NEW YORK STATE OF OPPORTUNITY. Department of Health

INTEGRATED CARE WORKGROUP

Meeting #5

May 18, 2015

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:00 – 10:10	Foster Gesten
2	The APC Straw-Person – Revised • Input received • Closeout issues	10:10 – 11:00	Foster Gesten Susan Stuard
3	Stakeholder Engagement	11:00 – 11:20	Hope Plavin Laurel Pickering (NEBGH)
4	Common Measure Set for APC • Assumptions • Context	11:20 – 12:00	Foster Gesten/Susan Stuard
5	WORKING LUNCH – Common Measure Set Discussion	12:00 – 12:30	All
6.	Payment Models Discussion • Context • Goals – Balance and Alignment • Review of existing models	12:30 – 1:30	Foster Gesten/John Powell
7	Next Steps and Discussion • Practice Transformation RFP • TCPI/PTN • Straw Person/Measures/Payment: Putting it Together • Attribution	1:30 – 2:00	Susan Stuard/Foster Gesten

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Past slides posted online:
https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm

Welcome and Introductions

The APC Straw-Person – Revised

Advanced Primary Care: Providing An Overview

“Advanced primary care is an expanded system of caregiving by family doctors (and internists and pediatricians) that incorporates the provision of urgent care, behavioral health, health education, and care management and coordination.

This kind of caregiving requires an electronic medical record as an essential tool.

Done well, it can be expected to yield both enhanced clinical quality and significant downstream financial savings—two outcomes which are subject to measurement.

Connecting effectively with one’s referral specialists has a magnifying effect as well (viz, medical home to medical neighborhood).

This kind of system is, for sure, costly to develop and also to operate, but the prudent investment of money and energy over a defined time period by providers and payers together can be expected to produce outsize benefits which should in turn be realized through value-based payments.”

APC Straw-Person (1 of 4)

PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
1. CARE MANAGEMENT	**1. CARE MANAGEMENT**	**1. CARE MANAGEMENT**
a. Identify high risk* patients who would benefit from care management and provide/offer care management as appropriate. b. Provide screening, treatment and referral where indicated for behavioral health issues.	All previous plus: a. Provide/offer to **at least 75% of** patients at high risk*. b. Electronic medication reconciliation for patients transitioning from institutional care sites. c. Provide core elements of collaborative care model for depression screening and management, including assessment, data collection and tracking metrics over time d. Offer or refer patients to structured health education programs such as group classes, peer support, and self-management programs.	All previous plus: *a.* *Provide/offer* care management services to **all** patients at high risk. b. Integrate practice care management with Medicaid health home and health plan care managers for eligible patients as appropriate. c. Provide evidence based screening, intervention and referral to treatment (such as SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
2. PATIENT ACCESS TO CARE	**2. PATIENT ACCESS TO CARE**	**2. PATIENT ACCESS TO CARE**
a. Provide 24/7 same day patient access to nurse or other clinician via telephone and/or secure electronic messaging b. Implement services that are culturally and linguistically appropriate to promote access and quality.	All previous plus: a. Reliable access to EHR by the on-call clinician after hours. b. Ensure access to care during non-traditional hours including at least one session/week of evening/weekend office hours. c. Provide at least one method of synchronous and *asynchronous communication* such as secure electronic messaging between patient and provider with commitment to an explicit response time goal. d. Provide routine and same day appointments within agreed upon standard; include as part of QI protocol.	All previous

APC Straw-Person (2 of 4)

PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
3. PATIENT EXPERIENCE	**3. PATIENT EXPERIENCE**	**3. PATIENT EXPERIENCE**
a. Conduct at least **annual** patient survey, or patient advisory council or patient focus group and show evidence of incorporation of results as part of QI plan.	All previous plus: a. Conduct at least **semi-annual** patient survey, or patient advisory council or patient focus group and show evidence of incorporation of results as part of QI plan. b. Implement processes to evaluate and promote patient engagement.	All previous plus: a. Conduct at least **quarterly** patient surveys or patient advisory council or focus group and show evidence of incorporation as part of QI plan. b. Report survey results to patients, payers or both. c. Include patient or family member as part of practice advisory council or governance structure.
4. QUALITY IMPROVEMENT/POPULATION HEALTH	**4. QUALITY IMPROVEMENT/POPULATION HEALTH**	**4. QUALITY IMPROVEMENT/POPULATION HEALTH**
a. Evaluate practice performance using a set of standardized quality metrics (HEDIS, QARR, MU CQMs, etc.).	All previous plus: a. Measure and report at least six standardized measures (including behavioral health and patient experience) and one prevention agenda goal; set goals for each and incorporate results as part of a formal QI process. At least half of measures should be from EHR. a. Identify **at least annually** those patients due for preventive or chronic care management services and communicate reminders. b. Conduct a comprehensive health assessment for each patient inclusive of discussion of advanced directives c. Evaluate health disparities as part of QI plan.	All previous plus: a. At least half of measures make use of CQM data. b. Report results of at least one measure to patients, payers or both. c. Identify, **more than annually**, those patients due for preventive or chronic care management services, communicate reminders and **ensure provision of appropriate follow-up care**. d. Evaluate health disparities as part of QI plan **and develop plan to address** e. Maintain a list of community-based services that are relevant to the practice's high-risk population* and establish referral and feedback mechanisms for linking patients with these services**.

APC Straw-Person (3 of 4)

PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
5. CARE COORDINATION	**5. CARE COORDINATION**	**5. CARE COORDINATION**
a. System in place to track high risk referrals	All previous plus: a. Track referrals and reports and have processes to address uncompleted referrals or reports. b. Have care compacts or collaborative agreements with at least 2 groups of specialists (including behavioral health) to improve transitions in care. c. Have systems in place to identify and contact patients seen in an ED or hospital discharges.	All previous plus: a. Measure the effectiveness of care transitions processes in contacting and following up with patients and implement QI efforts as needed.
6. HEALTH INFORMATION TECHNOLOGY *	**6. HEALTH INFORMATION TECHNOLOGY***	**6. HEALTH INFORMATION TECHNOLOGY***
Practice able to meet one of the following: a. Willing to attest to Meaningful Use Stage 1 within one year b. Signed contract with an EHR vendor c. Demonstration of IT and data utilization capabilities including: • Tool to enable population health tracking and quality reporting over time • Access to and use of reports (clinical or claim-based) that identify high risk patients • Ability to electronically document a and share a care plan, developed in concert with patient preferences and goals, with all members of the practice.	All previous plus: a. Meaningful Use Stage 1 b. Connected to local RHIO or has plans to connect with six months.	All previous plus: a. Meets all MU Stage 2 and Stage 3 requirements. b. Connected to local RHIOs and uses data for patient care activities.

