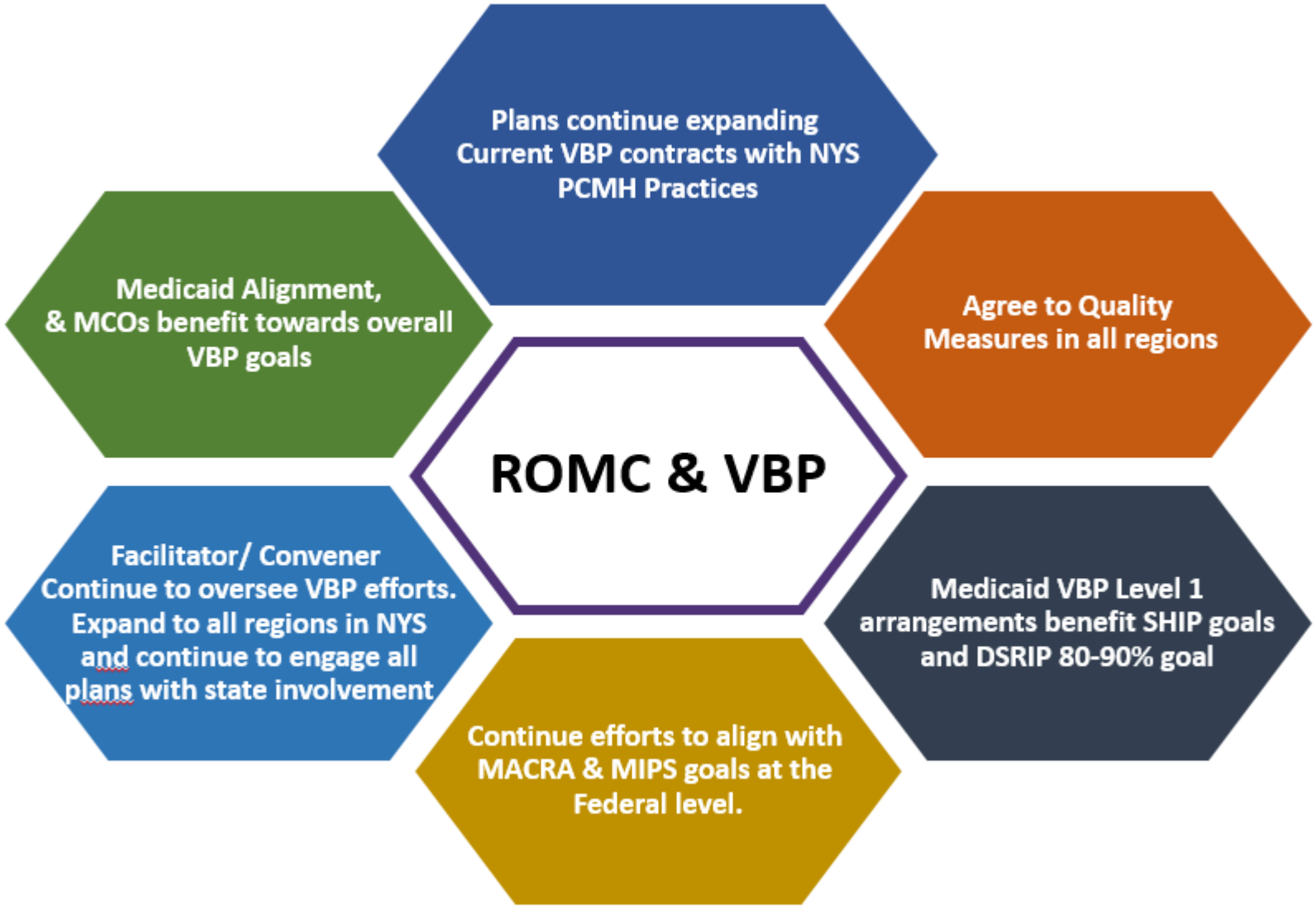
2018 ROMC VBP Goals



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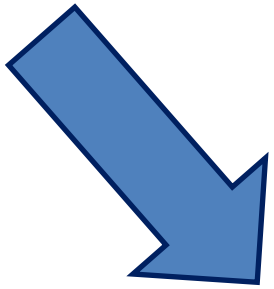
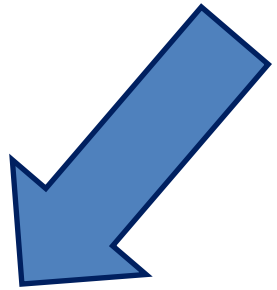
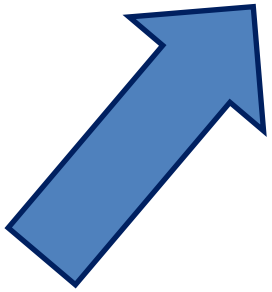
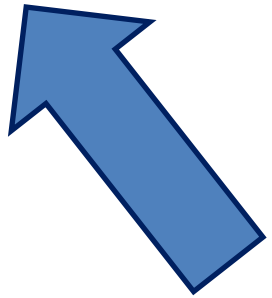
2018 & Beyond ROMC VBP Goals

- We have a great opportunity with the State involvement through anti-trust safe harbor
- Need to think about the importance of alignment both at the statewide and federal level
  - Medicaid VBP and NYS PCMH Alignment
  - MACRA/MIPS
- Need to think about sustainability and the opportunity for the ROMC's to expand statewide

We need to continue to have a central motive
and
focus on the…

Person/Consumer/Patient!

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Caring for our patients is more than pills, potions, and mechanical things that we can do;

We as primary care must stand in front of them, behind them and beside them;

– EPH 2014

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Consumer Engagement

SIM Team is proposing three initiatives

- Designing and supporting consumer engagement initiatives that:

- Engage and educate patients about NYS PCMH
  - What they should expect for care
  - How to navigate care

- (2) Support and reinforce patient adoption of NYS PCMH standards
  - Advanced care planning
  - Self management of chronic conditions
  - Increase patient engagement across health silos

Concept I: Advanced Care Planning

Description: Identifying end of life needs and participation in outreach, engagement and encouragement of patients in Advanced Care Planning (ACP)

Benefits:

- identify and honor patients' wishes and enhance their self-sufficiencies when dealing with advanced illness and/or end of life care decisions
- promote patient centeredness by supporting and empowering patients to participate in their treatment decisions
- facilitate access to the right level of care and services, as valued by the patient

Concept II: Integrating Four Patient-Centered Strategies in Care Delivery

Description: Patients are empowered to participate in the use of four, patient-centric, care delivery strategies: 1) Be prepared to be Engaged; 2) Medication Management; 3) Teach-back; and 4) Warm Handoff

Benefits:

- improve care experience; quality and safety
