NEW YORK STATE OF OPPORTUNITY. | Department of Health

Integrated Care Workgroup Meeting #14

April 11th, 2016

Integrated Care Workgroup #14 Agenda

Timing	Topic	Lead
10:00-10:15 am	Welcome / APC Updates	▪ Foster Gesten ▪ Marcus Friedrich ▪ Amy Tippett-Stangler
10:15-11:45 am	Health Plan RFI: Status and Responses	▪ John Powell
11:45-12:15 pm	Open Discussion on RFI Responses	▪ John Powell
12:15-12:30 pm	Working lunch	
12:30-1:00 pm	New York State's Population Health Improvement Program (PHIP) Overview	▪ Lisa Ullman ▪ Alejandra Diaz
1:00-1:20 pm	NYC PHIP Update	▪ Sarah Shih ▪ Greg Burke
1:20-1:40 pm	Consumer Engagement Strategy	▪ Stefanie Pawluk
1:40-1:55 pm	APC Score Card Update	▪ Anne-Marie Audet
1:55-2:00 pm	Closing Remarks	▪ Foster Gesten

Welcome/APC Updates

Milestones need to satisfy all three requirements:

1. Will they improve patient care and promote outcomes that matter to patients and families?
2. Is it meaningful for the practice and providers?
3. Are payers willing to support it?

Recognizing applicable efforts from other funded initiatives as creditable:

1. NCQA PCMH 2014
2. TCPI
3. MU

High-level Overview of 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*
Milestone 1 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	**Prior milestones, plus …** i. Participation in TA Entity activities and learning (if electing support)	**Prior milestones, plus …**
Milestone 2 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)
Milestone 3 Population Health			i. Participate in at least two Prevention Agenda activities annually in conjunction with county health department. ii. Identification and outreach to patients due for preventive or chronic care management as needed/appropriate iii. Process to refer to self management programs and community-based resources
Milestone 4 Care Manage-ment/ 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
Milestone 5 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
Milestone 6 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
Milestone 7 Payment Model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing3 contracts with APC-participating payers representing 60% of panel

1 Uncomplicated, non-psychotic depression
2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework
3 Equivalent to Category 3 in the APM framework

APC Milestone technical specifications document example:

Milestone Technical Specifications

CARE MANAGEMENT and CARE COORDINATION	**Capability: Manage and coordinate care across multiple providers and settings by actively tracking the highest need patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and track and optimize transitions of care. Care Management is defined as: focus on the comprehensive support of the highest risk subset of practice's patient population. Care Coordination defined as: the practice contributes to seamless care of all patient transitions across all environments**					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to Identify Highest Risk Patients for Care Management at Gate 2 **Commitment to Integrate High Risk Patient data from other sources (including payers) at Gate 3**			Practice assigns patient to specific provider care team, small practices can serve as their own care team; Implement a Risk Stratification System for Care Management using a standardized tool (such as AAFP, AHRQ) or own developed process to define and track high risk patients; Annotate Risk Scores for easy staff/provider access and identify care management intervention on no less than 1% of highest risk patients in entire panel	Active patients are assigned to a provider (active patients defined as last seen within 2 years); Generate consecutive 6 month report with denominator as all active patients, numerator as all empaneled patients; Name and describe Risk Stratification tool; generate a consecutive 6-month report or devise spreadsheet identifying high risk patients by risk score	Practice has a system in place to actively manage high risk patients; integrate high risk patients data from other sources (including payers) Practice manages high risk patients internally or by using a collaborative "pod" model	Provide evidence of actively managing high risk patients (e.g. either through EHR or spreadsheet for patient panel or improved risk scores)

