New York State Department of Health Statewide Steering Committee

September 28, 2018

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 - 10:45	Marcus Friedrich Susan Stuard
2	SIM Progress & NYS PCMH ▪ Practice Transformation ▪ Standard QI 19	10:45 - 11:15	Scott Rader Lori Kicinski
3	ROMC Progress & HIT Enabled QM ▪ Regional Updates ▪ Statewide Coverage ▪ Qualified Entity Pilots	11:15 - 12:00	Thomas Mahoney Amy Tippett-Stangler Susan Stuard Maria Ayoob, Jim Kirkwood
4	Lunch	12:00 – 12:30	
5	NYS SIM Quality Measure Review Subcommittee – Recommendations	12:30 – 1:00	Lindsay Cogan Scott Hines
6	SIM Sustainability Planning/Operation Plan	1:00 - 2:20	Marcus Friedrich
7	Closing Remarks and Next Meeting	2:20 - 2:30	Susan Stuard Marcus Friedrich

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SIM Progress & NYS PCMH

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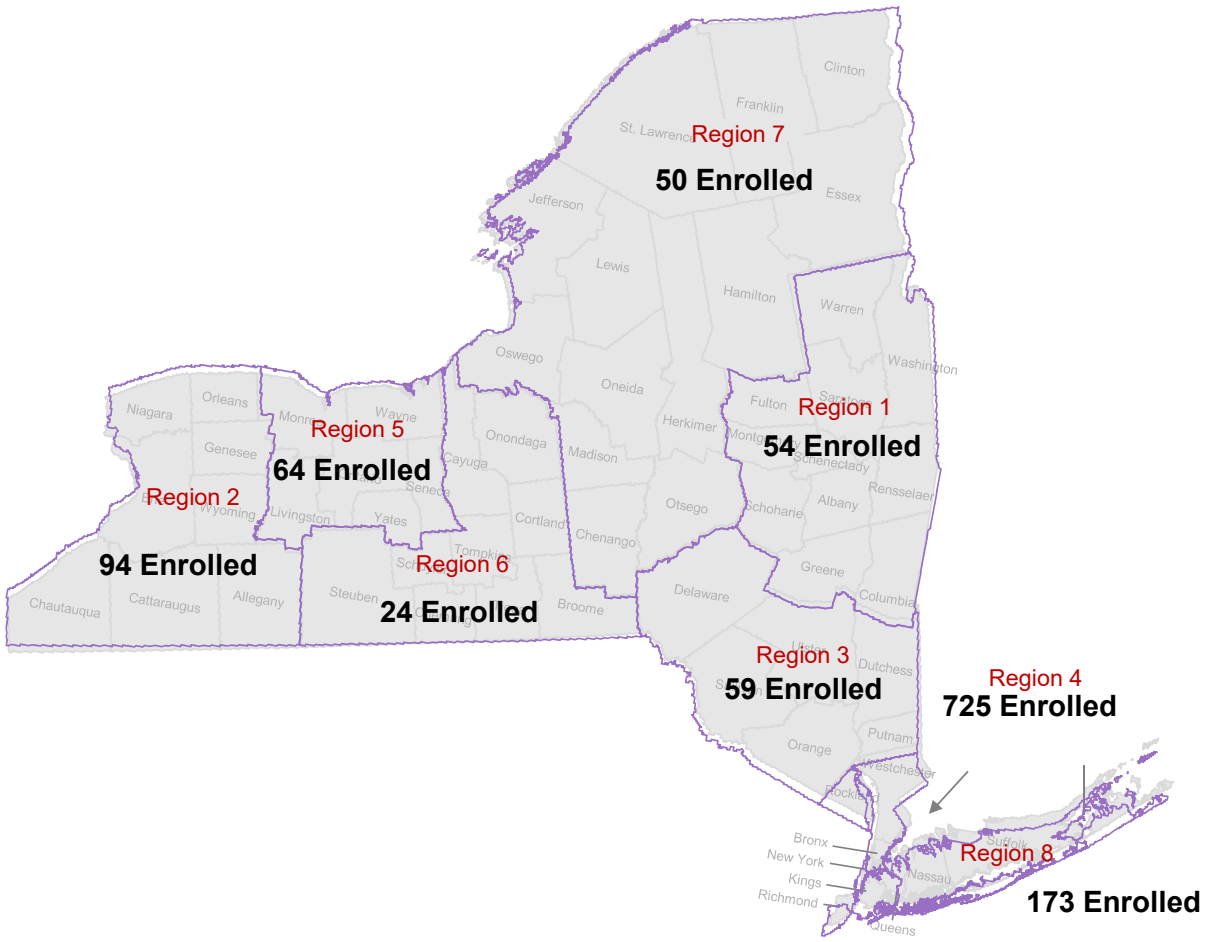
NYS PCMH Recruitment Status – 09/4/18



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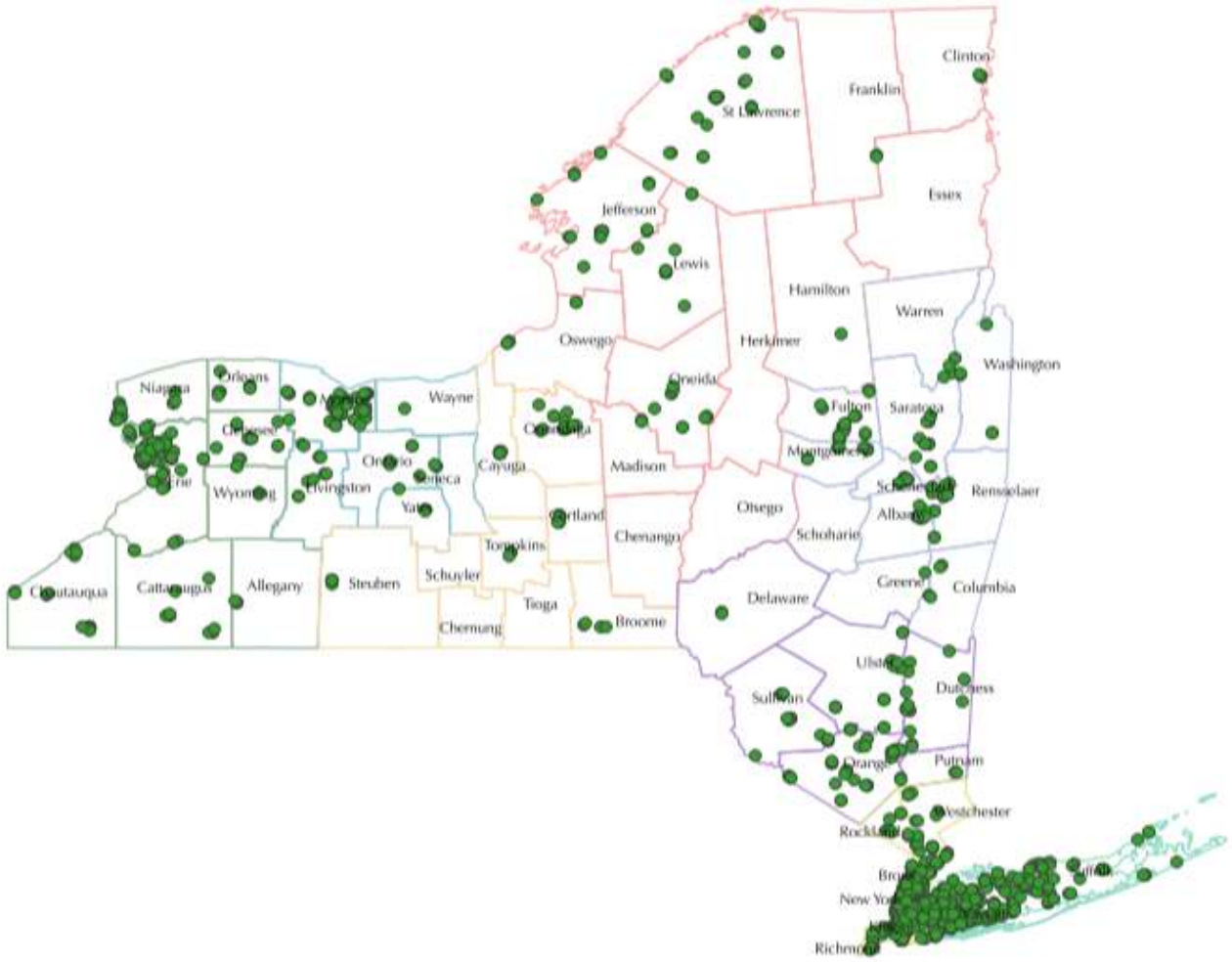
NYS PCMH Enrollment Status – September 4, 2018