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APC Straw-Person (4 of 4)

PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
7. PARTICIPATION AGREEMENT	**7. PARTICIPATION AGREEMENT**	**7. PARTICIPATION AGREEMENT**
a. Completion of a standardized self-assessment tool and on-site audit to evaluate readiness for/interest in change. b. Up-to-date board certification.	All previous	All previous
8. PAYMENT MODEL	**8. PAYMENT MODEL**	**8. PAYMENT MODEL**
a. Agreement to transition to alternative payment model(s) with payers	a. Negotiates alternative payment model (s) with payers.	a. Negotiates alternative payment model(s) with payers including shared savings/risk

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Stakeholder Engagement

Common Measure Set for APC

Measure Set for APC – Assumptions

- All measures have problems
- Measures should fit purpose(s)
- Purpose(s) include:
  - Evaluate whether APC standards are in place and working effectively
  - Evaluate patient experience, clinical quality, and avoidable costs
  - Use for ‘value based’ payments

Measure Assumptions (cont.)

- Should strive towards alignment and parsimony
  - Alignment = same measures across payers
  - Alignment = measures that serve multiple purposes within APC, and without
- Avoid completely new measures
- Mix of process and outcome

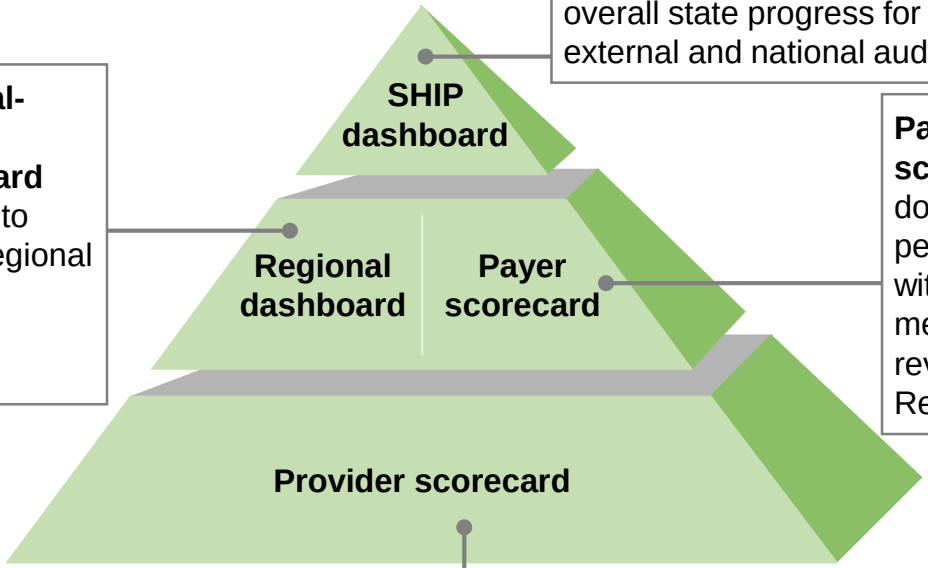
Measure Assumptions (cont.)

- Limited to zero ability to influence/change existing CMS/ONC/NCQA programs and requirements
  - Either for Medicare or Medicaid
- Can influence/change commercial plan measures (not otherwise mandated by CMS) and measures within SIM

Measure Context

- DSRIP
- Common Scorecard
  - HIT Workgroup
  - UHF Quality Institute
- NQF Measurement Application Partnership (MAP)

We set out to create 4 levels of a common scorecard, targeting 4 major stakeholders: providers, payers, regions, and the State



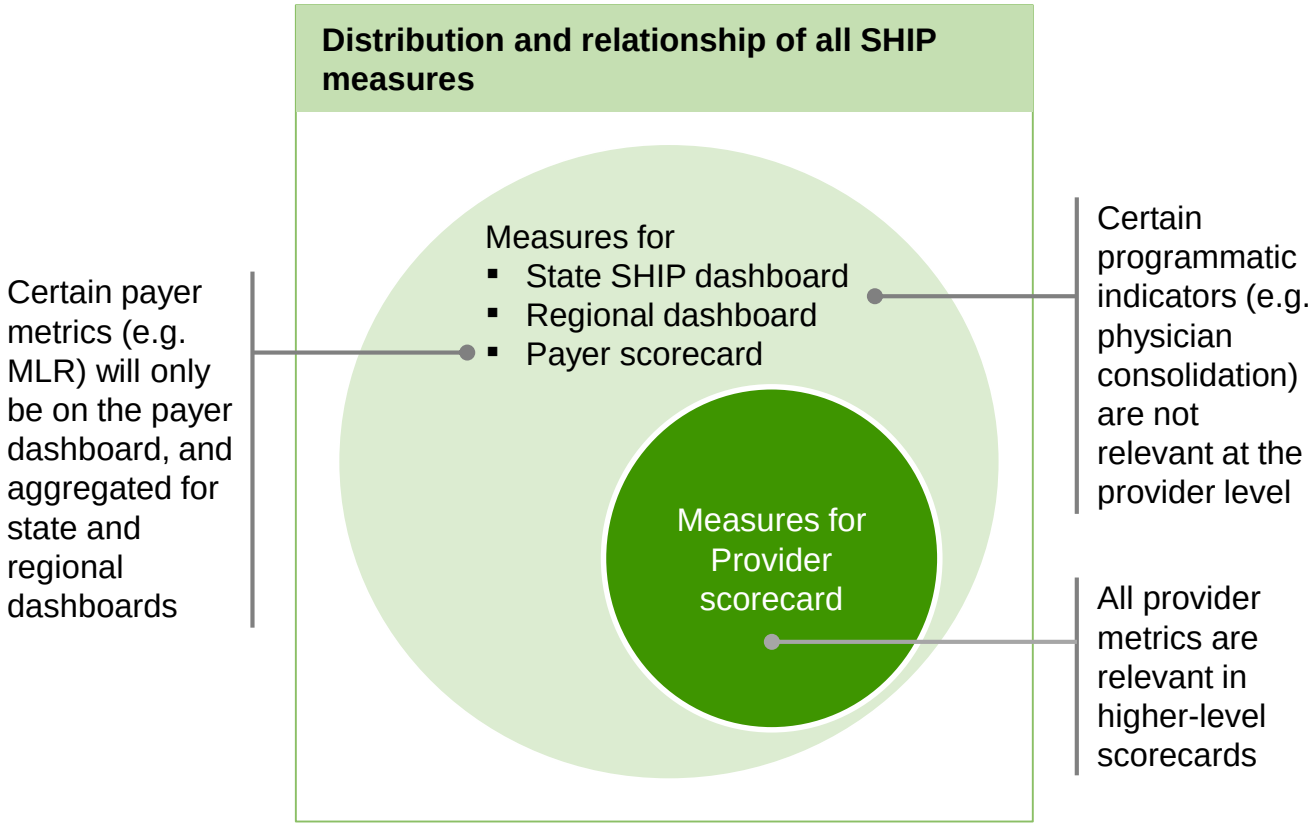
State-level SHIP dashboard tracks overall state progress for state leaders, external and national audiences

