NEW YORK STATE OF OPPORTUNITY. Department of Health

NYS Health Innovation Council

May 31, 2017

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 – 10:45	Paul Francis Dr. Howard Zucker
2	Evaluating SIM Progress to Achieve Goals: Key Questions	10:45 – 11:10	Kerry Griffin New York Academy of Medicine
3	SIM Implementation Progress: Successes and Challenges		
	• Provider Transformation - PT TA Expansion - Regional Rollout - PCMH Alignment - APC Scorecard Alignment - HIT Enabled Quality Measurement	11:10 – 12:00	Dr. Marcus Friedrich Edward McNamara Jim Kirkwood
	• Payer Engagement - Medicaid Primary Care Support - Health Plan alignment with APC - MACRA and APC Alignment	12:00 – 12:40	Carlos Cuevas Dr. Marcus Friedrich John Powell
	• Workforce	12:40 – 1:00	Lisa Ullman
	• Population Health	1:00 – 1:15	Dr. Barbara Wallace
4	Next Steps	1:15 - 1:30	Paul Francis Dr. Howard Zucker

NEW YORK STATE OF OPPORTUNITY. Department of Health

SIM Evaluation Questions

New York Academy of Medicine

NEW YORK STATE OF OPPORTUNITY. Department of Health

New York State Innovation Model (SIM) Evaluation

NYS Health Innovation Council Meeting

May 31, 2017

The New York Academy of Medicine

SIM Evaluation: Context and Scope

- Goal: Support effective implementation of NY SIM
  - Note: objectives different than those of federal evaluation
- Mixed Methods: quantitative and qualitative
- Partnership between The New York Academy of Medicine and FAIR Health, Inc.

THE NEW YORK ACADEMY OF MEDICINE
HEALTHY CITIES. BETTER LIVES.

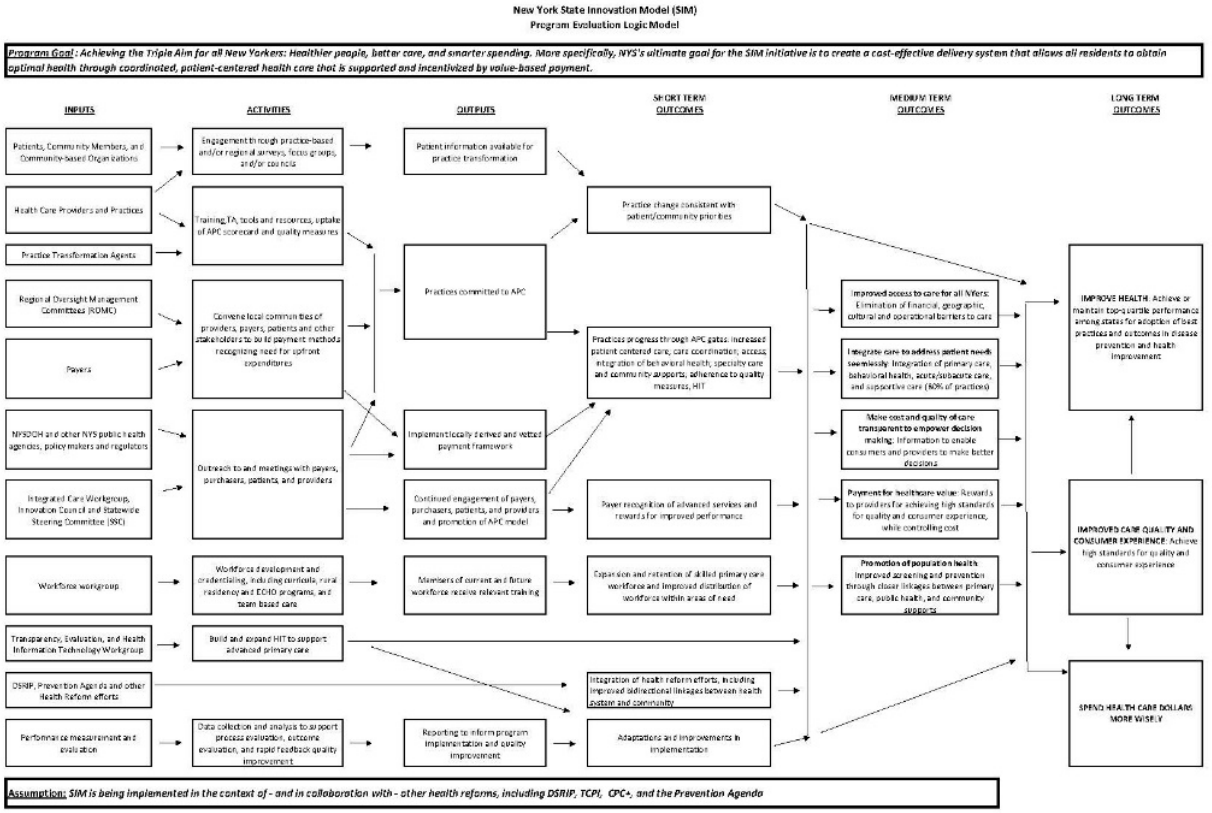
Guiding Questions

- What is the value-added of SIM?
- To what extent is NYS meeting its SIM targets?
- How is implementation proceeding, and what are the facilitators and barriers?
- What is the level of engagement from different stakeholders and what factors affect engagement?
- What are the most notable successes to date, and the drivers?
- What have been the key challenges?
- Have there been unintended consequences?
- How effectively is SIM addressing population health?
- Are there sufficient and appropriate resources to facilitate health innovation and improvement?

Analytical Approach

- An assessment of changes in program participation, and related costs, quality, and population health metrics statewide, regionally, and at the practice level
- Multi-pronged: complementary quantitative and qualitative research methods, including primary and secondary data, to evaluate the SIM and its component parts
- Timeframe: pre-SIM period (lookback of three years) through implementation (Nov 2018)
- Flexible and iterative, responding to program changes as they occur

Logic Model


New York State Innovation Model (SIM)
Program Evaluation Logic Model
Program Goal: Achieving the Triple Aim for all New Yorkers: Healthier people, better care, and smarter spending. More specifically, NYS's ultimate goal for the SIM initiative is to create a cost-effective delivery system that allows all residents to obtain optimal health through coordinated, patient-centered health care that is supported and incentivized by value-based payment.
INPUTS
ACTIVITIES
OUTPUTS
SHORT TERM OUTCOMES
MEDIUM TERM OUTCOMES
LONG TERM OUTCOMES
Patients, Community Members, and Community-based Organizations
Health Care Providers and Practices
Practice Transformation Agents
Regional Oversight Management Committees (ROMC)
Payers
NYSDOH and other NYS public health agencies, policy makers and regulators
Integrated Care Workgroup, Innovation Council and Statewide Steering Committee (SSC)
Workforce workgroup
Transparency, Evaluation, and Health Information Technology Workgroup
DSRIP, Prevention Agenda and other Health Reform efforts
Performance measurement and evaluation
Engagement through practice-based and/or regional surveys, focus groups, and/or councils
Training, TA, tools and resources, uptake of APC scorecard and quality measures
Convene local communities of providers, payers, patients and other stakeholders to tie to payment methods recognizing need for upfront expenditures
Outreach to and meetings with payers, purchasers, patients, and providers
Workforce development and credentialing, including curricula, rural residency and ECHO programs, and team based care
Build and expand HIT to support advanced primary care
Data collection and analysis to support process evaluation, outcome evaluation, and rapid feedback quality improvement
Patient information available for practice transformation
Practices committed to APC
Implementation-ally derived and vetted payment framework
Continued engagement of payers, purchasers, patients, and providers and promotion of APC model
Members of current and future workforce receive relevant training
Reporting to inform program implementation and quality improvement
Practice change consistent with patient/community priorities
Practices progress through APC gates: increased patient centered care; care coordination; access; integration of behavioral health; specialty care and community supports; adherence to quality measures; HIT
Payer recognition of advanced services and rewards for improved performance
Expansion and retention of skilled primary care workforce and improved distribution of workforce within areas of need
Integration of health reform efforts, including improved bidirectional linkages between health system and community
Adaptations and improvements in implementation
Improved access to care for all NYers: Elimination of financial, geographic, cultural and operational barriers to care
Integrate care to address patient needs seamlessly: Integration of primary care, behavioral health, acute/subacute care, and supportive care (80% of practices)
Make cost and quality of care transparent to empower decision making: Information to enable consumers and providers to make better decisions
Payment for healthcare value: Rewards to providers for achieving high standards for quality and consumer experience, while controlling cost
Promotion of population health: Improved screening and prevention through closer linkages between primary care, public health, and community supports
IMPROVE HEALTH: Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement
IMPROVED CARE QUALITY AND CONSUMER EXPERIENCE: Achieve high standards for quality and consumer experience
SPEND HEALTH CARE DOLLARS MORE WISELY
Assumption: SIM is being implemented in the context of - and in collaboration with - other health reforms, including DSRIP, TCPI, CPC+, and the Prevention Agenda

Assessing APC Model Performance & Implementation: Quantitative

Comparing different levels and stages of APC implementation

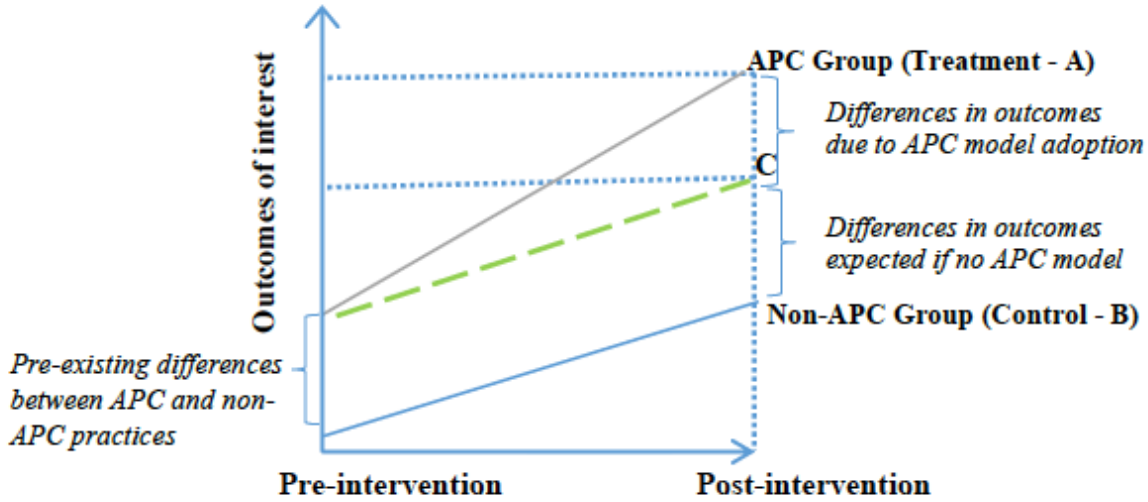
- APC vs. APC-like (e.g., PCMH) vs. control
- Account for regional roll-out strategy

Measures of performance

- Measures calculated from multi-payer data using FAIR Health claims warehouse
  - HCI3 Episode of Care Measures for Chronic Conditions (cost and quality)
  - Total cost of care, hospitalizations, emergency department use
- APC scorecard measures

THE NEW YORK ACADEMY OF MEDICINE
HEALTHY CITIES. BETTER LIVES.