DFS Regions

- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8

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NYS PCMH Enrollment

- Q-PASS NYS PCMH Enrollment as of 9/27/2018:
  - Total Overall: **1,322** practice sites
  - Total APC & New Transforming Practices: **535 (40%)**
  - Total PCMH Sustaining Practices: **739 (56%)**
  - Some additional practices are still finalizing the enrollment process or have not selected a SIM TA to work on NYS PCMH Transformation

- Transformation Agents across NYS are realizing that the enrollment numbers may exceed initial projections regarding capacity to serve practices in NYS. They are working to expand the capacity they currently have to exceed the initial projection of 2300+

- Marketing Campaign w/ NCQA late 2018-early 2019

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NYS PCMH Enrollment

Practice size breakdown:

- **69%** small practices (1-4 providers)
- **21%** medium practices (5-10 providers)
- **10%** large practices (11+ providers)

Pediatric & Family Medicine Practices:

- **425** practices that included pediatrics **among** their specialties
- **261** practices that included **only** pediatrics as their specialty
- **478** practices that included family medicine **among** their specialties
- **302** practices that included **only** family medicine as their specialty

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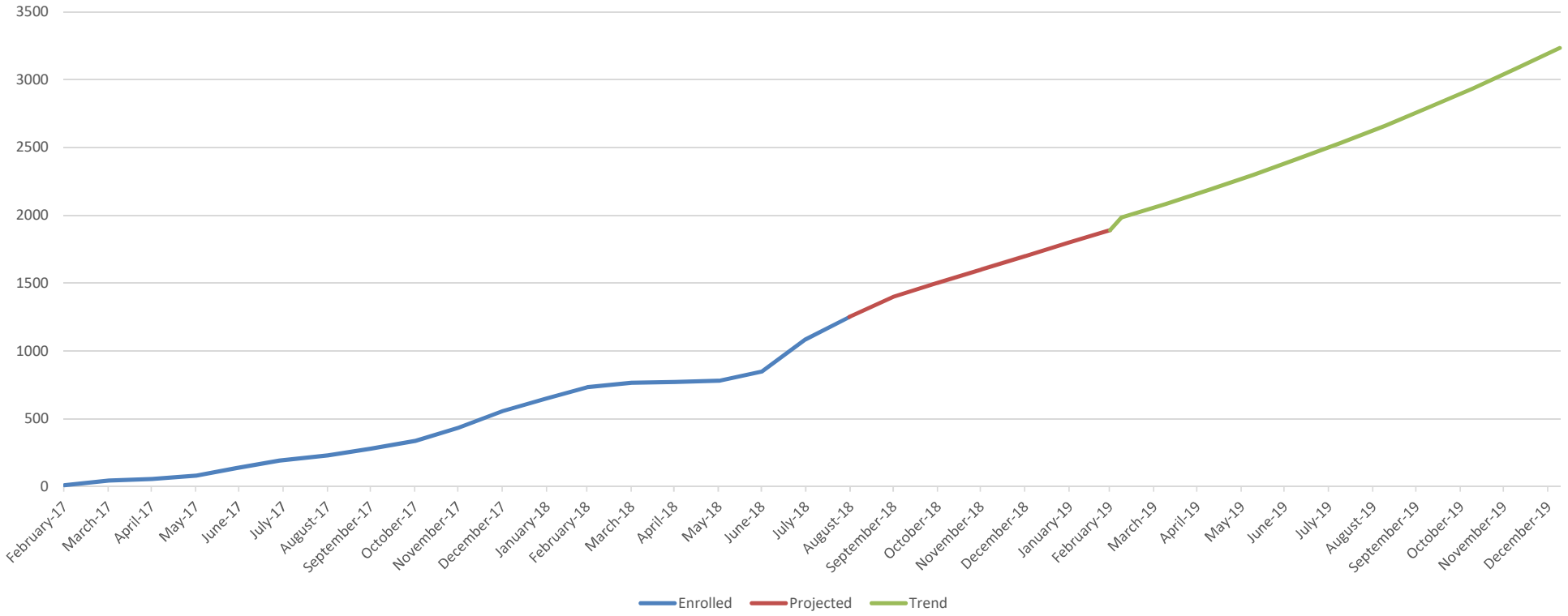
NYS PCMH Enrollment with Projections (Up to 01/31/2020)



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Transformation Timeline

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NCQA endorses CMS's definitions of VBP:

In order to align with many federal and state initiatives, including MACRA, NCQA has adopted broad definitions of VBP to satisfy the requirement of: "Engage in a VBP contract agreement for either an upside or two-sided risk contract."

- **Pay-for Performance (P4P) - 1 Credit** - Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- **Shared Savings - 1 Credit -** Payments are FFS, but provider/practitioners who keep medical costs below established expectations retain a portion (up to 100%) of the savings generated. Providers/ practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the proportion of total savings.
- **Shared Risk - 2 Credits -** Payments are FFS, but providers/practitioners whose medical costs are above established expectations are liable for a portion (up to 100%) of cost overruns.
- **Two-sided Risk Sharing – 2 Credits -** Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- **Capitation/population-based Payment – 2 Credits -** Payments are not tied to delivery of services, but take the form of a fixed per member, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below that amount. Payments, penalties and awards depend on quality of care.