Regional-level dashboard will help to inform regional health planning priorities

Payer scorecard will document payer performance, with select measures tied to revised Rate Review process

APC provider scorecard will report on measures across the Triple Aim, with select ones tied to APC eligibility and payment

Scorecards are tightly linked and provider measures roll up to payer and programmatic levels

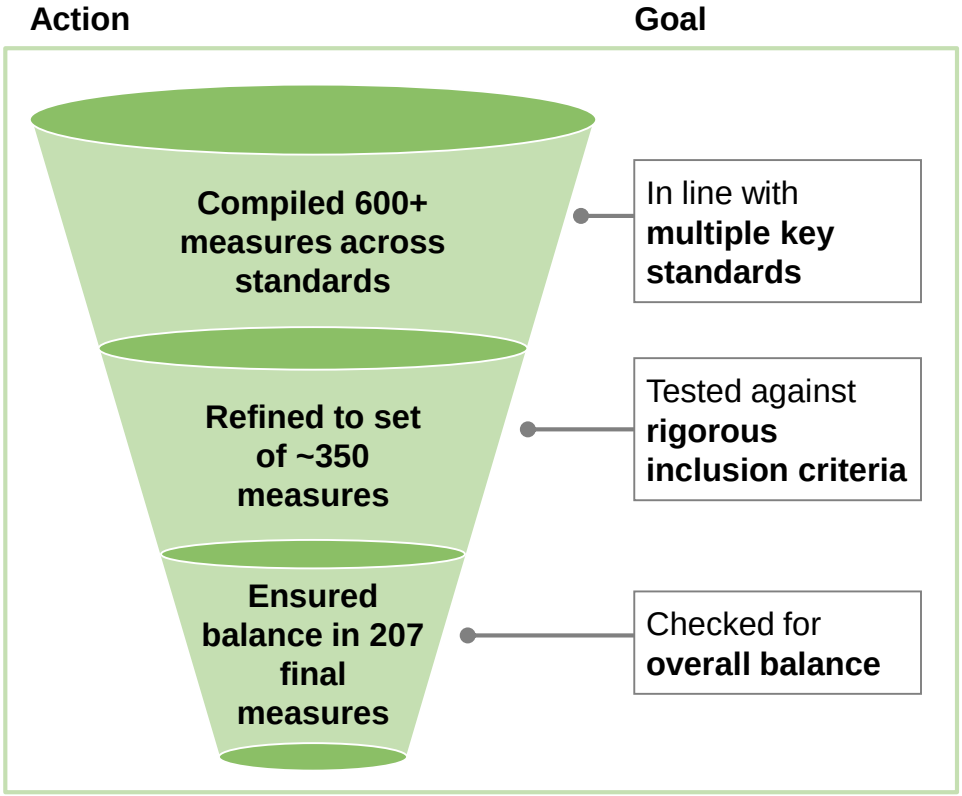


We designed a framework to measurement grounded on the Triple Aim with the addition of 2 contextual categories[2]

	Categories		Primary domains	
Triple Aim[1]	1	**Health improvement**	1.1	Behavioral risk factors
			1.2	Prevalence and Incidence
			1.3	Health outcomes
	2	**Care improve-ment**	2.1	Patient experience of care
			2.2	Quality of care
			2.3	APC eligibility criteria
	3	**Cost reduction**	3.1	Total cost of care
			3.2	Utilization
Context	4	**Landscape**	4.1	Demographics
			4.2	Payer market structure
			4.3	Provider market structure
	5	**Transformation** (Per SHIP frame-work)	5.1	Improving access to care
			5.2	Ensuring integrated care for all
			5.3	Making healthcare transparent for all consumers
			5.4	Paying for value, not for volume
			5.5	Connecting healthcare with the community
			5.6	Workforce strategy
			5.7	Health Information Technology Adoption

1 Institute of Medicine, "Core Measurement Needs for Better Care, Better Health, and Lower Costs: Counting What Counts: Workshop Summary," 2013
2 5-part framework per McKinsey Health Care Value Analytics

Our criteria for success were alignment with external standards, feasibility and value at the measure level, and appropriate overall balance



…. in line with multiple key standards

… with national stewards

Center for Medicare & Medicaid INNOVATION

cahps Surveys and Tools to Advance Patient-Centered Care

NCQA Measuring quality. Improving health care.

NATIONAL QUALITY FORUM

BRFSS

HEDIS

National Patient Safety Goals

PQRS

… with leading integrated care programs

develop models · improve system & payment · demonstrations · care · providers · testing · new · delivery · Medicare · CMS · Medicaid · innovation · health · quality · Center · patients

Shared Savings Program

Comprehensive Primary Care Initiative

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

eHR INCENTIVE PROGRAM

… with New York programs

NEW YORK state department of HEALTH

2013 Quality Assurance Reporting Requirements

ADIRONDACK REGION MEDICAL HOME PILOT

New York State Department of Health Prevention Agenda

Redesigning THE MEDICAID PROGRAM DSRIP

… tested against rigorous inclusion criteria

Criteria	Details	✓ Example measure included in scorecard	✗ Example measure excluded from scorecard
A Improvability	▪ Within PCP control ▪ Sufficient variation in baseline figures (across time and providers)	Adult access to preventive/ ambulatory health services ▪ Relevant to primary care Medication management for people with asthma ▪ Statistically significant variation across providers	Surgical site infection ▪ Acute setting-specific **Asthma:** Pharmacologic Therapy ▪ High performance across all providers
B Feasibility	▪ High technical feasibility ▪ Low provider burden	Follow-up after hospitalization for mental illness ▪ Already reported (claims-based HEDIS measure)	Evidence-based referral process (Leapfrog Group) ▪ Not currently reported and cannot be measured from existing data
C Applicability	▪ Relevant to broad patient panel	**Diabetes:** LDL management ▪ Target population reasonably broad	**Adult CAD:** Percentage of patients with DM with LDL-C >= 130mg/dL ▪ Target population too narrow
D Efficient set	▪ Without redundancies	**HTN:** Controlling blood pressure (<140/90 mm/Hg) ▪ HEDIS measure	Percentage of patients who had diagnosis of HTN and blood pressure <130/80 mm/Hg ▪ Redundant