Example of auto-credit for other programs: Sub-Milestone Guidance and Resources

Allowance Tables for Milestone 4, Gate 2: Care Management and Care Coordination

Milestone 4 Sub-Milestone	Gating Criteria	Task Requirement	Guidance	MU 1,2	Auto-credit PCMH 2014	Auto-Credit TCPI*
Continued: CM and CC Commitment to both creating (at Gate 1) and utilizing a systematic Referral Tracking System (at Gate 2)	●Develop capability for systematically tracking patients throughout referral processes ●Create clinical/ non-clinical staffing workflow patterns to track referrals made, patients seen, consultation reports received and flagging missing information	●Practice provides plan for tracking patients throughout the referral process and submits example of workflow pattern ● Demonstrate that staff workflow assignments have been operationalized and provide screenshots of EHR referral tracking workflow	**1** **2**		5B, 1-10 MUST PASS 6 points required 5B,8 see above	PAT Phase 2.5, 3.8, 3.10, 3.11 Score 2 or 3 3.8, 3.11 above, and 3.5

1 Referral Tracking System: Practices should begin to create processes at a system level for establishing a reliable flow of information from one setting to another. This will require active and routine contact with hospital, ED and SNF facilities and establishment of specific ear-marked roles in the practice to obtain information and close gaps in care. Setting internal benchmarks and using a run chart format could help show trends in performance. The AAFP also offers some simple tools at: http://www.aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=26.

2 Staff Assignments and Workflow for Referral Tracking: Background information is available through several internet sources and also at: http://www.improvingchroniccare.org/downloads/3_referral_tracking_guide.pdf .

Health Plan RFI: Status and Responses

Reminder: Goals of the RFI

- To better understand payers' current primary care delivery and payment models
- To help determine the extent to which those models are aligned with the APC model
- To identify opportunities and challenges for multi-payer alignment
- To inform the ICWG discussions:
  - What does it mean to be an APC-qualified program?
  - Should we focus on plans' existing programs or on practices that are currently not under any APC-like program?
  - Should we focus on certain regions of the state?
  - How can payers and providers implement the APC model?

High Level Findings

- Almost every payer currently has in place or in development programs that support some type of team based care together with value-based payment models
- There is wide variation in payers' models
- Many programs are aligned, at least in part, with the APC model
  - Better alignment on measures than payment or gates
- Current penetration of these models is relatively low
- There is plenty of room in the marketplace to bring APC adoption without disrupting payers' current programs

Specific Findings: Funding Practice Transformation

RFI Response from Plans	APC
Most plans provide funding for practice transformation – broadly defined and often retrospective. **Examples:** • Population management payments • Performance based payments • Care management payments • Quality incentive and shared savings	Technical assistance to TA vendors for practice transformation to practices from GATE 1 to GATE 3 funded through SIM Grant Financial support during transformation from GATE 1 to GATE 2 via payer funded PMPM

Specific Findings: Examples of Current In-Kind Support and Practice Investments

- ACO data and analytics
- Daily and monthly practice data
- Communications tool kits
- Analytics
- Care management tools
- Medication reconciliation
- Dashboard tools
- Stipend to support time away from the practice
- Funding for EHR, regional HIE and meaningful use
- PMPM fees paid to groups and ACOs to develop systems and infrastructure need to coordinate care – calculated on a case-by-case basis

Specific Findings: Alternative or Outcome Based Payment Models

RFI Response from Plans	APC
❑ Most plans report some sort of outcome based payment model for a portion of their providers. ❑ There is wide variation in payment models **Examples:** • FFS with link to quality • P4P • PMPM for care coordination • Shared savings and shared risk • Global capitations	Outcome based payments for all participating practices starting in GATE 2 which could be either shared savings, risk sharing, or capitation gated by quality on APC core measures Care Coordination payments, payer funded PMPM payments, risk adjusted starting at GATE 2

Specific Findings: Quality Measures

- Most payers noted alignment with the proposed APC core measures.
- Examples of payer comments:
  - One payer commented that APC measures align well with existing measures with the exception of influenza, fluoride and tobacco use screening
  - Two plans noted an intent to align with APC
  - One plan noted that 12 APC measures are aligned and 7 differ; alignment in 2017 is possible
  - One plan determines measures based on annual results and discussions with providers