Addressing Practice Barriers to Achieve VBP in NYS PCMH:

OQPS and Medicaid convened to review current practice barriers to meeting VBP requirements, and have made the following determinations*:

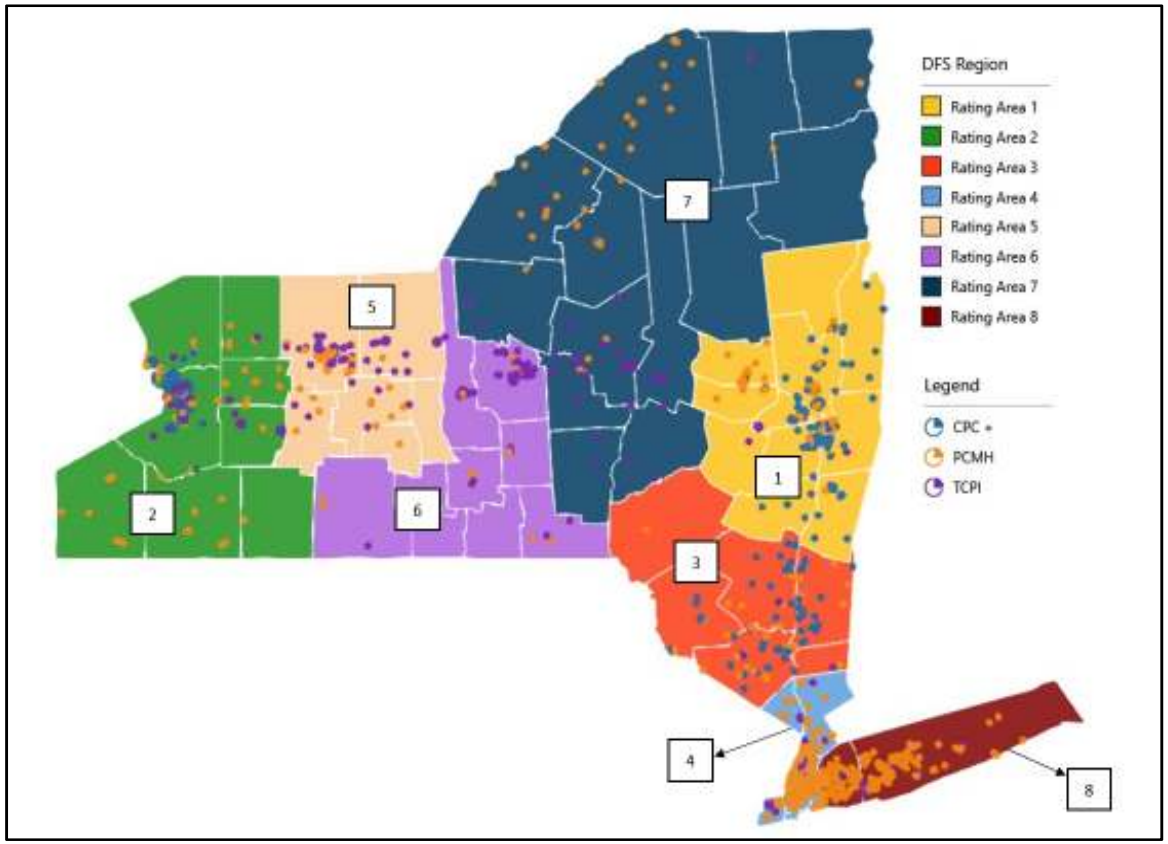
- **PCMH 2014 Level 3 & PCMH 2017:** Practices participating in the NYS PCMH model that are unable to meet this standard at the time of their annual renewal (Annual Reporting) date will have the option to attest that they will complete this requirement within one year.

- **Former APC & new practices:** will continue to have the designated 12-15 months to complete the QI 19 requirement.

*DOH will continue to monitor NCQA data in 2019 to determine any additional requirement changes.

Depiction of Primary Care Transformation in NYS:

2,376 practices recognized PCMH 2014 and more than 1,800* primary care practices are in some state of “active” transformation across NYS. Greater than 90% have achieved some level of PCMH



*As of: 8/20/18

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Addressing Small Practice Barriers & Solutions:

Areas of Focus for 2019

- Increase enrollment for new and AR practices under NYS PCMH
- Expand geographical impact for PT TA services
- Integrate small practice “VBP skills” to sustain business modeling and incentive support
- Increase stakeholder engagement with NYS Provider Associations: education and communication
- Expand business intel solutions leveraging concurrent Statewide HIT programs
- Develop a “Train-the-Trainer 2.0” program to better resource practices with SDH and BH tools and strategies
- Increase small practice connectivity with State/non-State funded community health organizations and specialty care through “Medical Neighborhoods”

ROMC Progress & HIT Enabled QM

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Finger Lakes ROMC

State Steering Committee

Thomas Mahoney, MD

September 28, 2018

Environment

In the FL region providers consolidated into 2 large system driven ACOs and the FQHCs