… checked for balance overall

… by measure type

 Structure

 Process

 Outcome

… by care type

 Healthy

 Acute

 Chronic

… by target population

 Women

 Elderly

 Children

 At risk

… by disease focus

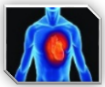
 Addiction

 Cancer

 Diabetes

 Obesity

 Mental health

 Cardio-logy

 Immuni-zations

 Pulmo-nary

Selection Criteria

1. Valid and reliable
2. Opportunities for performance improvement
3. Measure the provider's performance in an area within the targeted providers' influence
4. Endorsed by a national body, such as the National Quality Forum (NQF) or the National Committee for Quality Assurance (NCQA)
5. Sufficient denominators to produce reliable measurement
6. Relevant benchmarks
7. Focused on meaningful outcomes or processes closely related to outcomes
8. Feasible to implement
9. Aligned with existing state measure sets and initiatives, currently used by plans/providers, national/federal initiatives

Some Challenges

- There are many state/regional performance measures for providers in use today
- There is not enough alignment across measures sets
- Despite thousands of measures there appears to be a need for new standardized measures in many ‘gap’ areas: self management, behavioral health, functional and patient reported outcomes, cost, and care management and coordination

IOM Vital Signs - Core Metrics for Health and Health Care Progress: Recommendations (1/3)

- Recommendation 1: The parsimonious set of measures identified by the committee should be widely adopted for assessing the state of America's health and health care, and the nation's progress toward the goal of better health at lower cost.
- Recommendation 2: All people should work to understand and use the core measure set to assist in taking an active role in shaping their own health prospects and those of their families, their communities, and the nation.
- Recommendation 3: With the engagement and involvement of the Executive Office of the President, the secretary of the U.S. Department of Health and Human Services (HHS) should use the core measure set to sharpen the focus and consistency and reduce the number and burden of measure reporting requirements in the programs administered throughout HHS, as well as throughout the nation.

IOM Vital Signs - Core Metrics for Health and Health Care Progress: Recommendations (2/3)

- Recommendation 4: With the engagement and involvement of the Executive Office of the President, the Secretary of HHS should develop and implement a strategy for working with other federal and state agencies and national organizations to facilitate the use and application of the core measure set.
- Recommendation 5: The secretary of HHS should establish and implement a mechanism for involving multiple expert stakeholder organizations in efforts to develop as necessary, maintain, and improve each of the core measures and the core measure set as a whole over time.
- Recommendation 6: Governors, mayors, and state and local health leaders should use the core measure set to develop tailored dashboards and drive a focus on outcomes in the programs administered in their jurisdictions, and should enlist leaders from other sectors in these efforts.

IOM Vital Signs - Core Metrics for Health and Health Care Progress: Recommendations (3/3)

- Recommendation 7: Clinicians and the health care organizations in which they work should routinely assess their contributions to performance on the core measures and identify opportunities to work collaboratively with community and public health stakeholders to realize improvements in population health.
- Recommendation 8: Employers and other community leaders should use the core measures to shape, guide, and assess their incentive programs, their purchasing decisions, and their own health care interventions, including initiatives aimed at achieving transparency in health costs and outcomes and at fostering seamless interfaces between clinical care and supportive community resources.
- Recommendation 9: Payers and purchasers of health care should use the core measures to capture data that can be used for accountability for results that matter most to personal and population health, refine the analytics involved, and make databases of the measures available for continuous improvement.
- Recommendation 10: Measure developers, measure endorsers, and accreditors, such as the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), and the Joint Commission, should consider how they can orient their work to reinforce the aims and purposes of the core measure set, and should work with the secretary of HHS in refining the expression and application of the core measure set nationally.

Counting What Counts

MEASURING PROGRESS TOWARD BETTER HEALTH AT LOWER COST

What matters most for improving the health of Americans and the affordability of our health care? Because what gets measured gets done, progress in health and health care depends on the measures used to guide our efforts, and our focus can be blurred without a sense of what's most important among the thousands of measures in use across the nation. Our challenge is to identify a small, practical set of key indicators of our progress—how we are doing in achieving better health, better care, lower costs, and in involving people more in their own health and care. We need core metrics for continuously learning health and health care in America.

TODAY'S CHALLENGES

- Too many measures
- Uneven relevance
- Little sense of priority
- Uncoordinated efforts
- Limited multi-level comparability

A PATH TO IMPROVEMENT

- Specify a core set of measures
- Align measures to focus on the most important priorities
- Assess progress across the system, from the organizational, community, regional, state to national levels

INFRASTRUCTURE FOR MEASURES

- Build data systems that capture and exchange key data elements
- Integrate measures into processes for reporting, regulation, and payment
- Develop approach to continuously update measures and adapt to new technologies

ANTICIPATED BENEFITS

- Reduce the measurement burden on clinicians and organizations
- Allow for comparisons and identification of best practices
- Promote collaborations and coalitions
- Ensure data systems capture the most important information

BUILDING ON CURRENT INITIATIVES

- Leading Health Indicators for Healthy People
- AHRQ's National Healthcare Quality Report
- CMS's ACO Measures
- Consumer Reports health rating metrics
- ONC's Meaningful Use
- NQF's Buying Value and MAP
- NCQA's Quality Measurement Programs

This graphic summarizes themes that emerged from a workshop.
For more information, please visit www.iom.edu/countingwhatcounts.

NOTES: *ACO* = accountable care organization; *AHRQ* = Agency for Healthcare Research and Quality; *CMS* = Centers for Medicare & Medicaid Services; *MAP* = Measure Applications Partnership; *NCQA* = National Committee for Quality Assurance; *NQF* = National Quality Forum; *ONC* = Office of the National Coordinator for Health Information Technology.