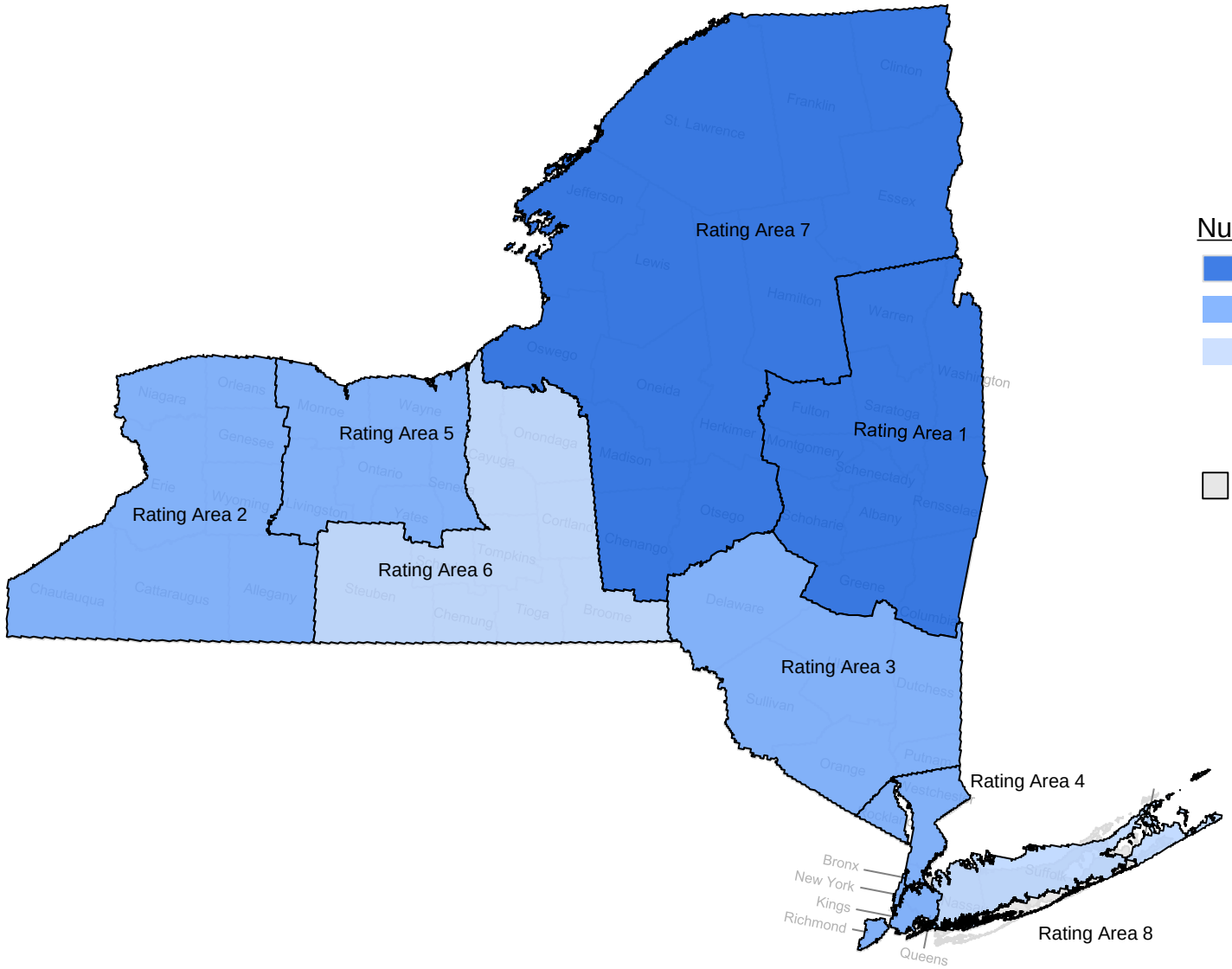
Specific Findings: Penetration

Current penetration ranges from less than 1% of PCPs to 58%

Examples:

- FFS with quality bonus
  - 2.1% of members
  - 3% of spend and 34% of members
- P4P with quality bonus
  - 5% of HMO
  - 42% of ACO
  - 21% with global cap
- Membership receiving services from a practice with ACO with PMPM budget
  - 35% of current members with goal of 70%.
- PMPM care coordination with value component
  - 58% currently with goal of 75% by 2020

Specific Findings: Penetration of current programs in New York Insurance Rating Areas*