Very few providers not in VBP

- Commercial
- ASO
- Managed Medicaid
- Medicare Advantage

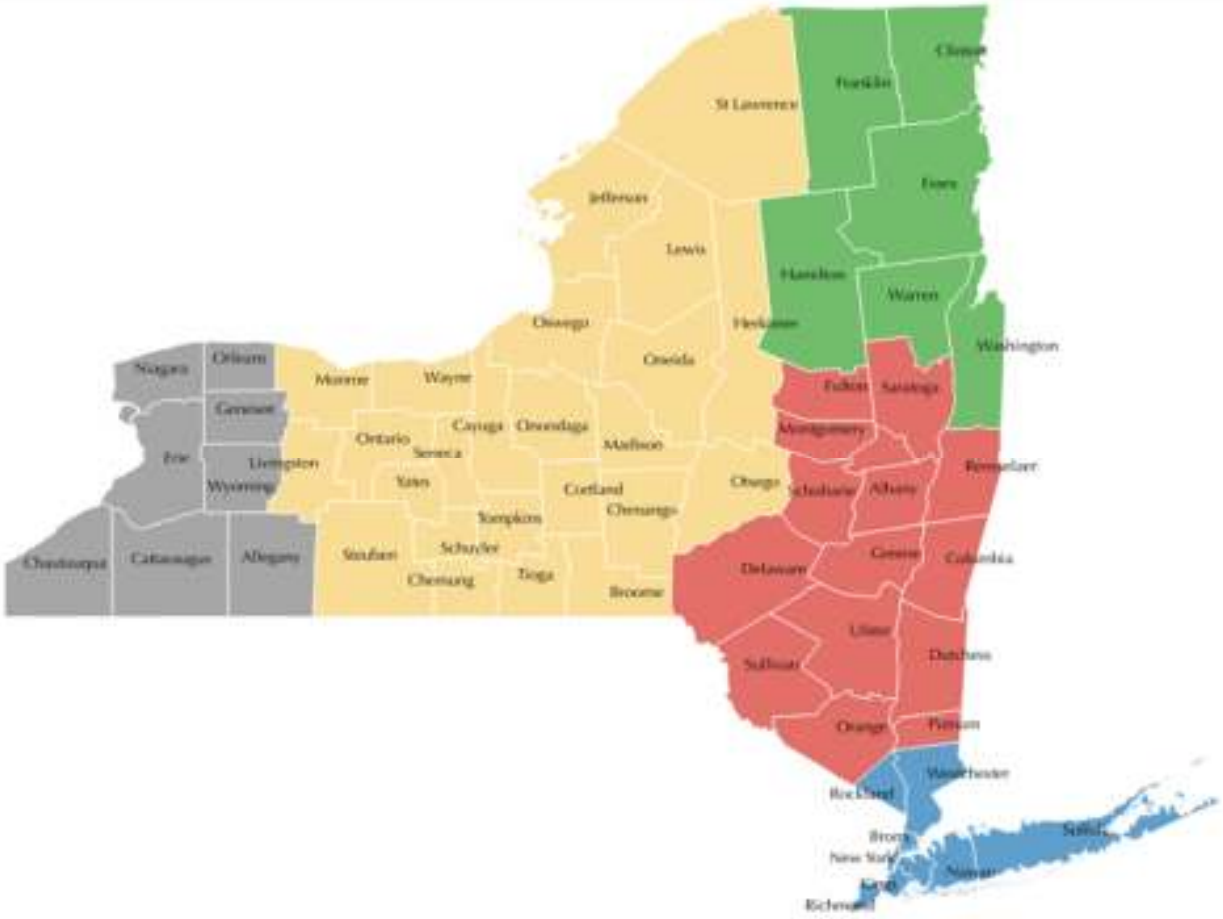
Payer Discussions

- Barrier to finding room for multipayer activity related to very small number of providers not excluded/inadequate number of enrollees in FL region
- Opportunities however may exist in the Central NY area, western ADK region
- Consensus that if we were going to look for opportunities should expand the area and include full spectrum of product lines

Actions

- Worked with the State to expand the ROMC region
- Added insurers with significant enrollment if product lines beyond just commercial were considered
- State engaged in presenting the lessons of panel aggregation

Finger Lakes, CNY, ADK ROMC Coverage



Designated Regions

- Metro
- Capital and Hudson Valley
- Adirondack Medical Home Initiative
- Finger Lakes, Western Adirondacks and Central

Non-Designated Region

- Western/Buffalo

Next

- Insures are submitting panel data including VBP engagement
- Currently “cleaning” submissions
- Meetings with individual insurers after aggregation and normalization to look for opportunities

Regional Oversight Management Committees

Multiple Approaches

Environment

- Many Differences
  - Local Experiences
  - Insurer Mix
  - Priorities and approaches

ROMC work reflects those differences

Multiple Approaches

- Market has Large National Players
- Insurers membership are evenly split
- Large numbers of small independent group practices
- Group discussions resulted in collaboration

- RFA in progress

Western NY

NYC

Finger Lakes

- Two large system driven ACOs
- Single dominant insurer
- Small insurer will follow the leader
- Expansion of the region in search of opportunities

Capital District

- Experience with CPC and CPC+
- Developed trust working together
- Farthest along the continuum

Moving toward the last year

- Support
  - Health Care is Local
    - Decision making is regionally developed and owned
      - Unique approach
      - Criteria
  - Collaboration among ROMC facilitators and the State
  - Analytics
    - Network
    - Quality

Data-driven collaboration and innovation
from the Finger Lakes region

Common Ground Health

1150 University Ave | Rochester, N.Y. 14607-1647 | (585) 224-3101
Susan Hagen | Director of Communications | Susan.Hagen@commongroundhealth.org | (585) 224-3156

NYC ROMC Update

Achievements

- Identified an initial cohort of target practices (300-400 threshold); further assessment underway
- High-level alignment of payment model
- Joint communication piece to help recruit practices to transform to NYS PCMH; under review
- Launch targeted for 1/1/2019

Creating Regional Multi-payer Models

1.) Convene stakeholders (payers)
2.) Payers define approach for multi-payer model
    *Select value-based measures
    *Identify eligible practices
    *Identify health plan payment model(s)
3.) Operationalize model
    *Develop communication strategy
    *Collaboration with practice transformation agents
    *Contract
4.) Monitor model and track progress

Current Activity

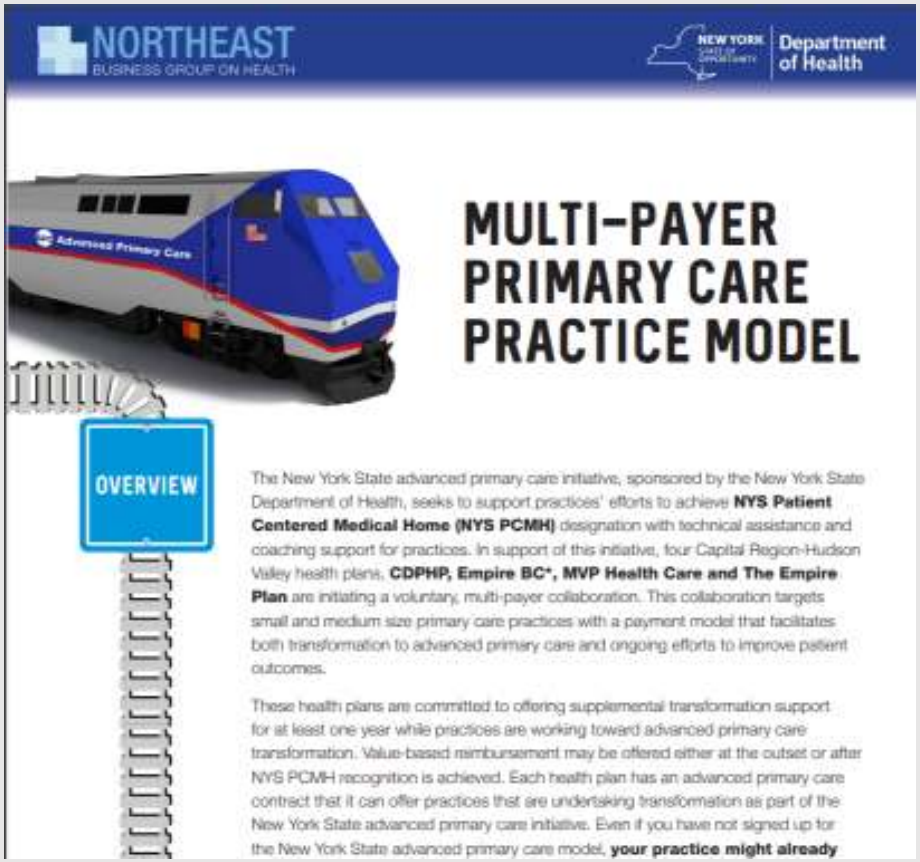
- How are plans (individually) planning to evaluate, monitor, and/or report on the target TINs?

- Is there information or support that NYSDOH can provide to support evaluation?
  - Progress through NYS PCMH model?
  - Aggregate lives covered under VBP/PCMH?
  - Counts of VBP contracts per TIN?
  - Help identifying additional TINS?
  - APC Scorecard?