Assessing APC Model Performance & Implementation: Quantitative (Cont'd)



THE NEW YORK ACADEMY OF MEDICINE

Proposed Metrics

Custom measures for primary care providers calculated from the FAIR Health database, supplemented with Medicare and Medicaid (pending) claims data, including:

- Total cost of care
- Hospital admissions
- ED utilization
- Primary care utilization

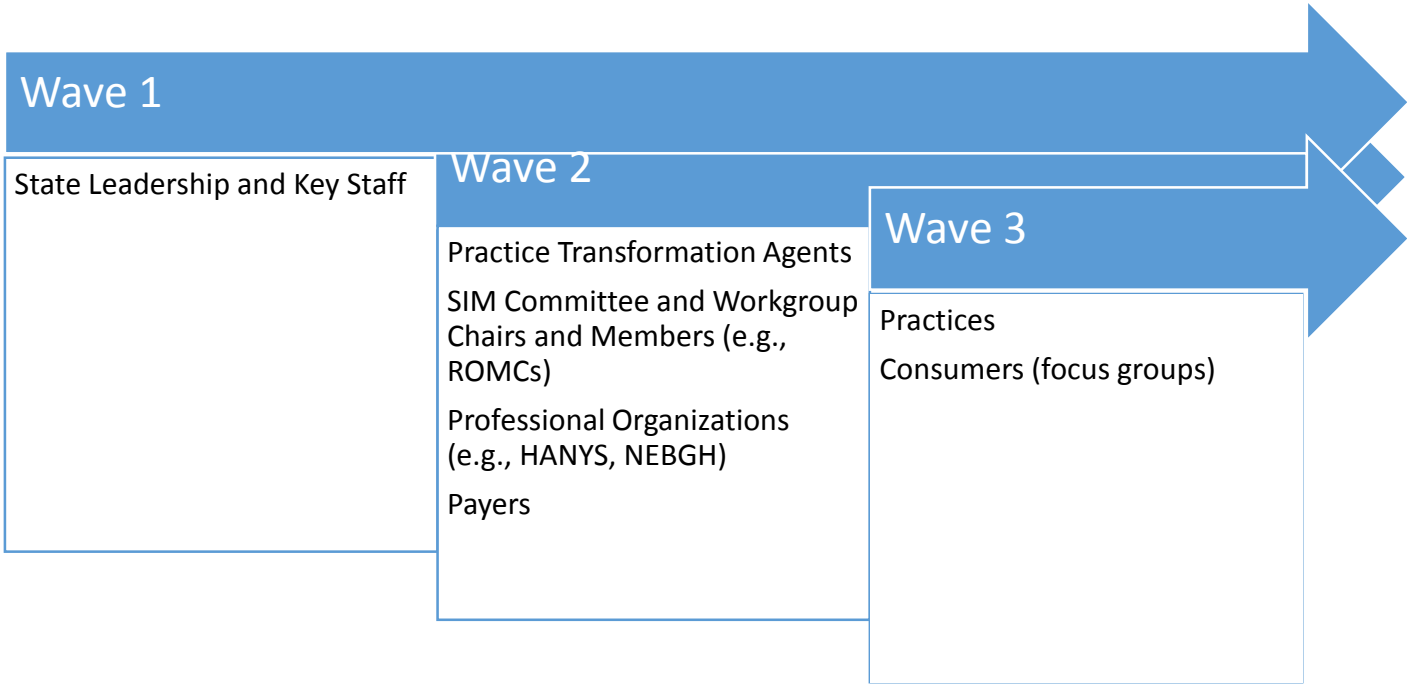
THE NEW YORK ACADEMY OF MEDICINE

Proposed Metrics (Cont'd)

HCI3 Episodes of Care sensitive to changes in primary care. Each episode measure encompasses cost and quality:

Episode of Care Measure	**Variable Name**	#
Asthma	ASTHMA	EC0401
Chronic Obstructive Pulmonary Disease	COPD	EC0402
Coronary Artery Disease	CAD	EC0508
Depression & Anxiety	DEPANX	EC1909
Diabetes	DIAB	EC1001
Heart Failure	HF	EC0521
Hypertension	HTN	EC0511
Low Back Pain	LBP	EC0801
Preventive Care	PREVNT	EX9901

Assessing APC Model Performance & Implementation: Qualitative



Future waves: repeat interviews with stakeholders

Stakeholder Interviews: Sample Questions & Themes

State Leadership and Key Staff (Wave 1)

- Status of SIM implementation and how it fits into broader reform efforts
- What's going well, what are key challenges thus far and in future? Have your plans changed?
- What information would be helpful to you as we speak with others? Who should we be sure to speak with?

SIM Committee and Workgroup Chairs and Members

- Status of relevant components (e.g., workforce)
- Expectations of progress; on track?
- Challenges or concerns now or in future?

Sample Questions & Themes (cont'd)

Practice Transformation Agents

- Availability of tools and resources to facilitate practice transformation
- Early challenges/ concerns recruiting practices

Practices

- Choosing APC vs. other vs. none; factors underlying choices
- Supports and resources necessary for transformation
- Early challenges/concerns

THE NEW YORK ACADEMY OF MEDICINE
HEALTHY CITIES. BETTER LIVES.

Sample Questions & Themes (cont'd)

Payers

- Incentives for supporting APC
- Role and engagement with ROMCs
- Early challenges/concerns

Professional Organizations (e.g., HANYS, NEBGH)

- Perceived value of SIM vs other reform efforts
- Level of engagement of members and factors affecting engagement
- For NEBGH: level of engagement of payers, purchasers? Challenges and opportunities for engagement moving forward?

Key Questions for Stakeholders (cont'd)

Consumers (focus groups)

- Experience of care at APC practices (vs. desired experience; vs. experience at "non-transformed" primary care practices)
- Knowledge of and preferences for advanced primary care models

Closing Thoughts

- Focus is on generating information that will be useful as SIM is being implemented (vs. seeing if “CMMI SIM program works overall”)

- Will be flexible in evaluation strategy as implementation strategy changes over time – being responsive to questions as they arise

- Will support sustainability planning for NY SIM

THE NEW YORK ACADEMY OF MEDICINE
HEALTHY CITIES. BETTER LIVES.

Project Key Contacts

Kerry Griffin, MPA, Project Director
kgriffin@nyam.org

Jose Pagan, PhD, Co-Principal Investigator – Quantitative Analysis
jpagan@nyam.org

Linda Weiss, PhD, Co-Principal Investigator – Qualitative Analysis
lweiss@nyam.org

Anthony Shih, MD, Executive Sponsor
ashih@nyam.org

THE NEW YORK ACADEMY OF MEDICINE
HEALTHY CITIES. BETTER LIVES.

Questions/Comments

Provider Transformation

NY State Transformation Activities- Guiding Principles:

- Multi-payer scale and alignment are critical to transformation
- Fundamental change requires consistent focus and support over time, not just a proliferation of innovation
- Transformation requires actionable insights driven by data that are comprehensive, transparent, and relevant
- The public sector at both the State and Federal levels should continue to take an active leadership role, and commit to a step-change improvement in alignment and collaboration

NY State of Transformation – SIM/APC Facts

- Launched Round 2 Practice Transformation (PT TA) vendors- 16 in 8 DFS Regions
- Held the first APC PT TA In-Person Summit:

  - attended by 38 Agents from 10 entities,12 Content Experts from 5 agencies, RHIOs, NYAM, and DOH APC staff
- PT TA "Train-the-Trainer" Webinars, Monthly Round Table, 1:1 Monthly PT TA "Pulse" conference calls with APC team
- As of May 24th, 101 practices enrolled, 58 in discussions
- 65% of the practices are small provider size (1-4 provider), the rest medium (5-10) and large (>10)

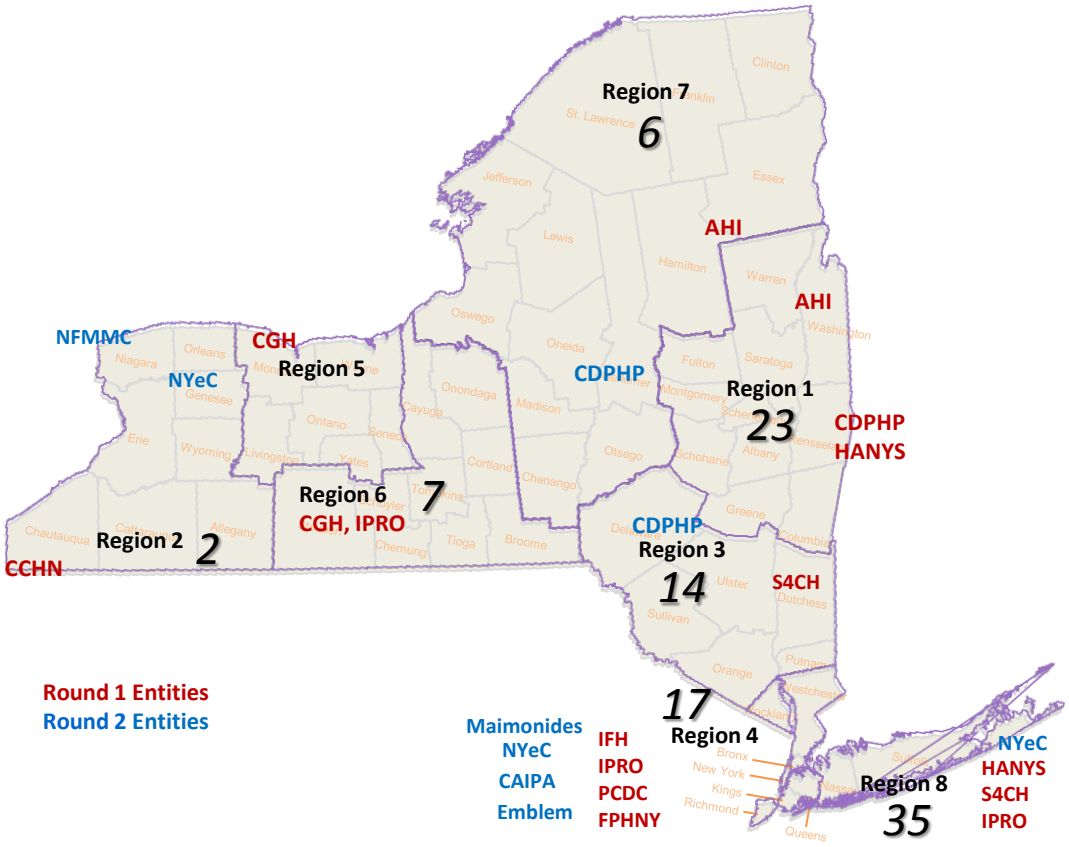
NY State Transformation – TA Vendors

#	Name of Awardee		Regions
1	Adirondack Health Institute	AHI	Capital District and Adirondacks
2	CDPHP	CDPHP	Capital District, Mid-Hudson Valley and North Country
3	HANYS	HANYS	Capital District and Long Island
4	Chautauqua County Health	CCHN	Western (Buffalo)
5	Solutions 4 Community Health	S4CH	Mid-Hudson Valley and Long Island
6	Institute for Family Health	IFH	NYC
7	IPRO	IPRO	NYC, Central NY (Syracuse) and Long Island
8	PCDC	PCDC	NYC
9	Fund for Public Health in New York	FPHNY	NYC
10	Finger Lakes (Common Ground Health)	CGH	Finger Lakes (Rochester) and Central NY (Syracuse)
11	Niagara Falls Memorial Medical Center	NFMMC	Western New York Region
12	New York eHealth Collaborative	NYeC	Western New York Region, NYC, and Long Island
14	Chinese American IPA, Inc. d/b/a Coalition of Asian-American IPA	CAIPA	New York City Region
15	EmblemHealth Services Company, LLC	Emblem	New York City Region and Long Island
16	Maimonides Medical Center	Maimonides	New York City Region

Round 1 Entities
Round 2 Entities

NEW YORK STATE OF OPPORTUNITY. Department of Health

NY State Transformation – TA Vendors and enrolled practices



Capacity Projections-All Regions*

Region	Practices
Region 1	130
Region 2	216
Region 3	125
Region 4	1081
Region 5	70
Region 6	70
Region 7	115
Region 8	379
Total:	**2335**

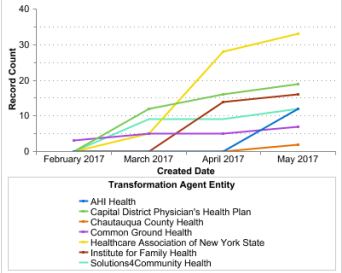
NEW YORK STATE OF OPPORTUNITY. Department of Health

Practice Transformation Tracking System (PTTS)

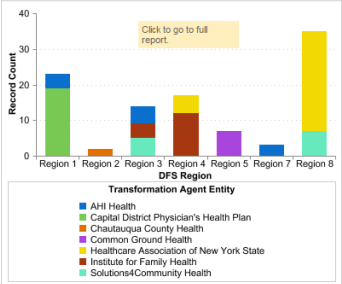
Practice Recruitment

Find a dashboard... Edit Clone Refresh As of Today at 12:49 PM

Practice Sites Enrolled



Enrolled Practice Sites by Region & TA



Practice Sites Engaged

Practice Sites Engaged:	58

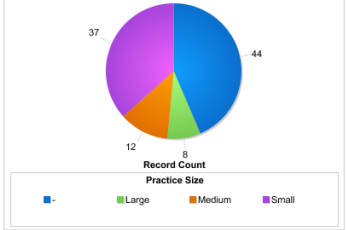
Enrolled Practice Sites by PT TA

Transformation Agent Entity	Record Count
AHI Health	12
Capital District Physician's Health Plan	19
Chautauqua County Health	2
Common Ground Health	7
Healthcare Association of New York State	33
Institute for Family Health	16
Solutions4Community Health	12

Enrolled Practice Sites by Region

DFS Region	Record Count
Region 1	23
Region 2	2
Region 3	14
Region 4	17
Region 5	7
Region 7	3
Region 8	35