*Rating area penetration not indicated by all respondents

Specific Findings: Concerns Expressed by Payers

- Prospective payments may turn out to be unwise investments (practice investments never recouped)
- Potential that providers will be incentivized to regress to a lower GATE to avail selves of up front care management payments
- Operational implementation requirements must be assessed
- Individualized approach that recognizes unique provider characteristics is needed to ensure sustainability
- Small and solo practices will not transform absent capital
- ASO clients will want a clear answer on the value and ROI for their participation in VBP programs before moving into VBP arrangements

Next Steps

- Need to follow up with payers to clarify some of the data and better understand current status and future plans.
- Work with individual payers to discuss:
  - What parts of their program align with APC?
  - Can certain aspects of their program be modified to align with APC?
  - Identifying practices not currently under any outcome based payment model and how they can be included
  - Development of an MOU on shared goals and participation

Open Discussion on RFI Responses

Discussion items for ICWG

- How do we best create alignment with core APC features without disrupting current successful value based contracting?
- What does it mean to be an ‘APC qualified’ program?
- What are the key next steps for multi-payer APC implementation?
- Should resources/efforts/recruitment be focused on practices “unexposed” to previous transformation efforts?
  - How do we best identify practices not in any primary care value –based programs?
  - How do we ensure current multi-payer efforts (ADK, Hudson Valley) continue?
- Is regional implementation the optimal approach?
  - If so, what are key components that must be in place for success?

Working Lunch

New York State Population Health Improvement Program (PHIP) Overview

PHIP Overview

- The New York State Department of Health's Population Health Improvement Program (PHIP) promotes the Triple Aim – better care, better population health and lower health care costs
- Regional PHIP contractors provide neutral forums for identifying, sharing, disseminating and helping implement best practices and strategies to promote population health and reduce health care disparities in their respective regions
- Within their regions, PHIP contractors
  - support and advance the Prevention Agenda
  - support and advance the State Health Innovation Plan (SHIP)
  - serve as resources to Delivery System Reform Incentive Payment (DSRIP) Program Performing Provider Systems upon request

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
-

ALIGNMENT:

Improve Population Health
Transform Health Care Delivery
Eliminate Health Disparities

MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

Key Themes:

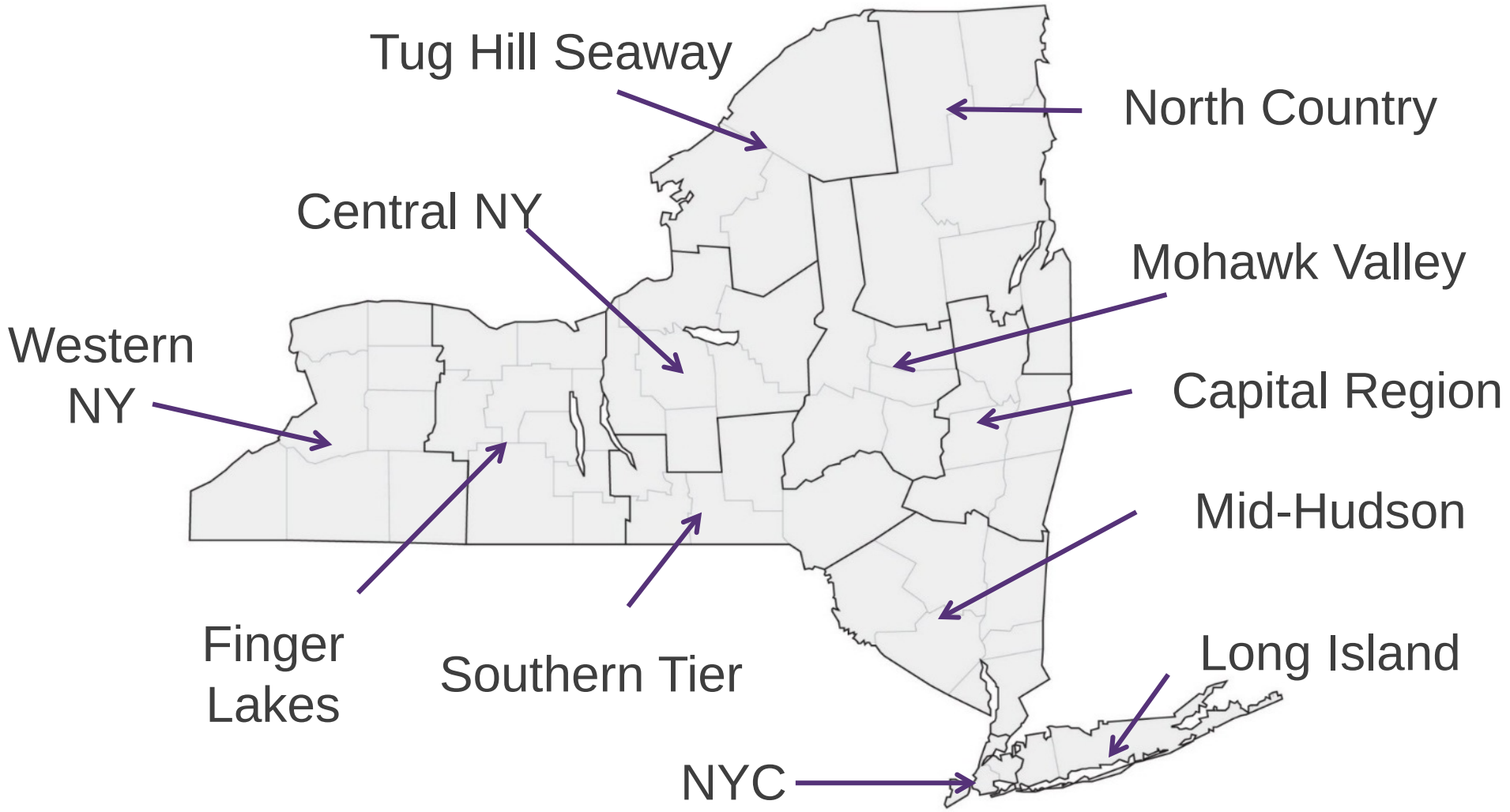
- Integrate delivery – create Performing Provider Systems
- Performance-based payments
- Statewide performance matters
- Regulatory relief and capital funding
- Long-term transformation & health system sustainability
- Promote population health

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 Systems upon request

PHIP Regions



PHIP Lead Organizations

Capital District	Healthy Capital District Initiative
Central New York	HealtheConnections
Finger Lakes	Finger Lakes Health Systems Agency
Long Island	Nassau-Suffolk Hospital Council
Mid-Hudson	HealthlinkNY
Mohawk Valley	The Mary Imogene Bassett Hospital
New York City	Fund for Public Health in New York
North Country	Adirondack Health Institute
Southern Tier	HealthlinkNY
Tug Hill Seaway	Fort Drum Regional Health Planning Organization
Western New York	P2 Collaborative of Western New York

PHIP Stakeholders

- Health care consumer and patient advocacy organizations
- Behavioral health advocacy organizations
- Disability rights organizations
- Health, behavioral health and disabilities service providers
- Rural health networks
- Insurers and other payers
- Local public health officials and other local officials
- Local human service agencies
- Business community
- Unions
- Schools and institutions of higher education
- Local housing authorities
- Local transportation authorities

PHIP Responsibilities

- Convening stakeholders
- Providing a neutral forum
- Incorporating strategies to address health disparities, including promoting the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
- Promoting consumer engagement
- Coordinating with regional health and human services agencies
- Collecting, analyzing and utilizing data
- Analyzing regional needs and coordinating regional initiatives to improve health
- Facilitating and advancing Prevention Agenda priorities
- Providing data analytics to support a regional workforce strategy under SHIP
- Reporting on Prevention Agenda and SHIP metrics

Questions?