- Timeline for payments
  - NCQA check in

Capital District/Hudson Valley ROMC Update

Communication Piece on DOH website



https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/docs/2018-05_joint_communication_piece.pdf

Capital Hudson ROMC
Recap: Small Practice, Multi-Payer Primary Care Model

- Voluntary multi-payer collaboration announced to transformation agents at end of March
- Targets small and medium size primary care practices
- Four health plans are participating
  - CDPHP, Empire BCBS, MVP Healthcare, UHC The Empire Plan
- Each plan has an advanced primary care contract that it may offer practices
- Variability in the payment models, but alignment on some key principles
  - Mechanism to provide financial support during transformation
  - Value-based contracting options after NYS PCMH is achieved
- Identified ***131 practice TINs*** to target for this program

Monitoring and Tracking Progress

1

Enrollment of target practice TINs in NYS PCMH program

2

Payer contracting with target practices TIN

Enrollment in NYS PCMH

NYS PCMH Enrollment for Targeted Practices (Measured at TIN level, as of September 2018)		
Practices Targeted	131	
Under Contract	21	16%
Approached-Not Engaged	14	11%
Approached-Engaged	2	2%

- Low uptake among these practices
- Almost no change since March when target practice list was shared with TAs
- Aware that these practices/TINs may be most difficult cohort to engage

Contract Monitoring

TINs segmented by # of VBP/enhanced PC contracts		
Contracts	**Practices**	**Percent**
0 contracts	36	27%
1 contract	51	39%
2 contracts	38	29%
3 contracts	8	6%
4 contracts	1	1%

- View this as the baseline measurement
- Plan to monitor if rate of VBP/enhanced PC contracting increases over time in this target group

Barriers and Possible Supports for Model

Some barriers:

- Estimating practice revenue opportunity
- Lack of staff and other resources to support transformation effort
- No EHR
- No patient portal
- Confusion regarding whether practice or health plan initiates outreach after enrollment

Support ideas:

- DOH letter to target practices highlighting opportunity
  - NCQA fee, transformation support services, Medicaid pmpm, commercial contract opportunity
- Generate other support ideas in conversation with TAs and commercial health plans
  - 1:1 conversations with TAs in early October
  - Discussion with health plans in mid-October

Future State Vision

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***

QE Quality Measurement Pilot

Goals:

- Demonstrate the potential value of clinical data to fulfill unmet needs
- Pilot the QE s potential as a source of high quality clinical data for quality measurement
- Support the quality measurement needs of the ROMC participants

Key Activities:

- QEs will design, implement and test capabilities to deliver electronic clinical data to health plans
- QEs will generate and share quality measures with PCMH practices
- Document data standards, data quality and other lessons learned

Outcomes:

- A shared understanding of participant data needs
- An assessment of the feasibility of statewide scalability and potential barriers
- A shared understanding of measure specifications
- Meaningful improvement to measure results

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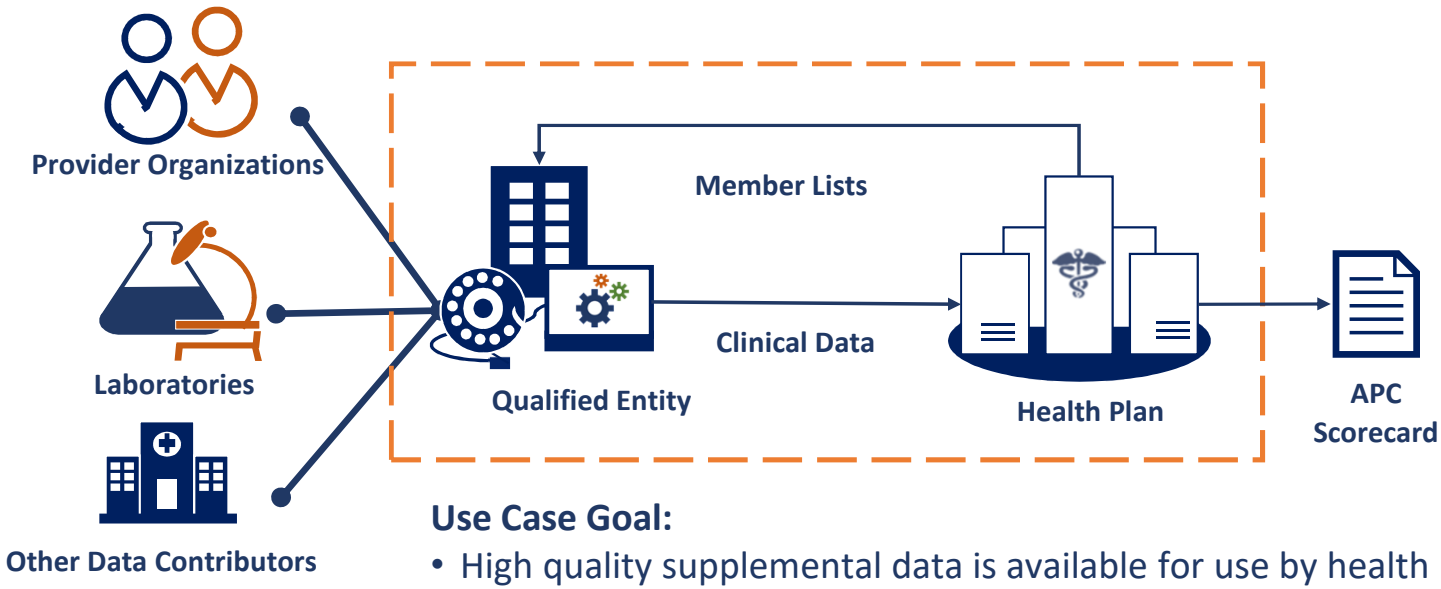
QE Pilot Use Case #1: Data Delivery to Health Plans



Use Case Goal:

- High quality supplemental data is available for use by health plans in calculating outcome measures to inform the APC Scorecard

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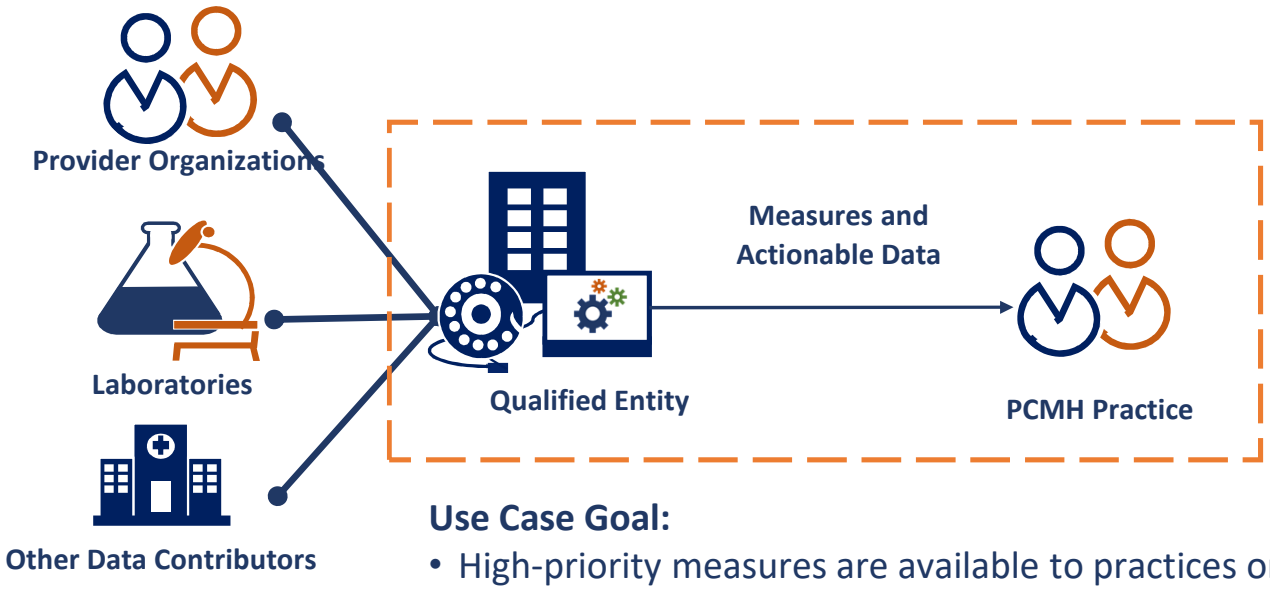
QE Pilot Use Case #2: Generating Measures for PCMH Practices