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Primary Care Measure Sets

PCMH Evaluators Collaborative: Cost and Utilization Measures

Core Cost and Utilization Measures for Cross-Study Comparison of PCMHs

- Utilization
  - Emergency department visits, ambulatory care–sensitive (ACS) and all
  - Acute inpatient admissions, ACS and all
  - Readmissions within 30 days
- Cost
  - Total per member per month costs
  - Total per member per month costs for high-risk patients

Technical issues: all utilization and cost issues should be risk-adjusted; method of pricing should be transparent and standardized if possible

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Source: Commonwealth Fund Patient-Centered Medical Home Evaluators' Collaborative.

PCMH Evaluators Collaborative: Quality Measures

- Evaluators should use standardized, validated, nationally endorsed measures. The PCMH Evaluators' Collaborative clinical quality work group recommends selecting a group of quality measures from the lists in Appendix A2 and Appendix A3. We recommend the measures listed in Table 3 as a core set.

- Evaluators should select measures from each of the following areas of primary care: preventive care, chronic disease management, acute care, overuse, and safety.

- Evaluators should apply a validated approach to data collection. This is particularly important if pulling measures from the medical record or electronic health record.

- Evaluators should use consistent measures across practices within a demonstration.

Source: Commonwealth Fund Patient-Centered Medical Home Evaluators' Collaborative.

NYS MAPCP – Adult Measures

Blood pressure management	Number of patients whose most recent BP is adequately controlled based on the following: - Members 18-59 years as of December 31 of the measurement year whose BP was <140/90mm Hg - Members 60-85 years as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm HG - Members 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm HG
Colon cancer screening	Any of the following meet the criteria: - Fecal occult blood test during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type. - Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. - Colonoscopy during the measurement year or the nine years prior to the measurement year.
Pap smear	The number of patients who have had a pap smear within the last 3 years or patients who have had a pap and HPV with service dates 4 or less days apart during the measurement year or the four years prior
Breast cancer screening	The number of patients who received one or more mammograms any time on or between October 1st two years prior to the measurement year and December 31st of the measurement year
Depression Screening (12 & Older)	Patients screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented. (PHQ-2 / PHQ-9)
Pneumonia vaccine	The number of patients who received a pneumococcal vaccine
Diabetes Hgb A1C - Poor control	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year.
Retinal Eye Exam	Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following: -a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year OR –a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. For exams performed in the year prior to the measurement year, a result must be available.

NYS MAPCP – Pediatric Measures

Immunizations	
HPV Vaccines	Received at least three doses of the human papillomavirus (HPV) vaccine with different dates of service on or between their 9th and 13th birthdays.
Childhood Immunization Status	Children who have evidence showing they received recommended vaccines by their second birthday including four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines
Adolescent Immunization Status	Adolescents who have evidence showing they received recommended vaccines by their 13th birthday including one meningicoccal and one Tdap or Td
Weight Assessment	
BMI Assessment	Body mass index (BMI) percentile documentation
Nutrition counseling	Documentation of nutrition counseling
Physical Activity Counseling	Documentation of counseling for physical activity
Access to Care/Preventive Care	
Chlamydia Screening	At least one chlamydia test during the measurement year.
ADHD Follow Up Visits - Initial Phase	An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD (index prescription start date)
ADHD Follow Up Visits - Continuation & Maintenance Phase	Patient who meet the following: numerator compliant for initial phase and then at least two follow-up visits from 31-300 days (9 months) after the IPSD with any practitioner
Annual Depression Screening	Patients screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented. (PHQ-2 / PHQ-9)

NYS CPCi (1 of 2)

NQF ID	Clinical Quality Measure Title	Required in 2013	Required in 2014 & 2015	Domain
0018	Controlling High Blood Pressure	Yes	Yes	Clinical Process/ Effectiveness
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Yes: CO, OK, OR No: AR, NJ, NY, OH	Yes: CO, OK, OR No: AR, NJ, NY, OH	Population/ Public Health
0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Yes	Yes	Population/ Public Health
0031[2]	Breast Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
0034	Colorectal Cancer Screening	Yes	Yes	Clinical Process/ Effectiveness
0036	Use of Appropriate Medications for Asthma	Yes: CO, NJ, NY, OH, OK, OR No: AR	Yes: CO, NJ, NY, OH, OK, OR No: AR	Clinical Process/ Effectiveness
0041	Preventive Care and Screening: Influenza Immunization	Yes	Yes	Population/ Public Health
0059	Diabetes: Hemoglobin A1c Poor Control	Yes	Yes	Clinical Process/ Effectiveness
0061	Diabetes: Blood Pressure Management	Optional[3]	No	Clinical Process/ Effectiveness
0064	Diabetes: Low Density Lipoprotein (LDL) Management	Yes	Yes	Clinical Process/ Effectiveness
0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Yes	Yes	Clinical Process/ Effectiveness

[2] NQF 0031 is no longer NQF endorsed.
[3] NQF 0061 should be reported if the CPC practice site was able to obtain the MU Stage 1 measure in their ONC Certified EHR. NQF 0061 was not included in Stage 2 MU, therefore it is considered optional.

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NYS CPCi (2 of 2)

NQF ID	Clinical Quality Measure Title	Required in 2013	Required in 2014 & 2015	Domain
0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Yes	Yes	Clinical Process/ Effectiveness
0101	Falls: Screening for Future Fall Risk	No	Yes	Patient Safety
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	No	Yes	Population/ Public Health

DSRIP Quality Measures (1 of 3)

Domain 2: System Transformation Projects
Potentially Avoidable Emergency Room Visits ±
Potentially Avoidable Readmissions ±
PQI 90 – Composite of all measures ±
PDI 90– Composite of all measures ±
Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement
Percent of eligible providers with participating agreements with RHIOs, meeting Meaningful Use criteria and able to participate in bidirectional exchange
Percent of PCP meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards
CAHPS - Primary Care - Usual Source of Care - Q2
CAHPS - Primary Care – Length of Relationship – Q3
Adult Access to Preventive or Ambulatory Care – 20 to 44 years
Adult Access to Preventive or Ambulatory Care – 45 to 64 years
Adult Access to Preventive or Ambulatory Care – 65 and older
Children's Access to Primary Care – 12 to 24 months
Children's Access to Primary Care – 25 months to 6 years
Children's Access to Primary Care – 7 to 11 years
Children's Access to Primary Care – 12 to 19 years
CAHPS - Getting Timely Appointments, Care and information (Q6, 8, 10, and 12)
CAHPS - Helpful, Courteous, and Respectful Office Staff (Q24 and 25)
Medicaid Spending on ER and Inpatient Services ±
Medicaid spending on Primary Care and community based behavioral health care
H-CAHPS – Care Transition Metrics (Q23, 24, and 25)
CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers

DSRIP Quality Measures (2 of 3)

Domain 3: Clinical Improvement Projects
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) ±
Antidepressant Medication Management – Effective Acute Phase Treatment
Antidepressant Medication Management – Effective Continuation Phase Treatment
Diabetes Monitoring for People with Diabetes and Schizophrenia
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase
Follow-up care for Children Prescribed ADHD Medications – Continuation Phase
Follow-up after hospitalization for Mental Illness – within 7 days
Follow-up after hospitalization for Mental Illness – within 30 days
Screening for Clinical Depression and follow-up
Adherence to Antipsychotic Medications for People with Schizophrenia
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)
Prevention Quality Indicator # 7 (HTN) ±
Prevention Quality Indicator # 13 (Angina without procedure) ±
Cholesterol Management for Patients with CV Conditions – LDL-C Testing
Cholesterol Management for Patients with CV Conditions – LDL-C > 100 mg/dL
Controlling High Blood Pressure
Aspirin Use
Discussion of Risks and Benefits of Aspirin Use
Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Medication
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Strategies
Flu Shots for Adults Ages 18 – 64
Health Literacy (QHL13, 14, and 16)

DSRIP Quality Measures (3 of 3)

Domain 3: Clinical Improvement Projects (continued)
Prevention Quality Indicator # 1 (DM Short term complication) ±
Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±
Comprehensive diabetes care - LDL-c control (<100mg/dL)
Prevention Quality Indicator # 15 Younger Adult Asthma ±
Pediatric Quality Indicator # 14 Pediatric Asthma ±
Asthma Medication Ratio (5 – 64 Years)
Medication Management for People with Asthma (5 – 64 Years) – 50% of Treatment Days Covered
Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered
HIV/AIDS Comprehensive Care : Engaged in Care
HIV/AIDS Comprehensive Care : Viral Load Monitoring
HIV/AIDS Comprehensive Care : Syphilis Screening
Cervical Cancer Screening
Chlamydia Screening (16 – 24 Years)
Viral Load Suppression
Prevention Quality Indicator # 9 Low Birth Weight ±
Prenatal and Postpartum Care—Timeliness of Prenatal Care
Prenatal and Postpartum Care—Postpartum Visits
Frequency of Ongoing Prenatal Care (81% or more)
Well Care Visits in the first 15 months (5 or more Visits)
Childhood Immunization Status (Combination 3 – 4313314)
Lead Screening in Children
PC-01 Early Elective Deliveries ±
Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain
Risk-Adjusted percentage of members who had severe or more intense daily pain ±
Risk-adjusted percentage of members whose pain was not controlled ±
Advanced Directives – Talked about Appointing for Health Decisions
Depressive feelings - percentage of members who experienced some depression feeling ±
Annual Monitoring for Patients on Persistent Medications – ACE/ARB

CMMI's Recommended Metrics – SIM

- Cost of care: Total cost of care population-based per member per month (PMPM) index Beneficiaries impacted by SIM
- Ambulatory Care: Emergency Department Visits (HEDIS)Providers participating in SIM
- Plan All-Cause Readmissions
- Hospital Consumer Assessment of Health Care Providers and Systems Survey
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Controlling High Blood Pressure
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Categories of 19 most frequently used measures (Bailit Consulting)

7 Diabetes Care

- Comprehensive Diabetes Care (CDC): LDL-C Control <100 mg/dL
- CDC: Hemoglobin A1c (HbA1c) Control (<8.0%)
- CDC: Medical Attention for Nephropathy
- CDC: HbA1c Testing
- CDC: HbA1c Poor Control (>9.0%)
- CDC: LDL-C Screening
- CDC: Eye Exam

6 Preventative Care

- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status
- Colorectal Cancer Screening
- Weight Assessment and Counseling for Children and Adolescents
- Tobacco Use: Screening & Cessation Intervention

4 Other Chronic Conditions

- Controlling High Blood Pressure
- Use of Appropriate Medications for People with Asthma
- Cardiovascular Disease: Blood Pressure Management <140/90 mmHg
- Cholesterol Management for Patients with Cardiovascular Conditions

1 Mental Health/Sub-stance Abuse

- Follow-up after Hospitalization for Mental Illness

1 Patient Experience

- CAHPS Surveys (various versions)

NEW YORK STATE OF OPPORTUNITY. Department of Health

Working Lunch – Common Measure Set Discussion

Payment Models Discussion

Principles*

- Health care cost containment (and therefore affordability) cannot be achieved without delivery system transformation across multiple aligned payers.
- Delivery system transformation is predicated upon access to high-quality primary care and supporting services.
- High-quality primary care is more likely to occur in a formally recognized, patient-centered medical home setting.
- The nurturing of primary care transformation can only be successful in a uniformly applied, multi-payer model (involving many different health care payers) coupled with collaborative learning and team-based care.

*http://healthaffairs.org/blog/2014/09/04/new-report-from-the-milbank-memorial-fund-aligning-payers-and-practices-to-transform-primary-care/ accessed May 5, 2015.

APC Payment Assumptions

- Providers need resources for:
  - Transformation activities
    - Likely not ‘one and done’ but should diminish over time
    - Commercial payer ‘enthusiasm’ for this investment limited
    - MU, HEAL, DSRIP, SIM, ?TCPI, CMMI Grants, provide much of this

Payment Assumptions (cont.)

- Providers need resources for:
  - APC infrastructure, new activities, not reimbursed by FFS payments
    - Care management, consultations with medical neighborhood, ‘virtual’ visits, etc.
- Providers/Payers want payment to support/incent:
  - Improved quality, patient experience, and cost avoidance
  - P4P, Shared Savings, etc.

Payment Lessons Learned

1. Value-Driven Payment - Health plans and providers must move away from volume-driven to value-driven payment. This change can be prompted by competition; led by a “first-moving” entity with substantial market share, or by major provider organizations.