Enrolled Practice Sites by Practice Size

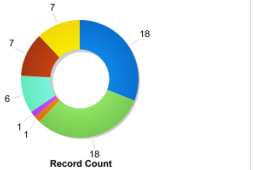


Small = 1-4 primary care physician and mid-level providers; medium = 5-10; large = 11+

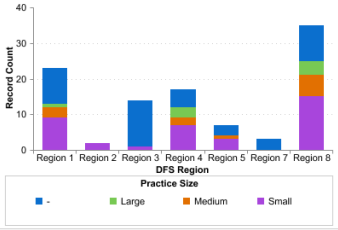
Practice Sites Enrolled

Practice Sites Enrolled:	101

Practice Sites Engaged



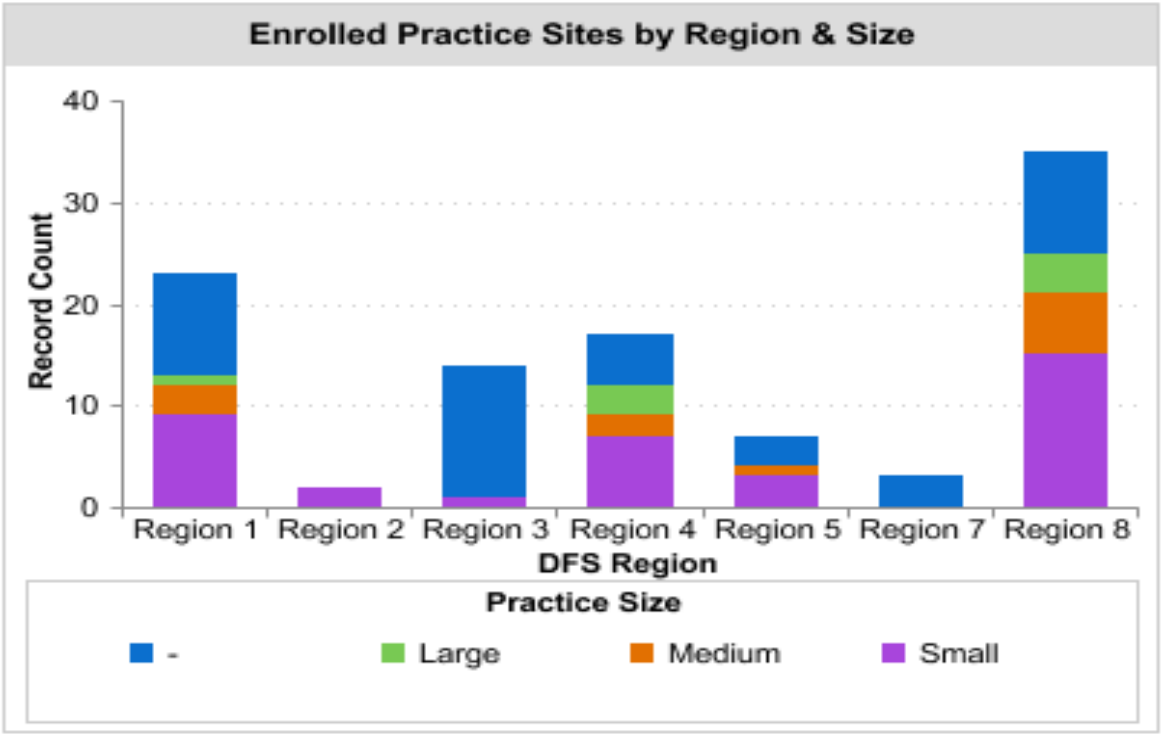
Enrolled Practice Sites by Region & Size



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

NEW YORK STATE OF OPPORTUNITY. Department of Health

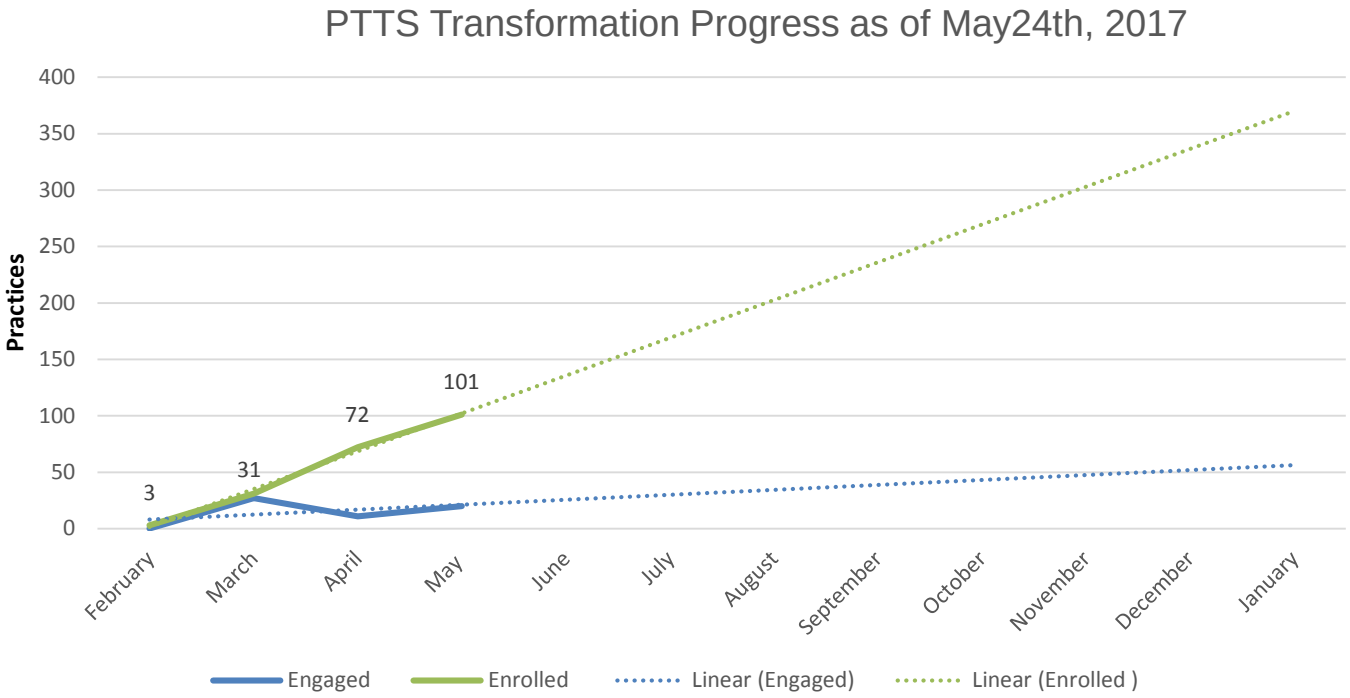
Current enrolled practices by size and region



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

NEW YORK STATE OF OPPORTUNITY. Department of Health

NY State of Transformation - Facts



Practice target based on Round 1 TA Agent estimates for 2017.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Success to achieve NY State SHIP goals depends on:

- Providers embracing and succeeding in APC and other concurrent value-based programs
- Payers meaningfully evolving primary care transformation programs in a way that is aligned with and reinforcing of APC
- Medicaid DSRIP providers succeeding on VBP roadmap related components driven by primary care
- Building and achieving sustainability of APC beyond SIM

Summary

- SIM/APC is operational and has capacity
  - How can we accelerate success towards NY State SHIP goals?
  - How do we objectively measure success?
  - How can we achieve sustainability?

Regional Rollout

Integrated Care Workgroup transition: Regional Rollout

Movement from:		To:
Development	→	Implementation
Gathering Input	→	Solving Problems
Statewide Only	→	State Steering and Regional Committees

ROMC Goals

Establish a collaborative in each region that will:

- **Guide the implementation** and operationalization of APC and provide input into the APC model as required
- **Convene providers and payers** to consider how best to advance payment reform according to the APC model
- **Facilitate engagement** of clinicians, payers, purchasers and patients in APC
- **Address regional population health priorities** as recommended by the NYSDOH and statewide steering committee
- **Support shift to value-based reimbursement** by working toward alignment on measures and expectations of primary care practices

Regional Rollout

Commercial Plans
(BSNENY, CDPHP, Empire BCBS, Empire UHC, Excellus, Fidelis, MVP)

TA Vendors
(AHI)

ADK Medical Home
(25- 30 participants)
Facilitator: Dennis Weaver, MD
Convener: AHI

Public Payers
(Medicare FSS & Medicaid)

Providers
(ACOs, FQHC, Private Practice, Medical Society)

Plans
(Aetna, Excellus BCBS, MVP)

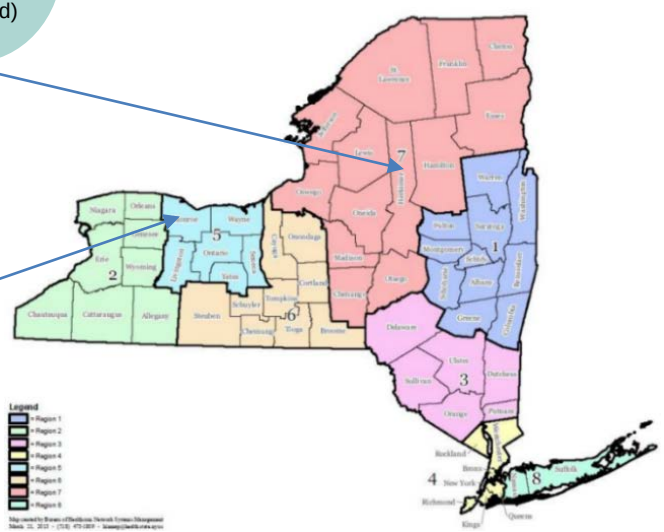
TA Vendors
(Common Ground Health)

Finger Lakes ROMC
(15-20 participants)
Facilitator: Tom Mahoney, MD
Convener: Common Ground Health

Employers
(Kodak, Paychex, RIT)

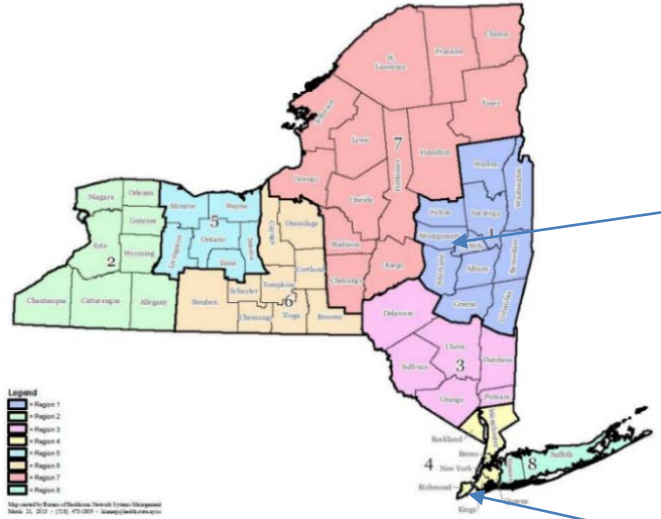
Consumers

Providers
(ACOs, FQHC, Private Practice, Medical Society)



NEW YORK STATE OF OPPORTUNITY. Department of Health

Regional Rollout



Capital/Hudson Valley ROMC
(15-20 participants)
Facilitator: Susan Stuard
Convener: NEBGH

- **Health plans** (CDPHP, Empire BCBS, MVP and UHC-Empire Plan)
- **TA Vendors** (CDPHP, HANYS, Solutions for Community Health)
- **Employers** (GE and Albany Medical Center)
- **Consumer Groups** (AARP)

NYC ROMC
(40-60 participants)
Facilitator: Dennis Weaver
Convener: NEBGH

- **Health plans** (Aetna, Affinity, Emblem, Empire BCBS, HealthFirst, UHC and UHC-Empire Plan)
- **NYS DOH staff**
- **Employers** (1199, 32BJ, National Grid, and NYC OLR)
- **Providers** (large health systems, IPAs, ACOs and small practices)

NEW YORK STATE OF OPPORTUNITY. Department of Health

PCMH Alignment

NY State Practice Transformation Programs: Alignment with SHIP

DSRIP	SIM/APC	TCPI	MACRA	CPC +
Primary care model: PCMH or APC	**Primary care model:** SIM/APC primary care model	**Primary care model:** TCPI transformation program	**Primary care model:** medical home generally	**Primary care model:** CMMI transformation program
VBP: Medicaid VBP roadmap	**VBP:** Commercial payers provide prospective, risk-adjusted PMPM payments	**VBP:** No VBP component	**VBP:** Advanced APM as part of CMS Medicare programs	**VBP:** CMS, payers provide prospective, risk-adjusted PMPM payments

Goals of Alignment

Reduce confusion for providers and payers by:

- leveraging natural alignment
- achieving incremental changes where possible

NEW YORK STATE OF OPPORTUNITY. Department of Health

While we are making progress, there is significant room for alignment and acceleration of implementation

	From …	… to (ILLUSTRATIVE)
Provider adoption	80+ practices signed up in 4 regions	Over 1000 practices signed up by the end of 2017
Payer support	Compatible support from Medicaid and selected private payers	Critical mass in each of the regions (>60% population covered)
Regional coverage	ROMCs in 4 regions	Statewide implementation with ROMCs covering all regions
Impact	Early communication and awareness	Reduction in cost of care, sustained or improved quality, and increased access
Alignment	Multiple program options with limited coordination	APC is a tool to facilitate greatest feasible alignment among various primary care transformation programs

NEW YORK STATE OF OPPORTUNITY. Department of Health

NCQA PCMH program alignment - overview

State and ICWG designed APC criteria with intention that this would be best solution for NYS needs

- Verifiable progress over time
- Transition to performance
- Consistency of financial and technical support

…But complexity in the setting of multiple primary care transformation programs has been an ongoing challenge

Critical question to address:

What approach toward reconciliation of APC and NCQA 2017 standards would increase provider participation and adoption, and facilitate greater payer support?