Use Case Goal:

- High-priority measures are available to practices on a timely basis

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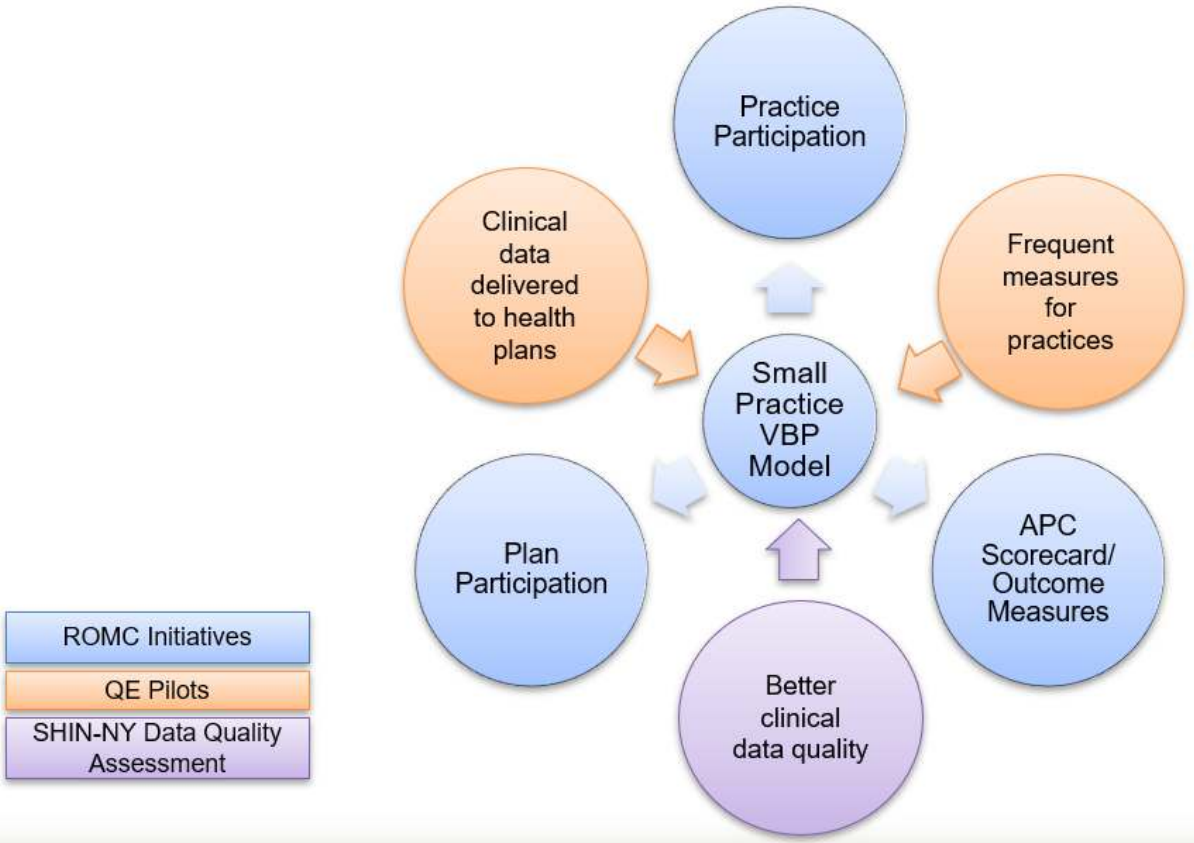
Impact of QE Pilots on ROMC Initiatives



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Next Steps

- Announcement of Awardees
- Workplan development
- Pilot kickoff and stakeholder convening
- Requirements gathering

Related Work

- VBP Measure Testing Project
  - NYS Medicaid VBP Pilot participants are working to establish data feeds to incorporate clinical data into HEDIS measurement processes
  - Will enable measurement of Controlling High Blood Pressure for all members attributed to a VBP Contractor
- QE DSRIP MRR Project
  - QEs supporting delivery of clinical data for DSRIP measures that use medical record review

Lunch

NYS SIM Quality Measure Review Subcommittee – Recommendations

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NYS DOH Statewide Steering Committee

Report from the SSC Measures Subcommittee

September 28, 2018

Charge of the Subcommittee

- Collaborate with DOH on stewardship of the NYS Primary Care Core Measure Set.
- Participate in an annual review cycle and make recommendations for updating the measure set and achieving greater alignment with the State's other quality measurement programs.
- Prioritize a set of outcome based measures.

Goals of the Subcommittee

- Implement a formal process for **annual review and maintenance** of quality measures to ensure that the core measure set:
  - Informed by advances in measurement science
  - Reflects changes in national and NYS healthcare environment – VBP and other policies
  - Relies on available data and feasible methods for assessing the value of primary care
  - Reflects DOH measurement goals, priorities, and parameters
  - Minimizes collection and reporting burdens
- Provide input from a **diverse set of stakeholders** (~30) including providers, consumers, payers, technical assistance providers, researchers