2. Consensus is essential to secure broad multi-payer participation and to send uniform signals to providers within a common payment structure

3. Strong anti-trust vigilance and appropriate regulation are critical to ensure health plan and payer competition in the public interest.

4. Public transparency of price and quality is key. Incentives for consumers to include both price and quality in their choice of provider, is a critical element in supporting transparency.

The Building Blocks of Successful Payment Reform

1. **Flexibility** The revised payment system should provide sufficient flexibility to enable providers to deliver care in a way that they believe will achieve high quality or outcomes in the most efficient way and to adjust care delivery to the unique needs of individual patients
2. **Accountability for Spending** comes from a mechanism for controlling utilization and spending
3. **Accountability for Quality** comes from a mechanism for assuring adequate quality and outcomes
4. **Adequacy of Payment** comes from adjusting those mechanisms to reflect the real differences in patients' needs

The Building Blocks of Successful Payment Reform: Designing Payment Systems that Support Higher–Value Health Care. Harold D. Miller; President and CEO; Center for Healthcare Quality and Payment Reform

Ingredients to a successful PAYMENT MODEL

Harold D. Miller, executive director of the Center for Healthcare Quality and Payment Reform, says there are **four aspects** any payment model must have to successfully provide physicians with enough income and improve patient outcomes through accountability and quality measures:

Flexibility

In many of today's payment models, physicians don't have the flexibility to adapt their practice in a way that matches what the payer is asking for in terms of outcomes and cost savings. Giving physicians that flexibility to build a program that makes economic and clinical sense is key.

Accountability

Holding physicians accountable is the flip side of flexibility. If physicians are going to have leeway to adapt their methods to achieve outcomes, then they must be judged on whether their methods are effective.

Adequacy

Physicians must be paid enough to achieve the outcomes that the health plan seeks.

Adjustment

Payments must be adjustable to reflect the real differences in patient needs. Sicker patients require more resources, and hysicians should not be put at risk financially for taking on sicker patients.

Facilitating Value-based Payment*

- **Leadership**: Strong leadership from an experienced, honest, trusted convening organization to effectively broker competing interests

- **Organized Market Pressure**: Concentrated and sustained market pressure from organized purchasers.

- **Publicly accessible data.** An all-payer data base and health information exchange (HIE) can create measurement capacity and offer a platform for assessing price, quality, cost, and outcomes.

*http://healthaffairs.org/blog/2015/04/14/implementing-value-based-payment-reform-learning-from-the-field-of-practice/. Accessed April 15, 2015

Delivery System Reform and Payment Reform – Both Necessary; Alone Insufficient

1. The goal of setting **APC standards** is to develop consensus about core elements of high quality primary care desired by patients and valued by providers and payers.

2. The goal of **payment reform** in the context of setting APC standards: Develop a payment model that supports and promotes proven interventions leading to high quality cost effective care

3. How do we develop this payment model?

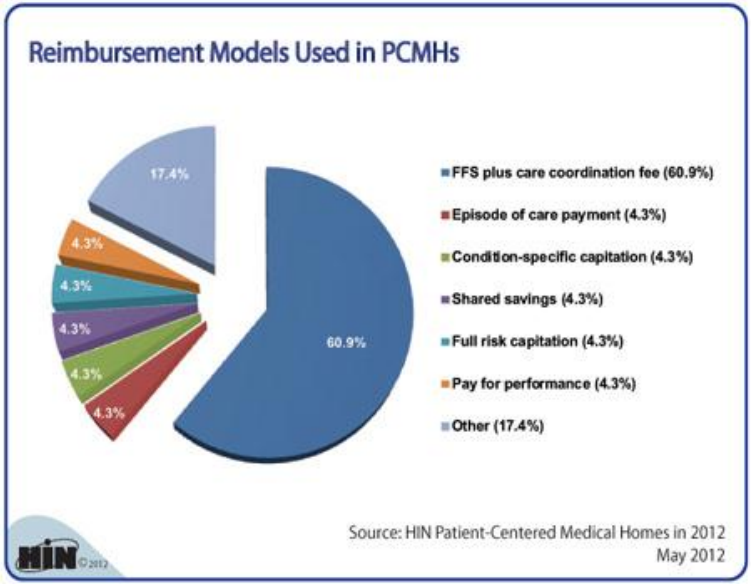
CMS: Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume

	Payment Taxonomy Framework			
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

DSRIP VBP Model

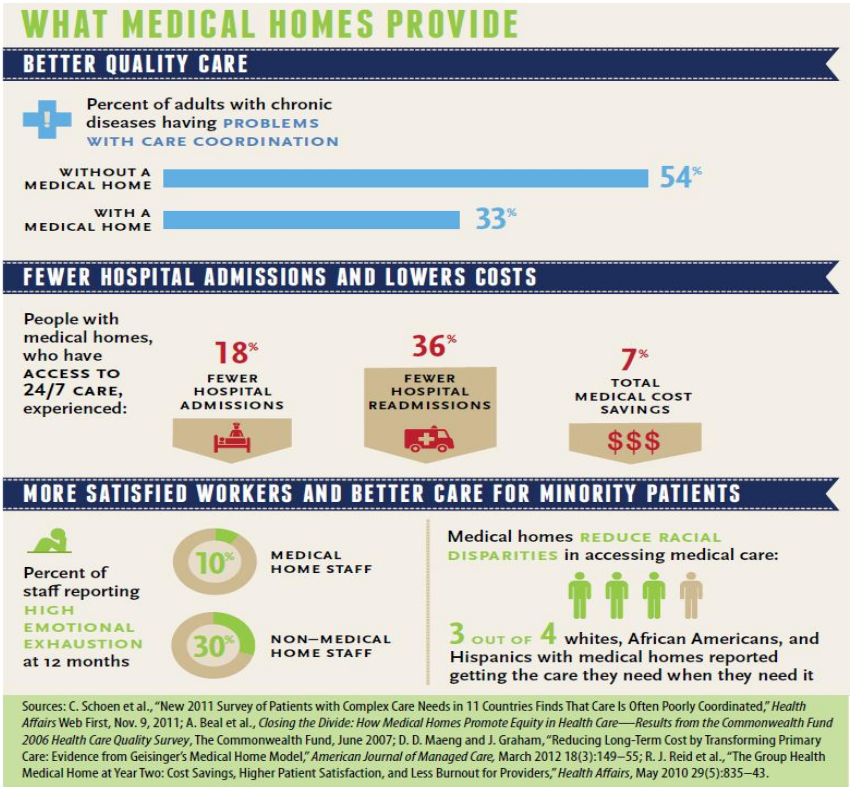
Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective Bundled Payment (with outcome-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

Reimbursement Models used in PCMHs



Selected Evidence to Date

Impact of Medical Homes



NEW YORK STATE OF OPPORTUNITY. Department of Health

Federal Multi-Payer Initiatives

- The CPC initiative, in its first year, decreased hospital admissions by 2% and emergency department visits by 3%, contributing to the reduction of expenditures nearly enough to offset care management fees paid by CMS.