NCQA PCMH Redesign

http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-redesign

Key points:

- Gradual submission
- Core and elective criteria updated
- Yearly check-ins

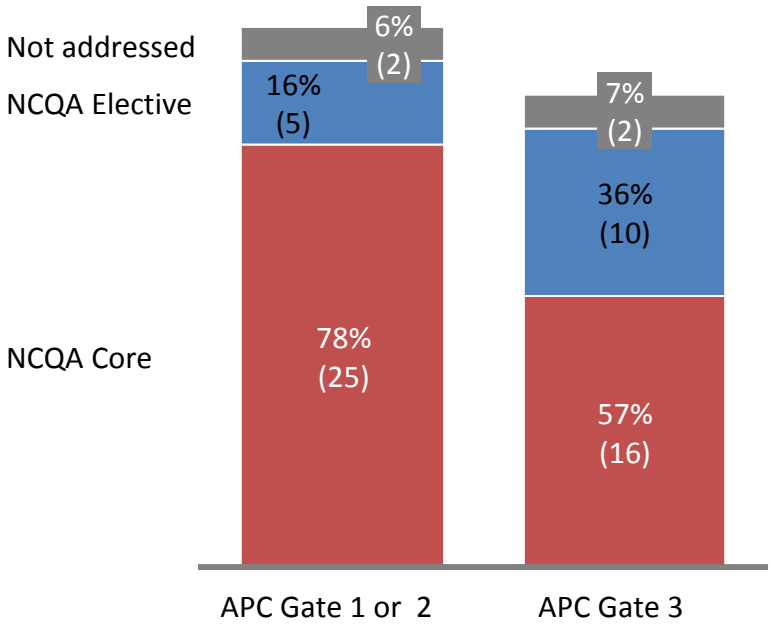
APC structural milestones

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

NCQA and APC are largely aligned

APC specifications addressed by NCQA

% of total (# of milestones)



Details of areas of difference

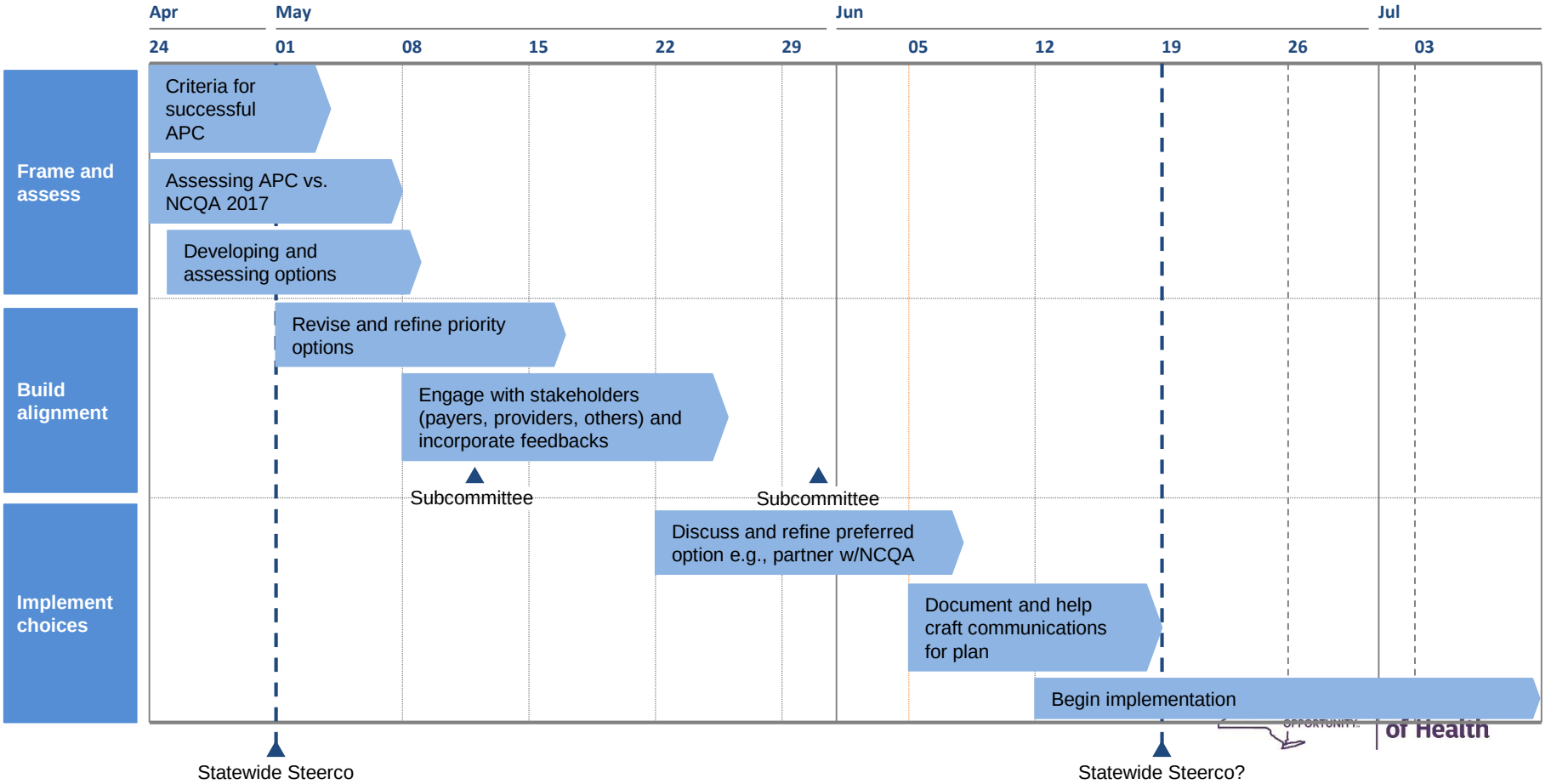
- **Behavioral health care management is 'elective' in NCQA**
- **Many APC CC/CM activities are 'elective' in NCQA** (e.g., 24/7 phone support, Culturally informed population health management, Systematic referral tracking), or not directly addressed (e.g., Establish systems to recruit and train care managers)
- **Advanced Directive integration with health IT and HIE is not directly addressed** in the NCQA framework

In this setting we have the opportunity to evaluate three options

Proposal options	What you have to believe
A Continue with independent NYS APC	▪ Remaining consistent with agreed-upon plan is important to maintaining APC momentum ▪ APC allows independence and self-determination for what is most important to the state ▪ Current TA resources with an independent verification body will be the most efficient way of moving forward while reducing fees to practices
B Adapt custom NCQA PCMH program to meet NYS needs	▪ Alignment with new NCQA guidelines will better allow for multi-payer support (e.g., Medicaid, Medicare, and private payers), provided that certain APC changes are made ▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY
C Use 2017 NCQA PCMH as-is for APC program	▪ The new NCQA guidelines now fulfill the reasons for which APC was designed, including gaining payor support, and adaptation would introduce unnecessary complexity ▪ NCQA is sufficient to merit financial support from Medicare, and nationwide alignment will make Medicare participation with APC more likely ▪ TA will prepare providers for current 2017 model ▪ NCQA verification can be financed through practice fees, and is a familiar framework for many practices in NY

NEW YORK STATE OF OPPORTUNITY. Department of Health

NYS APC/PCMH: Proposed timeline



Summary

- Could alignment with NCQA PCMH 2017 accelerate success towards NY State SHIP goals?
- Are there other options for approaching NCQA PCMH 2017 that better drive meaningful participation by payers and providers?
- How can we achieve sustainability beyond the grant?

APC Scorecard Alignment with other programs

Alignment of APC Measure set with Select National and State Reporting Programs, as of May 1, 2017

APC Scorecard Measures (NQF #/Measure Steward)	**eCQM**	**MIPS**	**CPC+**	**TCPI**	**QARR**	**DSRIP**
Cervical Cancer Screening (#32/HEDIS)	124v5	✓	✓		✓	✓
Breast Cancer Screening (#2372/HEDIS)	125v5	✓	✓		✓	
Colorectal Cancer Screening (#34/HEDIS)	130v5	✓	✓		✓	
Chlamydia Screening (#33/HEDIS	153v5	✓			✓	✓
Influenza Immunization - all ages (#41/AMA)	147v6	✓				
Childhood Immunization Status (#38/HEDIS)	117v5	✓			✓	✓
Fluoride Varnish Application (#2528/ADA)	Diff	Diff				
Tobacco Use Screening and Intervention (#28/AMA)	138v5	✓	✓	✓	✓	
Controlling High Blood Pressure (#18/HEDIS)	165v5	✓	✓	✓	✓	✓
Diabetes: A1C Poor Control (#59/HEDIS)	122v5	✓	✓	✓	✓	✓
Diabetes: HbA1c Testing (#57/HEDIS)					✓	✓
Diabetes: Eye Exam (#55/HEDIS)	131v5	✓			✓	✓
Diabetes: Foot Exam (#56/HEDIS)	123v5	✓				
Diabetes: Medical Attention for Nephropathy (#62/HEDIS)	134v5	✓			✓	✓
Persistent Beta Blocker Treatment after Heart Attack (#71/HEDIS)	145v5	✓			✓	
Medication Management for People With Asthma (#1799/HEDIS)		✓			✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents/BMI Screening and Follow-Up (#24/HEDIS and #421/CMS)	155v5	✓			✓	
Screening for Clinical Depression and Follow-up Plan (#418/CMS)	69v5	✓				Diff
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#4/HEDIS)	2v6	✓	✓		✓	✓
Antidepressant Medication Management (#105/HEDIS)	137v5	✓			✓	✓
Advance Care Plan (#326/HEDIS)	128v5	✓				
CAHPS Access to Care, Getting Care Quickly (#5/AHRQ)					✓	Diff
Use of Imaging Studies for Low Back Pain (#52/HEDIS)		✓	✓		✓	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (#58/HEDIS)	166v6	✓			✓	
Inpatient Hospital Utilization (HEDIS)		✓			✓	Diff
Plan All-Cause Readmissions (#1768/HEDIS)				Diff	✓	Diff
Emergency Department Utilization (HEDIS)				Diff	✓	Diff
Total Cost Per Member Per Month						

eCQM: Electronic Clinical Quality Measures, 2017;

MIPS: Merit-based Incentive Payment System, 2017;

CPC+: Comprehensive Primary Care Plus, 2017;