DOMAIN	NYS PRIMARY CARE CORE MEASURE SET (NQF#/STEWARD)	POPULATIONS	DATA SOURCE
Prevention	**Cervical Cancer Screening (#32/HEDIS)**	Adults: 21 – 64 years	Claims-only possible.
	Breast Cancer Screening (#2372/HEDIS)	Adults: 50 – 74 years	Claims-only possible.
	Colorectal Cancer Screening (#34/HEDIS)	Adults: 50 - 75 years	Claims/EHR
	Chlamydia Screening (#33/HEDIS)	Adol/Adult: 16 - 24 years	Claims-only possible
	Influenza Immunization - all ages (#41/AMA)	All: 6 months+	Claims/EHR/Survey.
	Childhood Immunization Status (#38/HEDIS)	Children: 2 years old	Claims-only possible.
	Fluoride Varnish Application (#2528/ADA)	Child/Adol: 1 - 21 years	Claims
Chronic Disease	**Tobacco Use Screening and Intervention (#28/AMA)**	Adults: 18 years+	Claims/EHR
	Controlling High Blood Pressure (#18/HEDIS)	Adults: 18 - 85 years	Claims/EHR
	Diabetes: A1C Poor Control (#59/HEDIS)	Adults: 18 - 75 years	Claims/EHR
	Diabetes: HbA1c Testing (#57/HEDIS)	Adults: 18 - 75 years	Claims
	Diabetes: Eye Exam (#55/HEDIS)	Adults: 18 - 75 years	Claims
	Diabetes: Foot Exam (#56/HEDIS)	Adults: 18 - 75 years	Claims
	Diabetes: Medical Attention for Nephropathy (#62/HEDIS)	Adults: 18 - 75 years	Claims
	Persistent Beta Blocker Treatment after Heart Attack (#71/HEDIS)	Adults: 18 years+	Claims/EHR
	Medication Management for People With Asthma (#1799/HEDIS)	All: 5 - 65 years	Claims-only possible.
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents/BMI Screening and Follow-Up (#24/HEDIS and #421/CMS)	All: 3 - 17 years/18 years+	Claims/EHR
Behavioral Health/ Substance Use	**Screening for Clinical Depression and Follow-up Plan (#418/CMS)**	Adol/Adult: 12 years+	Claims/EHR
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#4/HEDIS)	Adol/Adult: 13 years+	Claims/EHR
	Antidepressant Medication Management (#105/HEDIS)	Adults: 18 years+	Claims
Patient-Reported	**Advance Care Plan (#326/HEDIS)**	Adults: 65 years+	Claims-only possible.
	CAHPS Access to Care, Getting Care Quickly (#5/AHRQ)	All	Claims/EHR
Appropriate Use	**Use of Imaging Studies for Low Back Pain (#52/HEDIS)**	Adults: 18 – 50 years	Survey
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (#58/HEDIS)	Adults: 18 – 64 years	Claims
	Inpatient Hospital Utilization (HEDIS)	All	Claims
	Plan All-Cause Readmissions (#1768/HEDIS)	Adults: 18 years+	Claims
	Emergency Department Utilization (HEDIS)	All	Claims
	Outpatient Utilization (HEDIS)	All	Claims
Cost	**Total Cost Per Member Per Month**	All	Claims

Who's Who of the Subcommittee

- **Chairs**
  - Lindsay Cogan (DOH)
  - Scott Hines (Crystal Run)
- **Project Directors**
  - Marcus Friedrich, James Kirkwood, Anne Schettine (DOH)
- **Project Manager**
  - Patrick Russell (DOH)
- **Advisors**
  - Anne-Marie Audet, Lynn Rogut, Pooja Kothari (United Hospital Fund)
- **Stakeholders**

Subcommittee Overview

Meeting 1: June 12

- Review and discuss charge, objectives, workplan

Meeting 2: July 18

- Discuss criteria for assessing measures in the NYS Primary Care Core Quality Measure Set

Meeting 3: August 20

- Discuss scoring approach and solicit input

Meeting 4: September 25:

- Discuss process for annual scoring of measures and for decision making re. adding/removing measures

Subcommittee Accomplishments

- ✓ Consensus on matrix of principles and criteria for annual updating and maintenance of the NYS Primary Care Core Measure Set.
- ✓ Agreement on recommendations for a scoring approach to assess measures.
- ✓ Agreement on recommendations for an annual measure review process, including a decision making approach for adding/removing measures and voting.

Proposed Criteria for Assessing Measures

MEASURE PRINCIPLES, CRITERIA, CONSIDERATIONS		Score
PRINCIPLES	**Relevant to NYS primary care goals**	P/F
	Addresses the Quadruple Aim (Population Health, Experience/Quality of Care, Per Capita Cost, and Clinician Wellness)	P/F
	Standardized (validated and vetted or endorsed by a recognized accrediting or quality organization) *	P/F
ESSENTIAL CRITERIA	**Addresses high prevalence/impact area**	0-3
	Ease of Reporting/Can be Verified by Practices	
	Data readily available/ Can use existing infrastructure to report	0-3
	Minimize burden for providers	0-3
	Minimize burden for payers	0-3
	Average of 3 lines above	
	Aligned with Payer Measure Sets	
	Medicare (e.g. MIPS, CPC+, ACO, MSSP, etc.)	0-3
	Medicaid	0-3
	Commercial payers in NYS	0-3
	Average of 3 lines above	
	Outcome-based or evidence-based process measures proximal to outcomes, where outcomes can be challenging to capture	
	Type of Measure	0-3
KEY CONSIDERATIONS	**Measure can be evaluated at the level of analysis for intended use (e.g. Health Plan, Integrated Health System, Group/Practice, Clinician)**	0-3
	Notable performance gap or opportunity for improvement	0-3

Scoring Key	
Principles	
P	Pass
F	Fail
Essential Criteria and Key Considerations	
0	No
1	Low
2	Medium
3	High
Type of Measure	
0	Utilization
1	Process
2	Interim Outcome
3	Outcome
3	Patient Reported Outcome

*25 of the 29 measures in the core measure set are endorsed by NQF and have met four assessment criteria – important to measure, scientifically acceptable, useable and relevant, and feasible to collect.

Process for Annual Scoring

Volunteers from the Subcommittee score a subset of the measures annually

Volunteers divided into cohorts representing each stakeholder group (payer, provider, DOH, consumer)

Each measure will be scored by two or more cohorts

Results of scoring will be presented to full Subcommittee on an annual basis

Process for Adding/Removing Measures

Adding a measure	• If a new measure is proposed it will be scored by at least 2 cohorts (possibly all cohorts) • If the new measure scores higher than one or more existing measures, the new measure is brought to the full Subcommittee for discussion as to which lower scoring, existing measures would replace it
Removing a measure	• If during the annual scoring process one or more measures is clearly scoring below the other measures, that measure should be brought to the full Subcommittee to vote on whether or not the measure should be removed
Voting	• A simple majority (51%) would be needed to add or remove a measure

Scoring the Measure Set - Example

Measure	Score Reviewer 1	Score Reviewer 2	Score Reviewer 3	Sum	
Breast Cancer Screening	14	15	15	44	
Cervical Cancer Screening	14	12	15	41	
Colorectal Cancer Screening	14	15	15	44	
Chlamydia Screening for Women	14	15	14	43	
Influenza Immunization	13	14	16	43	
Childhood Immunization Status – Combo 3	13	14	14	41	
Fluoride Varnish Application	12	8	10	30	X
Tobacco Use: Screening and Cessation Intervention	13	15	12	40	
Controlling High Blood Pressure	13	15	15	43	
Diabetes Poor Control	14	15	16	45	
Diabetes: HbA1c Testing	13	13	11	37	
Diabetes: Eye Exam	12	14	13	39	
Diabetes: Foot Exam	11	14	11	36	
Diabetes: Nephropathy	13	12	12	37	
Persistent Beta Blocker Treatment After Heart Attack	11	12	11	34	
Medication Management for People with Asthma	14	14	14	42	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	14	15	12	41	
Body Mass Index Screening and Follow-Up Plan for Adults	14	16	12	42	
Screening for Clinical Depression and Follow-Up Plan	13	15	11	39	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	12	14	14	40	
Antidepressant Medication Management	12	14	14	40	
Advance Care Plan	10	12	9	31	X
CAHPS Access to Care/ Getting Care Quickly	13	15	12	40	
Imaging Studies for Lower Back Pain	9	12	10	31	X
Avoidance of Antibiotics for Acute Bronchitis	13	13	11	37	
Inpatient Hospital Utilization	11	10	12	33	
Plan All-Cause Readmissions	13	11	14	38	
Emergency Department Utilization	13	13	13	39	
Ambulatory Care	12	14	12	38	
Total Cost Per Member Per Month	9	9	12	30	X

Next Steps

- Continue the Subcommittee's annual review of the measures and include its input on the proposed process.
- Implement the proposed process for reviewing, scoring, and voting on measures.
- Discuss additional Subcommittee activities re. outcome measure prioritization and other relevant measure related issues.