- The MAPCP demonstration generated an estimated $4.2 million in savings through the use of advanced primary care initiatives. MAPCP challenges across states, that require further work, include:

  - A lack of data integration between systems and between practices, hospitals, and specialists which hindered practices' ability to manage care and assess progress.
    - Data sharing challenges are a significant barrier to reducing costs through reduced ER usage and hospital readmissions.
    - Stronger data sharing agreements between hospitals and practices are needed.

  - Patient engagement—educating patients about their health conditions and encouraging them to be more actively involved in making decisions about their care—is reported to be a challenge in all states.

Hudson Valley Initiative

- 6 health plans covering 70% of the community's commercially insured population.
- 10 quality measures for pay-for-performance.
- Financial incentives, $2 to $10 per patient per month, to practices that implemented level 3 PCMHs
- Findings:
  - Practices that implemented the PCMH improved their quality of care over time at a rate significantly greater than their non-PCMH peers.
  - The adjusted odds of receiving recommended care over time in the PCMH group were 7% higher than in the paper group and 6% higher than in the EHR group.
  - The PCMH group improved significantly more over time than either the paper group or the EHR group for 4 of the 10 measures (by 1 to 9 percentage points per measure): eye examinations and hemoglobin A1c testing for patients with diabetes, chlamydia screening, and colorectal cancer screening (adjusted $P < 0.05$ for each).

Patient-Centered Primary Care Collaborative (PCPCC) January 2015 Report

- Peer Reviewed Studies
  - Of 10 peer-reviewed studies that examined whether the PCMH was associated with a reduction in costs, six reported reductions (60 percent).
  - Of 13 studies that investigated the association between the PCMH and unnecessary utilization, 12 found a reduction in one or more measure (92 percent).
- State government reports (non peer-reviewed).
  - All seven state government evaluations reported reductions in at least one cost metric (100 percent) and six reported improvement in one or more measurement of utilization (86 percent).
- Industry reports (non peer-reviewed).
  - Six of seven industry publications reported reductions in at least one utilization metric (86 percent) and four reported reductions in one or more cost metric (57 percent).

The Bronx Community Accountable Healthcare Network (BAHN)*

- Part of the Montefiore Medical Center and a growing collaboration of pharmacies, hospitals, physicians, ancillary services, care management services, health plans and insurers, home care, public health agencies, long-term care facilities and mental health services, built on a foundation of primary care and a PCMH model.

  - Reduced hospital admissions by 28 percent and reduced ER utilization by 25 percent for the diabetes program (between 2008-2009);
  - Reduced hospital admissions (from 1.46 to 1.2 inpatient admissions per member per year) for the heart failure program (2008-2009);
  - Reduced hospital admissions (from 0.41 to 0.32 inpatient admissions per member per year) for the respiratory program (2008-2009); and
  - Reduced readmission rate (from 21.5 percent to 14 percent) for hospital follow-up program (2008-2009).

*Benefits of Implementing the PCMH: A Review of Cost & Quality Results, 2012

The Improving Mood/Promoting Access to Collaborative Treatment (IMPACT) Study

- Team-based interdisciplinary primary care and behavioral health
  - At 12 months, 45 percent of the IMPACT patients had a 50 percent or greater reduction in depression symptoms (compared to 19 percent in the control group).
  - IMPACT was more effective than usual care in all of the eight different health care organizations that were studied, regardless of whether the patients had other medical conditions or anxiety disorders.
  - IMPACT was equally effective across ethnic and racial backgrounds, with African American, Latino and white patients experiencing similar outcomes.

Geisinger Health System's PCMH

- ProvenHealth Navigator, provides health care services focused on
  the needs of patients with chronic disease, many of whom have multiple conditions and high health care costs.
  - For ProvenHealth Navigator Medicare patients (those patients who receive care in a PCMH), researchers found a 28 percent reduction in admissions to the hospital, and a 8.1 percent reduction in admissions to the ED (2009 data).
  - For ProvenHealth Navigator commercially insured patients, Geisinger found a 37.9 percent reduction in admissions to the hospital, and a 34.4 percent reduction in admissions to the ED (2009 data)

Blue Cross/Blue Shield Michigan PCMH*

- Interdisciplinary primary care including a systems of care approach:
  - Physician practices that used a team-based approach to care coordination scored better than those not using a team-based approach, according to the PCMH assessment tool.
  - Patients who received care from a PCMH had 11.4 percent lower ED visit rates for primary care-related conditions.
  - The generic prescribing rate for pharmaceuticals rose from 38 percent in 2004 to 74 percent
  - in 2011.
  - Since implementing the program, BCBS Michigan's program showed improved quality outcomes; greater collaboration/ improved relationships with clinicians; improved patient experience; improved reputation in the community; membership shift to high performing physicians; and increased physician investment in electronic systems and quality improvements

*Benefits of Implementing the PCMH: A Review of Cost & Quality Results, 2012

Impact of an EHR on Care for Persons with Diabetes*

- Patients at care sites with an EHR fared better on a set of standard quality measures for diabetes than those treated at paper-based sites.
  - Between July 2009 and June 2010, 50.9% of patients at EHR sites, as compared with 6.6% of patients at paper-based sites, received care for diabetes that met Better Health's Clinical Advisory Committee quality standards for diabetes, representing a difference of 44.3 percentage points.
  - EHR sites showed higher achievement on all components on a composite standard for care.
  - For diabetes outcomes, 43.7% of patients at EHR sites and 15.7% of those at paper-based sites had outcomes that met at least four of five Better Health standards, a difference of 28.0 percentage points.

*Electronic Health Records and Quality of Diabetes Care. Randall D. Cebul, M.D., Thomas E. Love, Ph.D., Anil K. Jain, M.D., and Christopher J. Hebert, M.D. N Engl J Med 2011; 365:825-833September 1, 2011DOI: 10.1056/NEJMsa1102519

Next Steps and Discussion