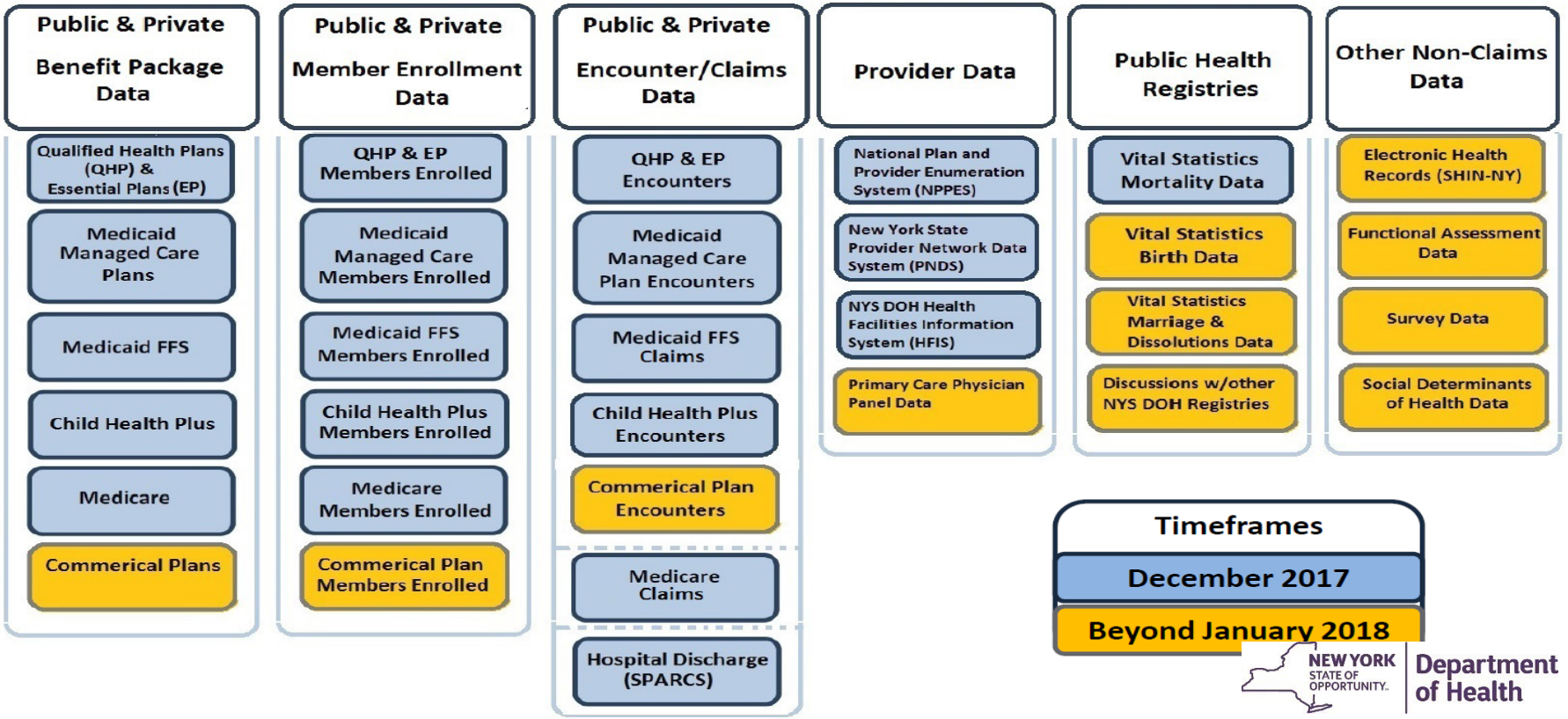
TCPI: Transforming Clinical Practices Initiative, January 2017;

QARR: Quality Assurance Reporting Requirements, 2017;

DSRIP: Delivery System Reform Incentive Program, 2017

Diff = Different Measure or version

APD Update



NEW YORK STATE OF OPPORTUNITY. Department of Health

APC Scorecard Version 1 – Measures calculated reliably with claims

Domains	NQF #/Developer	Measures
Prevention	32/HEDIS	Cervical Cancer Screening
	2372/HEDIS	Breast Cancer Screening
	33/HEDIS	Chlamydia Screening
	38/HEDIS	Childhood Immunization Status: Combination 3
	57/HEDIS	Comprehensive Diabetes Care: HbA1C Testing
	55/HEDIS	Comprehensive Diabetes Care: Eye Exam
	62/HEDIS	Comprehensive Diabetes Care: Medical Attention for Nephropathy
	71/HEDIS	Persistent Beta Blocker Treatment after Heart Attack
	1799/HEDIS	Medication Management for People With Asthma
Behavioral Health/ Substance Use	4/HEDIS	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	105/HEDIS	Antidepressant Medication Management
Appropriate Use	52/HEDIS	Use of Imaging Studies for Low Back Pain
	58/HEDIS	Avoidance of Antibiotic Treatment in adults with acute bronchitis

Conducted pilot in 4Q 2016

- Leveraged HEDIS 2016 (submitted in June 2016) with practice information attached to member level file
- 4 payers participated (2 Upstate and 2 NYC); Commercial, Medicaid and Medicare members
- Goal was to determine data issues with practice aggregation across payers
- Practice site defined by Tax Identification Number (TIN) which was able to be provided by all payers

NEW YORK STATE OF OPPORTUNITY. Department of Health

Process for initial report production and release

- Requesting patient level detail (PLD) files from insurers with practice attribution – 1st files due August 2017
- Multiplayer aggregated results calculated for scorecard reports at Tax Id Number (TIN) level*
- Practice reports will be distributed to those involved in APC Transformation
  - Shared with Practices (TIN), Practice Transformation Technical Assistance Agents and Insurers contributing data

During 2-3 Q 2017, explore ability to use other data sources to calculate practice site level results

– Insurer PLD Files, Practice Transformation Tracking System, PCMH file, Provider Network Data (PNDS)

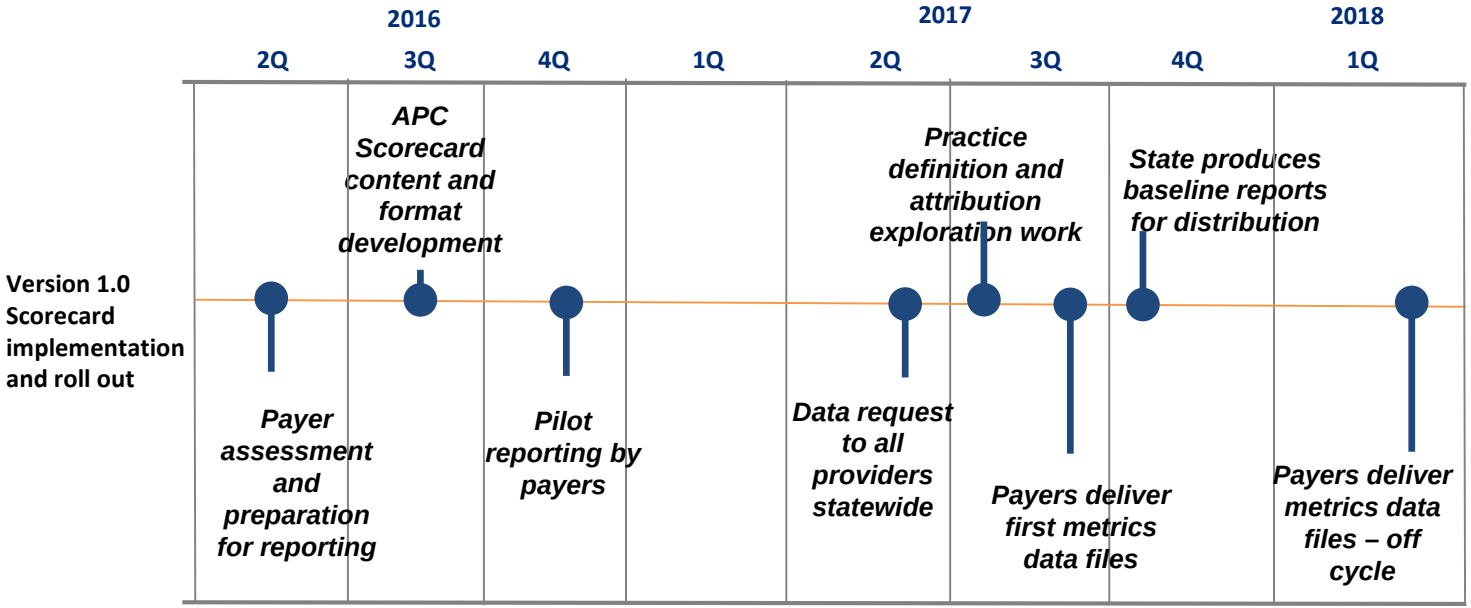
Reporting Frequency and Time line

- Semi-annual with move to quarterly if feasible

Period Covered	Specifications	Deadline
Calendar Year 2016 (Jan. 1st – Dec. 31st)	HEDIS 2017	August 15th, 2017
Rolling Year 2016/2017 (July 1st – June 30th)	HEDIS 2017	February 15th, 2018
Calendar Year 2017 (Jan. 1st – Dec. 31st)	HEDIS 2018	August 15th, 2018

- Utilization Measures – added June 2018 cycle
- All other measures – late 2018 - early 2019

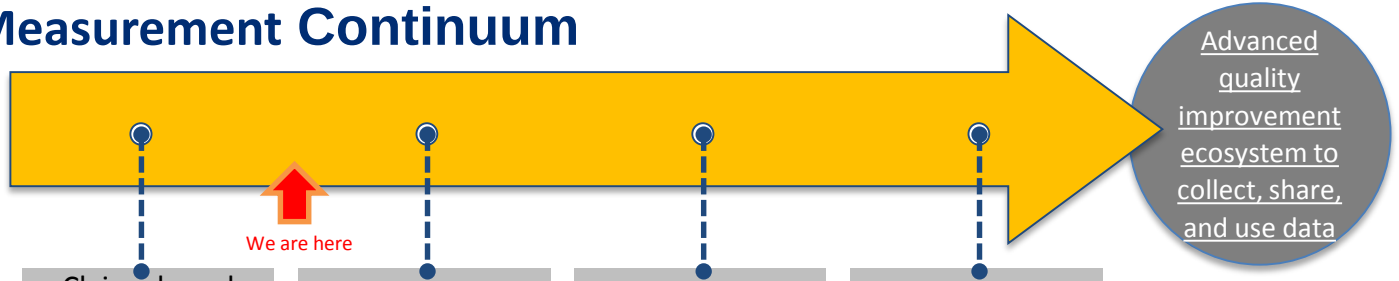
APC Scorecard Timeline - Updated



NEW YORK STATE OF OPPORTUNITY. Department of Health

HIT Enabled Quality Measurement

Quality Measurement Continuum



Claims-based Quality Measurement	Self-reported	Live automated data	Integrated data
Claims data quality measurement and/or HEDIS data collected from surveys, chart reviews, and claims data	Data captured, eCQM calculated in EHR and only numerator/ denominator reported	Automated data acquisition from EHRs to central aggregator tool for calculation, comparison, reporting, and population level measures	Claims and clinical data integrated to analyze quality and address population health needs

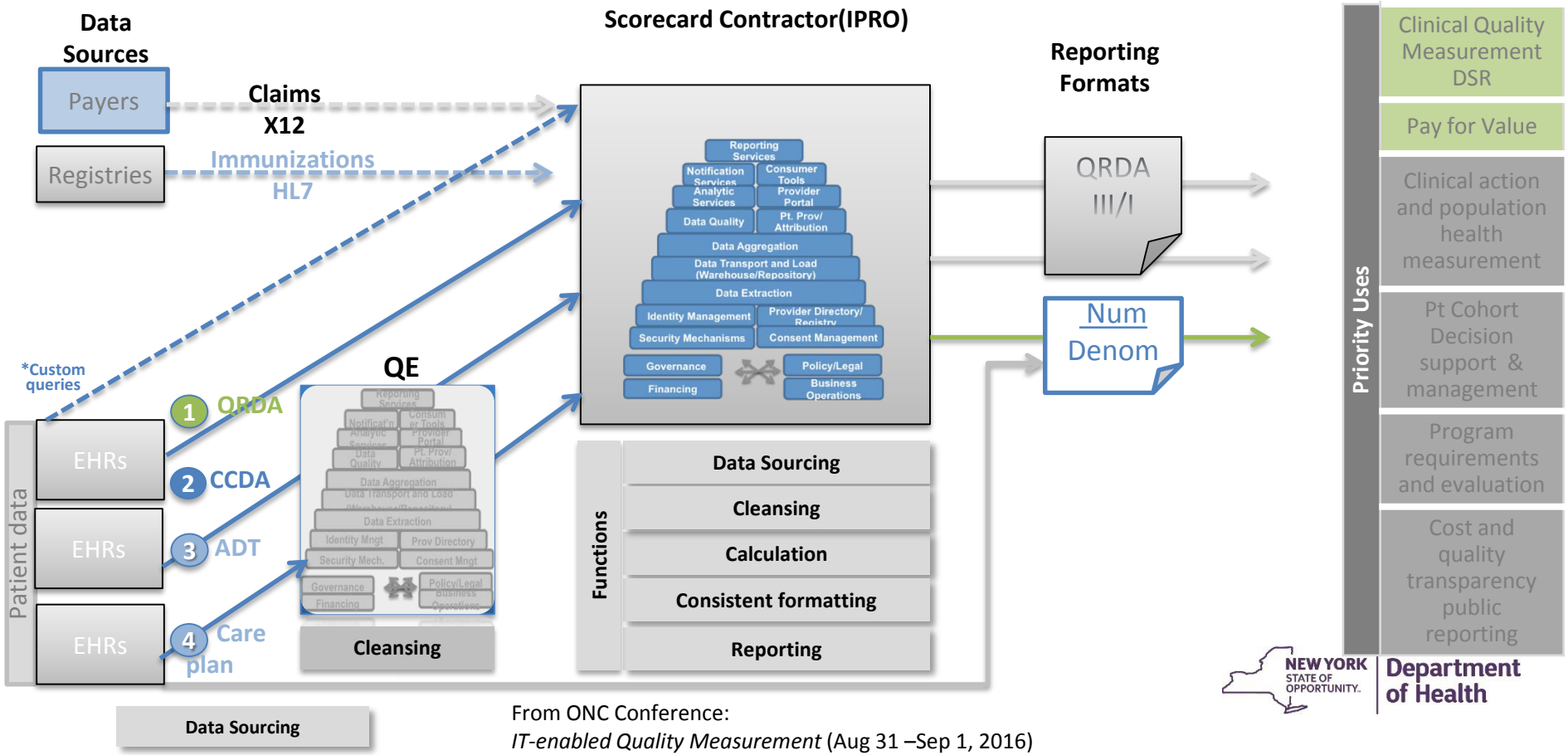
Provider/Practice/Encounter Level Data

Patient-Centric Reporting
Provider-Centric Reporting
Practice-Centric Reporting
System-centric Reporting
Population-level Reporting