- empower patients to self-manage their conditions effectively, and to self-advocate
- enhance communication between patient/health team; identify and address factors impeding patient engagement
- promote population health improvement outcomes, one patient at a time

Concept III: Building Partnerships with APC Practices through Patient Practice Advisors (PPAs) *and* Implementing a Campaign to educate the Public about the Roles of PCMH Model of Care

Description: Patients are recruited from APC practices; coached, mentored, and trained to be engaged in performance improvement (PI) activities. PPAs bring the patient perspective to care design, delivery and operations. Secondly, consumers are educated about the PCMH Model and care expectations

Benefits:

- enhance patient empowerment, patient-centric care, and care experience
- support patient involvement in care design, delivery and operation
- promote effective patient/provider communication and partnership
- heighten PCMH awareness and care expectations

Questions:

- In trying to achieve our goals, which proposal/concept do you feel would be most beneficial?
- Which concept/proposal is more sustainable in the future?
- Are there other comments that you think are valuable?

Sustainability Planning

Sustainability Planning

- Sustaining practice transformation and other elements of SIM is a key consideration for NYS
- With two years remaining in grant, there are opportunities to engage in projects to help support sustainability of the SIM initiative and practice transformation
- Especially important given changes in the project plan (ex. APC versus NYS PCMH)
- Would like the APC Steering Committee's input on these opportunities

Sustainability Questions

1. Thinking short term, what is your feedback on projects that the state could explore as we plan for the final year of the SIM demonstration in 2019?

2. How can the SIM work be sustainable beyond the life of the grant (February 2020 and thereafter)? What areas should the state focus on to sustain the momentum around primary care practice transformation? Some areas to consider include:

- Workforce development
- Health Information Technology – SHIN-NY
- Regional Oversight Management Committee's
- All Payer Database
- Value Based Payment & Payer Engagement
- APC Scorecard

Closing Remarks