Quality Measure Prioritization

- Prioritize a focused list of high value outcome quality measures for Value Based Payment (VBP) in NYS
- Key Principles in measure prioritization:
  - Process → Outcome;
  - Gather feedback from stakeholders on what are the "right" outcomes; and
  - Focus on efficient measurement
- Focus on measures compiled from clinical, rather than claims, data to allow for feedback loops from the measure back into clinical decision making
- Align quality measurement efforts across stakeholder communities and State and Federal-led quality programs

SIM Sustainability Planning/ Operation Plan

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Sustainability Planning/ Operation Plan

- Sustaining practice transformation and other elements of SIM is a key consideration for NYS
- CMS requires NYS DOH to formulate yearly operation plans
- With 16 months remaining in grant, there are opportunities to engage in projects to help support sustainability of the SIM initiative and practice transformation
- Would like the SIM Statewide Steering Committee's input on these opportunities

Recommendations Gathered From

- Feedback from last SSC
- New York Academy of Medicine (NYAM) SIM Model Evaluation Annual Report recommendations
- NYC-PHIP Project Small practices Initiative

Last SCC We asked Sustainability Questions in January

1. 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? What areas should the state focus on to sustain the momentum around primary care practice transformation?

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Feedback From Last SSC

Improve Small Practice Business Operation

- Revenue cycle improvement (leaving money on the table)
- Focus on financing- investment/start up phase
- Gaps of care/ gaps in initiative
- Decision support in EMR

Alignment

- Alignment with DSRIP
- Alignment around measures
- Alignment around social determinants of health

Small Practice Aggregation

- Smaller groups aggregate all the patients- groups can compare to this aggregate
- Aggregate for measurement
- Aggregate on payment
- Shared services

Communication

- Need a concise conversation/communication about the coordinate approach between consumers and providers
- Articulate value propositions to stakeholders
- Educate on VBP
- User groups/consumers could talk about best practices
- Improve communication across siloes

NYAM SIM Model Evaluation Annual Report recommendations

- Marketing of Advanced Primary Care by the State, through a simple one-page brochure and an outward facing website that providers can be referred to.
- State outreach to the DSRIP PPS's as a group, providing information on the APC and the benefits of transformation.

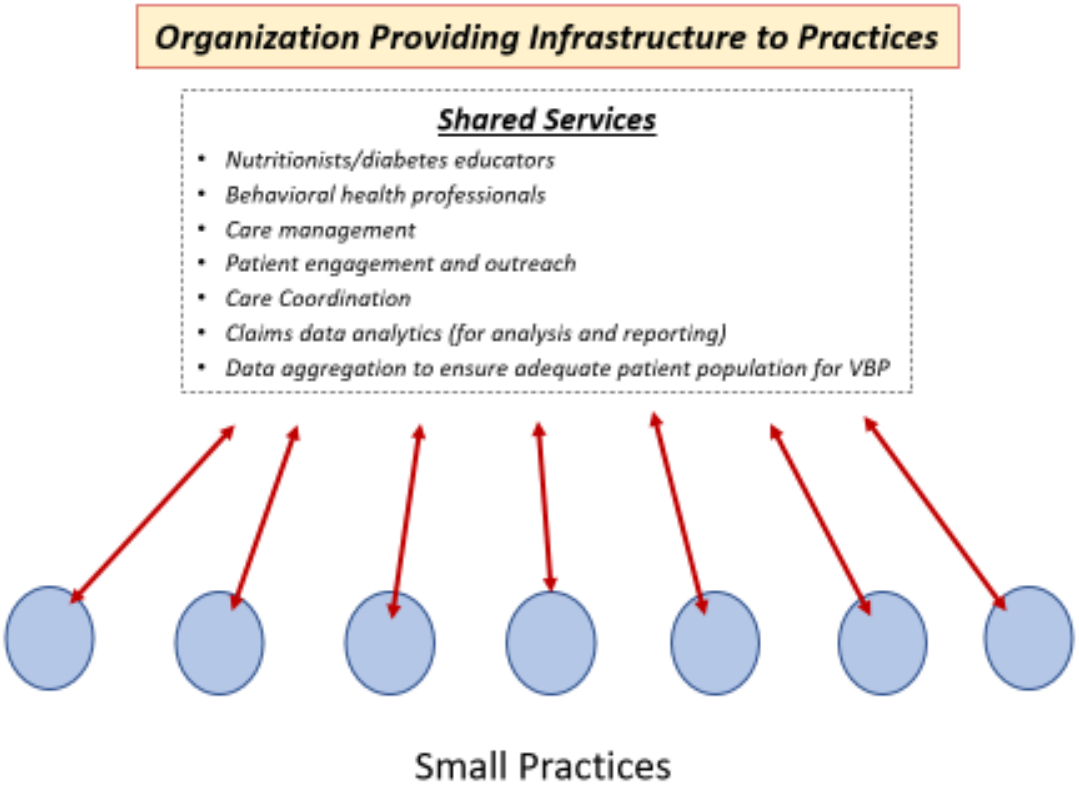
NYC-PHIP Project: What do small practices need?

Small independent practices face unique challenges, need to achieve scale to do medical homes and VBP

Things I Need, But Can't Find, or Afford

- Nutritionists/diabetes educators
- Behavioral health professionals
- Care management
- Patient engagement and outreach
- Care Coordination
- Claims data analytics (for analysis and reporting)
- Data aggregation to ensure adequate patient population for VBP….

NYC-PHIP Project: Shared Services



NEW YORK STATE OF OPPORTUNITY. Department of Health

Current State

Domain	Current state	Potential Operational Solutions
Small practice business operation improvement	TA vendors helping practices to improve processes	
Alignment	Subcommittee on measures alignment	
Small practice aggregation	Aggregation on measurement	
Communication	Existing contracts with physician organizations	

Questions:

1) What could be operationalized to improve small practice business operations?
2) What should the departments focus beyond alignment after measurement?
3) How could small practice aggregation be operationalized?
4) How can we improve communications with stakeholders? What is needed from the Department of Health?
5) Other recommendations?

Closing Remarks