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

NEW YORK STATE OF OPPORTUNITY. Department of Health

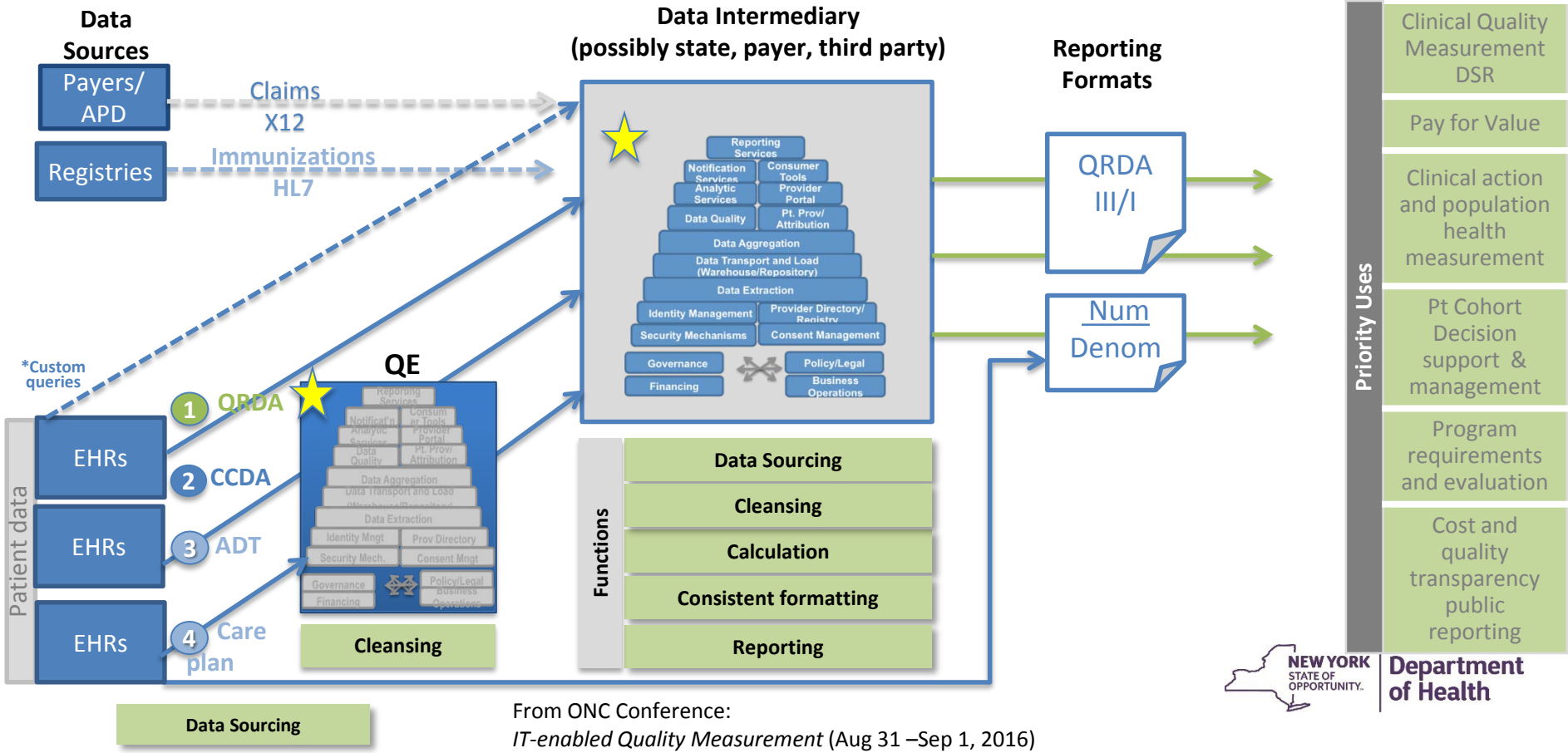
Intermediate Scorecard



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

NEW YORK STATE OF OPPORTUNITY. Department of Health

CQM Data Sources & Intermediaries



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

NEW YORK STATE OF OPPORTUNITY. Department of Health

Major Challenges to Implementing HIT-enabled Quality Measurement

- Increasing quality and completeness of data available through EHRs
  - EHR expectation vs. reality
  - How an EHR is used and implemented
  - Standardization
- Provider-Practice Site Problem
- Ensuring infrastructure is available and avoiding redundancy

Implementing Standards

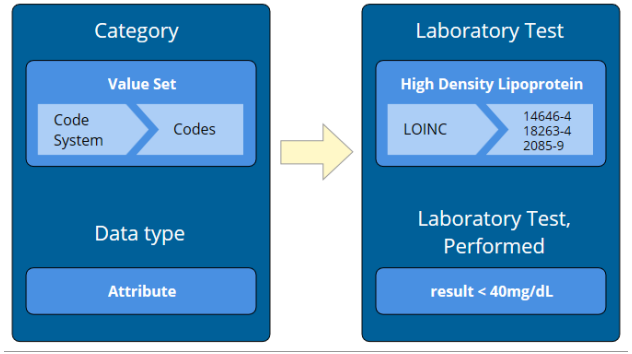
SHIN-NY is focused on aligning with standards for Certified Health Information Technology

- SHIN-NY regulation
- Incentive programs for providers to connect to the SHIN-NY
- Supports providers and hospitals that need to meet MACRA and Medicaid Meaningful Use Requirements
- Aligns with national activities electronic quality measurement initiatives

Aligning with National Activities

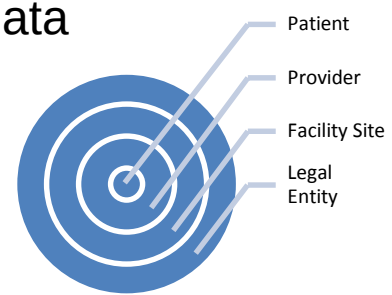
Quality Data Model- Describes the relationship between the patient and clinical concepts to support standardized quality measurement

- Building blocks of electronic clinical quality measures
- Relies on multiple, recognized standards implemented in the community



Developing a Provider Directory to Support Measurement

- Numerous provider directory/provider index activities ongoing
  - PPSs, Plans, NYSDOH
- Importance to quality measurement:
  - Need standardized way of representing patient-provider-facility site-legal entity relationship
- Coordinating activity on Provider Index
- Data sources:
  - Practice Transformation Database, Provider Network Data System, Qualified Entity Information, EHR based data



NEW YORK STATE OF OPPORTUNITY. Department of Health

Next Steps

Identify infrastructure currently in use that supports quality measurement

- Public, private and shared infrastructure
- Aligning with current measurement activities
- Avoid unnecessary duplication

Continue efforts to increase data quality

- Engaging APC providers on data necessary to support quality measure
- Identify more opportunities for standardization

Questions/Comments

Questions for Provider Topics:

How well is SIM coordinated with other health reform and relevant initiatives in New York State?

What considerations factor in practice decisions with respect to APC? How are these considerations addressed in the program?

What do practices perceive as the benefits and challenges of the APC model?

Payer Engagement

Medicaid

New York State Health Initiatives

PREVENTION AGENDA

Priority Areas:

- Prevent chronic diseases
- Promote a healthy and safe environment
- Promote healthy women, infants, and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine preventable diseases, and healthcare associated infections

STATE HEALTH INNOVATION PLAN (SHIP)

Pillars and Enablers:

- Improve access to care for all New Yorkers
- Integrate care to address patient needs seamlessly
- Make the cost and quality of care transparent
- Pay for healthcare value, not volume
- Promote population health
- Develop workforce strategy
- Maximize health information technology
- [illegible] measurement & evaluation

ALIGNMENT:

Improve Population Health
Transform Health Care Delivery
Eliminate Health Disparities

MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Key Themes:

- Integrate delivery create Performing Provider Systems
- Performance based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long term transformation & health system sustainability

POPULATION HEALTH IMPROVEMENT PROGRAM (PHIP)

PHIP Regional Contractors:

- Identify, share, disseminate, and help implement best practices and strategies to promote population health
- Support and advance the Prevention Agenda
- Support and advance the SHIP
- Serve as resources to DSRIP Performing Provider [illegible]

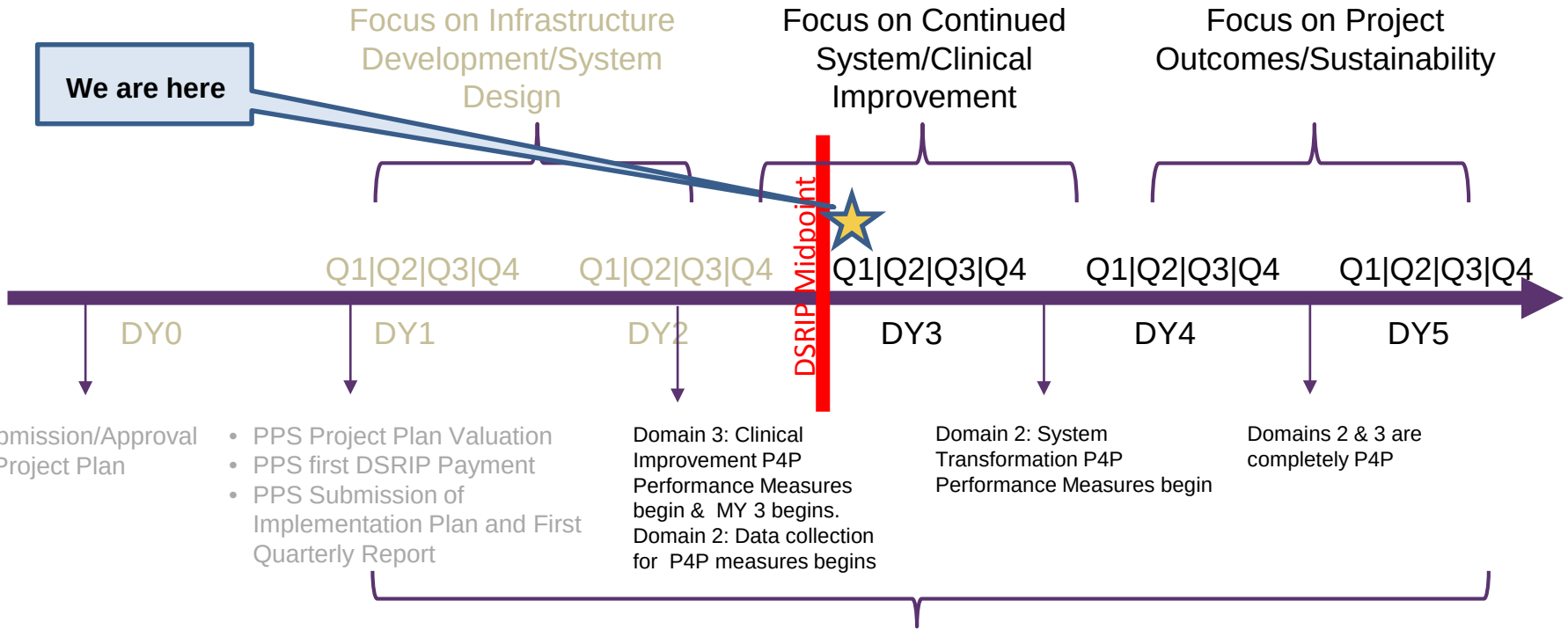
NEW YORK STATE OF OPPORTUNITY. Department of Health

DSRIP, VBP and CMS

- 1115 Waiver, which includes DSRIP, renewed by CMS for 5 years in December 2016.

- 2016 VBP Roadmap annual update approved by CMS in March 2017.

DSRIP Implementation Timeline and Key Benchmarks



Domain 4: PPS working in collaboration with community and diverse set of service providers to address statewide public health priorities; system improvements and increased quality of care will positively impact health outcomes of total population.

NEW YORK STATE OF OPPORTUNITY. Department of Health

How DSRIP and VBP Work Together

NEW YORK STATE OF OPPORTUNITY. Department of Health

The New World: Paying for *Outcomes* not *Inputs*

By DSRIP Year 5 (2020), all MCOs must employ VBP systems that reward value over volume for at least 80 – 90% of their provider payments.

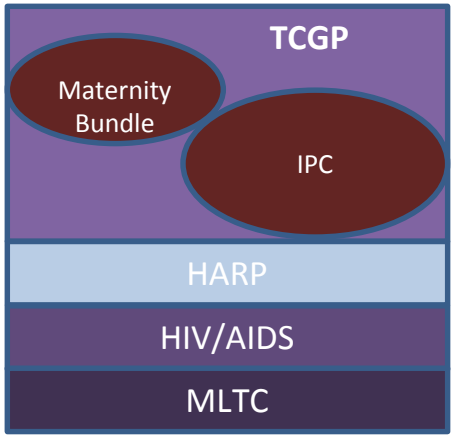
Value Based Payment (VBP)

- An approach to Medicaid reimbursement that rewards value over volume
- An approach to incentivize providers through shared savings and financial risk
- A method to directly tie payment to providers with quality of care and health outcomes
- A component of DSRIP that is key to the sustainability of the program

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Originally Published June 2015.Updated and approved by CMS March 2017.
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/2017-03-30_cms_vbp_roadmap_approval_letter.htm
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2016-06_vbp_roadmap_final.pdf

VBP Arrangements

- Arrangement **Types***
  - Total Care for the General Population (TCGP)
  - Integrated Primary Care (IPC)
  - Maternity Care
  - Health and Recovery Plans (HARP)
  - HIV/AIDS Care
  - Managed Long Term Care (MLTC)
    - **Arrangements do not yet include Dually Eligible members*



- Two VBP implementation subcommittees were created to focus on:
  - Social Determinants of Health and CBOs
  - Advocacy and Engagement
  - The full recommendations that came from these Subcommittees are available in the DOH VBP Resource Library:
    https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm

Aligning Initiatives

- All Primary Care practices in a PPS are encouraged to become 2014 PCMH Level 3 certified or APC recognized by March 31, 2018 (end of DY3)
  - Gate 2 APC will satisfy the DSRIP requirement for meeting APC milestones

- Medicaid Primary Care Incentive Program
  - It is Medicaid's intent to pay APC Gates 2 and 3 providers the same incentive as 2014 PCMH Level 3 (pending CMS approval)
  - Next steps include beginning to connect PCMH/APC incentives to value based efforts

- VBP measures selected for Total Care of the General Population and Integrated Primary Care arrangements were built upon the APC core measure set.

Health Plan Alignment with APC

Health Plans are a key stakeholder in implementation of APC:

Movement from:		To:
Development	→	Implementation
Gathering Input	→	Solving Problems
Statewide Only	→	State Steering and Regional Committees

Progress:

- Several payers were members of the Integrated Care Workgroup helping to design the APC model
- Almost all key payers are “at the table” with the ROMCs, actively engaged in discussions.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Health Plan challenges

All payers have their own primary care initiatives, different degrees of implementation

- Good news: payers recognize the value of transforming primary care, have seen results and have goals for more VBP uptake in primary care
- Bad news (but not so bad):
  - Payers' primary care programs don't exactly align with APC
  - Focus is on larger, higher performing practices

What are payers' incentives to engage?

Case studies

Plan 1 (regional plan)

- Developed their own primary care program, made substantial investments into their program, has a high market share in regional market, targeting larger practices
- Realizes that there is still room to grow as half of network not meaningful engaged, participate in APC ROMC discussion, looking for alignment to expand

Plan 2 (regional plan)

- Developed their own ACO program, made substantial investments into their program, has a high market share in regional market, targeting large ACO's with limited focus on primary care
- Primary care providers in ACO's are benefitting differently but success is linked to ACO's performance overall; less of an incentive to participate in meaningful APC ROMC discussions, looking for expansion within ACO contracts with limited need for expanding beyond existing contracts

At the ROMC: aligned goals between payers and NY State

As ROMC meetings progress, DOH and payers have shared goals:

- Building a high performing primary care system
- Controlling costs (e.g. by reducing preventable hospitalizations)
- Transform provider payments to value based
- Invest in HIT and make data available to make better informed decisions
- Align with prevention agenda and promote an evolved workforce

While sharing common goals, realization that payers have build their own programs:

- Recognition of existing payer primary care VBP programs that are successful and should be left untouched by APC

Suggested approach:

- Working together to identify practices that are not currently in payers' primary care initiatives and to engage them in APC.

Looking Ahead

- Planning second round of one-on-one meetings with payers to discuss implementations goals, hurdles, etc.
- Planning survey of payers on percentage of members and primary care payments going towards APC and other value-based contracts.
- Continuing to explore regulatory “levers” to facilitate participation and implementation of APC

Alignment of Agency Review of Risk Sharing Arrangements

- Risk sharing arrangements between payers and providers triggers oversight of DFS and DOH, depending on degree of risk sharing.
- With advent of value-based contract, DFS and DOH are updating and better coordinating the oversight process.
- Three tier review structure (see next page for details):
  - Tier 1: File and Use (DOH will oversee)
  - Tier 2: DOH Review
  - Tier 3: Multi-Agency Review (DOH and DFS)

Provider Contract Review Process

Individual Contract Comes in for Review

Does the contract include prepaid capitation that triggers Regulation 164)?

Yes

No

More than $1,000,000 of **annual** payments to provider at risk (shared losses, withhold)?

Yes

No

More than 25% of **annual** payments to provider at risk?

More than 15% provider's Medicaid Revenue?

Off Menu VBP Arrangement?

Yes

No to All

Tier 3

Multi-Agency Review

Tier 2

DOH Review

Tier 1

File and Use

All contracts may be subject to Programmatic Review in addition to Financial Review.

NEW YORK STATE OF OPPORTUNITY. Department of Health

VBP & Tier Crosswalk (detailed)

Risk Contract Review Tiers

VBP Arrangement Levels

	Level 0 VBP*	Level 1 VBP**	Level 2 VBP**	Level 3 VBP**
Tier 3: Multi-Agency (DOH + DFS) Review	An arrangement that triggers Regulation 164 but has NO quality component.	🚫	A risk-sharing arrangement that triggers Regulation 164 but is NOT *fully* prepaid.	A *fully* prepaid arrangement that triggers Regulation 164.
Tier 2: DOH Review	An arrangement that does NOT trigger Regulation 164, has NO quality component, and contains: **1)** >$1,000,000 of potential provider payments at risk; **AND** **2)** At least one of the following: **a)** >25% of annual Medicaid MC or MLTC payments at risk; **OR** **b)** >15% of a provider's total Medicaid revenue; **OR** **c)** An Off-Menu arrangement.	🚫	A risk-sharing arrangement that does NOT trigger Regulation 164 and contains: **1)** >$1,000,000 of potential provider payments at risk; **AND** **2)** At least one of the following: **a)** >25% of annual Medicaid MC or MLTC payments at risk; **OR** **b)** >15% of a provider's total Medicaid revenue; **OR** **c)** An Off-Menu arrangement.	🚫
Tier 1: File and Use	An arrangement that does NOT trigger Regulation 164, has NO quality component***, and contains: **1A)** ≤$1,000,000 of potential provider payments at risk; **OR** **1B)** >$1,000,000 of potential provider payments at risk; **AND** **2B)** None of the following: **a)** >25% of annual Medicaid MC or MLTC payments at risk; **OR** **b)** >15% of a provider's total Medicaid revenue; **OR** **c)** An Off-Menu arrangement.	An upside-only shared savings arrangement (usually FFS) based on a target budget.	A risk-sharing arrangement that does NOT trigger Regulation 164 and contains: **1A)** ≤$1,000,000 of potential provider payments at risk; **OR** **1B)** >$1,000,000 of potential provider payments at risk; **AND** **2B)** None of the following: **a)** >25% of annual Medicaid MC or MLTC payments at risk; **OR** **b)** >15% of a provider's total Medicaid revenue; **OR** **c)** An Off-Menu arrangement.	A *fully* prepaid payment arrangement that does not trigger Regulation 164.

* = Level 0 VBP arrangements include a cost-savings component or a quality component, but not both.
** = Level 1, 2, and 3 VBP arrangements must include a quality component in addition to a cost-savings component.
*** = There are a few exceptions such as P4P where there is a FFS arrangement with a quality bonus, but no cost-savings component.
🚫 = This type of VBP arrangement will not be subject to this particular Tier of contract review.

Acronyms and Abbreviations
DFS: Department of Financial Services
DOH: Department of Health
FFS: Fee-for-Service
MC: Managed Care
MLTC: Managed Long-Term Care
P4P: Pay for Performance
VBP: Value Based Payments

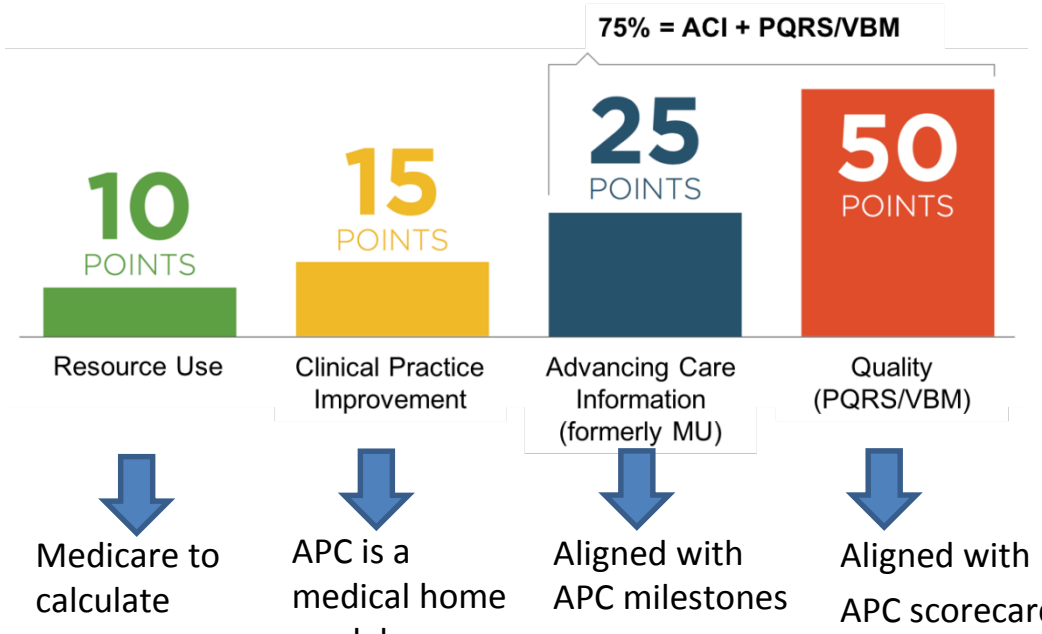
Tier 2 – DOH review, contract may be implemented 90 days after submission, could be prior to DOH approval

NEW YORK STATE OF OPPORTUNITY. Department of Health

Medicare – MACRA/ MIPS

Merit-based Incentive Payment System (MIPS)

Composite Performance Score (& payment adjustments)



NEW YORK STATE OF OPPORTUNITY. Department of Health

Graphic from Tom S. Lee, SA Ignite, HFMA presentation, May 2016

APC-Aligned MIPS Quality Payment Program (QPP) Categories

APC-participating practices will qualify for MIPS QPP points:

Quality accounts for **50%** of MIPS score with **80-90** points*

Improvement Activities (IA) account for **15%** of MIPS Final Score with maximum of **60** points**

Measure Categories:

- Preventive
- Chronic Disease
- Behavioral Health
- Patient Reported
- Appropriate Use

22 APC aligned measures

40-60+* points

7 of 9 IA Categories:

- Care Coordination
- Population Health
- Patient Safety & Practice Assessment
- BH and Mental Health
- Beneficiary Engagement
- Achieving Health Equality
- Expanded Practice Access

63 APC criteria align with IA sub-categories

44-60 points**

*Points vary by practice size
**Medium (weighted) points = 10
High (weighted) points = 20

NEW YORK STATE OF OPPORTUNITY. Department of Health

Roles of Practice Transformation in Aligning MIPS and APC

DOH is engaged in collaborative discussions to create a process to streamline alignment of MIPS during APC practice transformation.

- These tools will:
  - Reflect “timeline” criteria to best prepare practices to achieve maximum goals in both programs
  - Develop appropriate tools and messaging for APC practice transformation agents (PT TA) to assist practices in selecting aligned measures
    and performance activities that will satisfy both programs
  - Provide a continuous lens on MIPS QPP as a gateway to value-based payment opportunities reflective of both public and commercial payer

- Next Steps:
  - Engage stakeholders for discussion on best approach to ensure acknowledgement of the APC Model at CMS
  - APC Team will review activities prescribed at Gates 2, 3 to determine that practice capabilities reflect success for MIPS requirements
  - Provide timely awareness, education, and tools to APC PT TA’s

Questions/Comments

Questions on Payer Topics:

- Beyond our efforts, how can we ensure success for NY State Primary Care practices in MACRA?

- Are there other ideas to address factors that facilitate or hinder enhanced payments for APC?

SHIP/DSRIP Workforce Workgroup Update

Supporting Transformation through the Workforce Workgroup

- Workforce is one of the underlying enablers for the State Health Innovation Plan (SHIP), supporting the five pillars and helping achieve the SHIP objective of moving towards the Advanced Primary Care model
- The Workforce Workgroup also serves the goals of the Delivery System Reform Incentive Payment (DSRIP) Program and the work of Performing Provider Systems (PPS), supporting efforts to reduce avoidable hospital use and achieve the sustainable transformation of the delivery system
- The charge of the Workforce Workgroup is to promote a health workforce that supports comprehensive, coordinated and timely access to care that will improve the health and well-being of New Yorkers, consistent with these transformational initiatives

Identifying Barriers to Performance of Care Coordination Functions

- Workgroup Subcommittee # 1 is reviewing the scope of care coordination functions carried out by licensed and non-licensed workers as well as non-licensed family and friends
- While the scope of practice for licensed professionals generally does not preclude them from carrying out tasks related to care coordination, some barriers remain
- The subcommittee is in the process of identifying and prioritizing these barriers with potential recommendations for statutory, regulatory or administrative action to address them

Recommending Care Coordination Concepts for Licensed Practitioners

- Subcommittee # 2 is working to identify core concepts in care coordination that can be recommended for inclusion in the educational curricula for licensed professionals
- The subcommittee has reviewed existing curricula for training health care professions to see the extent to which care coordination concepts currently exist
- The subcommittee is in the process of developing a list of core competencies and learning objectives for each set of competencies

Developing Core Curriculum Guidelines for Care Coordination

- The Workgroup recognized the need to identify consistent training guidelines for workers who carry out care coordination functions
- Subcommittee # 3 developed core curriculum guidelines for training workers who provide care coordination
- These guidelines are available at:

https://www.health.ny.gov/technology/innovation_plan_initiative/docs/core_curriculum_train_ccw.pdf

- The guidelines, which have been widely distributed, will be updated as needed

Addressing Gaps in Health Care Workforce Data

- The Workgroup found that more robust information is needed about the health care workforce, particularly with respect to the distribution of practitioners
- As proposed by Subcommittee # 4, the Workgroup recommended statutory changes to support the collection of additional data from health care practitioners
- Legislation has been introduced to incorporate additional information into the Physician Profile and obtain data from other health care practitioners upon registration and re-registration with the State Education Department
- The information will be used for health care workforce research and planning with de-identified, aggregate information made available on the Department of Health website

Promoting Behavioral Health Integration and Building its Workforce

- Efforts to integrate physical and behavioral health care require an appropriately skilled workforce, which includes care coordination concepts but must also incorporate evidence-based interventions (e.g., motivational Interviewing and problem solving therapy) that require more specialized training
- Subcommittee # 5 is identifying barriers to effective integration, specifying key functions of behavioral health care managers, developing curricula, and recommending training guidelines to support behavioral health management for staff in primary care settings
- Recommendations will be incorporated into the work of other subcommittees as appropriate

Implementing the Rural Residency Program

- Six organizations are developing new primary care residency programs in rural communities
- SIM will provide two years of funding for the initial establishment of the programs and the organizations will provide support to cover ongoing costs (personnel, recruitment, curriculum development, accreditation, etc.)
- Each program will include a general hospital for inpatient rotations and community-based ambulatory care training sites (such as clinics, diagnostic and treatment centers, local health departments)
- Resident recruitment efforts will focus on rural communities and, when fully implemented, the programs will train approximately 50 residents each year

Implementing the Rural Residency Program (continued)

The six organizations that are developing new primary care residency programs are:

- Arnot Ogden Medical Center
- Cayuga Medical Center
- Champlain Valley Physicians Hospital
- Mary Imogene Bassett Hospital
- Samaritan Medical Center
- Sisters of Charity Hospital

Questions:

- Have workforce needs been identified?
- Are there licensure or other regulatory requirements that need changes?

Questions/Comments

Linking Interventions For Total Population Health

Linking Interventions For Total Population Health (LIFT Population Health)

- The funding for this initiative is from the 2015 State Innovation Model award provided by the Center for Medicare and Medicaid Innovation, which has central goals of promoting an integrated care system, providing patient centered, advanced primary care coordinated with community based and other health care providers.
- Total of six awards covering 18 counties
- Activities to be aligned locally with work being conducted by other initiatives in NYS (e.g., SIM, DSRIP, Prevention Agenda, PHIP, and other state and CDC-funded initiatives)

Three Buckets of Prevention

Auerbach J., The 3 Buckets of Prevention. Journal of Public Health Management and Practice 2016.
http://journals.lww.com/jphmp/Citation/publishahead/The_3_Buckets_of_Prevention_.99695.aspx

CDC

NEW YORK STATE OF OPPORTUNITY. Department of Health

Focus of LIFT

Communities will focus on one of five issues related to the Prevent Chronic Disease priority area of the New York State Prevention Agenda 2013-18

- Five projects chose Prevent and Control Obesity and Diabetes
- One project chose Prevent Cardiovascular Disease and Control High Blood Pressure

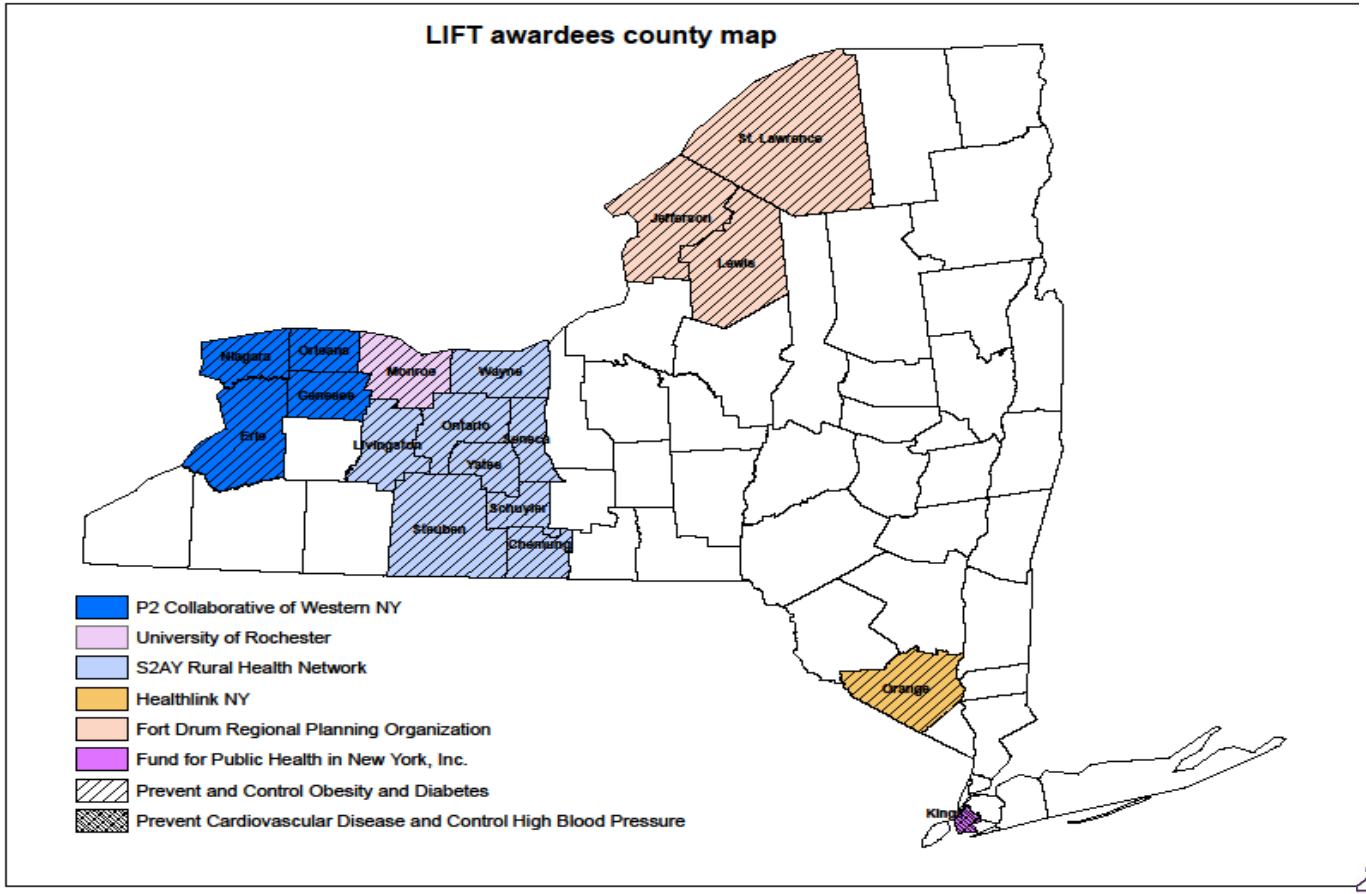
Awardees will develop portfolio of interventions across three categories or “buckets”

1. Traditional Clinical Prevention (10% of effort)
2. Innovative Clinical Prevention (30% of effort)
3. Total Population or Community-Wide Prevention (60% of effort)

Selected LIFT Awardees

Organization	Counties served	Focus Area
P2 Collaborative of Western NY	Erie, Niagara, Orleans and Genesee	Prevent and Control Obesity and Diabetes
University of Rochester	Monroe	Prevent and Control Obesity and Diabetes
S2AY Rural Health Network	Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne & Yates	Prevent and Control Obesity and Diabetes
Healthlink NY	Orange	Prevent and Control Obesity and Diabetes
Fort Drum Regional Planning Organization	Jefferson, Lewis & St. Lawrence	Prevent and Control Obesity and Diabetes
Fund for Public Health in New York, Inc.	Kings	Prevent Cardiovascular Disease and Control High Blood Pressure

***PENDING CMMI APPROVAL



NEW YORK STATE OF OPPORTUNITY. Department of Health

Bucket One LIFT Activities

- Build upon existing Public Health Detailing (PHD) campaign to target additional primary care providers, dentists, pharmacists and patients.
- Recruit health care providers to participate in alert system development
- Provide general professional education for community physicians
- Implement evidenced-based clinical guidelines to identify patients with prediabetes and diabetes
- Develop care coordination teams to ensure referral of patients to appropriate clinical and community-based programs

Bucket Two LIFT Activities

- Conduct visits to pharmacies within the defined catchment area to disseminate key messaging and educational materials
- Implement a bi-directional clinical/community referral system at primary care practice sites
- Embed Diabetes Prevention Program trained health advocates in physician practices
- Work with insurers to cover the cost of chronic disease self-management programs
- Increase capacity by sending at least four credentialed staff to attend a CDC National Diabetes Prevention Program Lifestyle Change training
- Provide technical assistance and support for three community based organization Diabetes Prevention Programs to connect to a secure, electronic health information exchange.
- Print educational materials in various languages prevalent among the target population, including English, Spanish, Russian, Chinese, and Arabic

Bucket Three LIFT Activities

- Lead efforts to enact Complete Streets ordinances in all communities without one; develop or revise a Complete Streets toolkit around health
- Inventory and promote summer feeding programs and farmer's markets through the Regional Farm to Cafeteria Committee
- Promote breastfeeding as a social norm and work with businesses, community based organizations, and public spaces to adopt breastfeeding friendly policies
- Run a multi-faceted prediabetes risk factor campaign that will include posters, radio PSAs, and transit ads
- Develop a workplace campaign to encourage staff to walk to increase physical activity
- Increase number of high-risk schools with comprehensive and strong Local School Wellness Policies

Questions/Comments

Next Steps

Next Steps

- Detailed Sessions for Topic areas (HIT, Workforce, Population Health)