Email PHIPinfo@health.ny.gov

Visit the PHIP website at www.health.ny.gov/community/programs/population_health_improvement

New York City Population Health Improvement Program

Strategic Plan for Promoting Higher-Performing Primary Care Across New York City

New York City PHIP

PHIP ACTIVITIES OVERVIEW

Community Health

Take Care New York (TCNY)
- Generate broad community and stakeholder participation in advancing Take Care New York, the New York City Strategic Health Agenda

Designing a Strong and Healthy New York City (DASH NYC)
- Develop sustainable strategies for reducing the burden of chronic disease

Age-Friendly NYC
- Develop strategies for promoting the health of older New Yorkers

Care Transformation

Advanced Primary Care (APC)
- Develop a strategic plan for expanding the adoption of the Advanced Primary Care Model by NYC primary care providers

Culturally and Linguistically Appropriate Services (CLAS)
- Develop plan for supporting enhanced implementation of CLAS standards

Regional Planning Consortium (RPC)
- Address issues brought about by the implementation of Medicaid managed behavioral health care

<u>Supporting Activities</u>

Governance Infrastructure
Health Equity trainings
Focus Groups and Deliberative panels
Analysis of Funding Sources
Partner Management Network Tool
Communications Planning

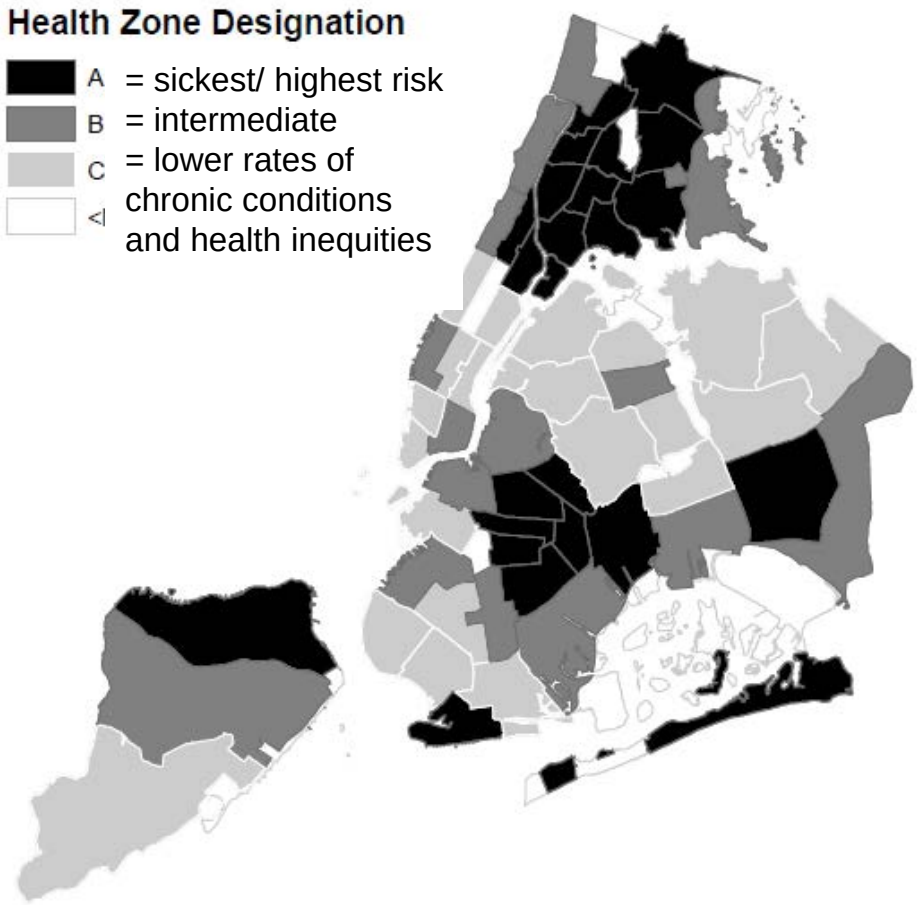
APC PHIP Approach

- Convene APC Work Group to help guide the development of the strategic plan
- Use data to identify communities with high health inequities
- Listen to additional stakeholders including providers, payers, consumers, TA vendors, and PPSs on the content and recommendations included in the plan
- Focus on the Big Issues
- A prejudice in favor of action
  - *Where we can, in NYC, do something*
  - *Where we can't, partner and support regional, statewide efforts*

Our Expert Advisors: The APC Work Group

Melinda Abrams, Commonwealth Fund
Joe Baker, Medicare Rights Center
Susan Beane, HealthFirst
Neil Calman, Institute for Family Health
Lawrence Casalino, Weill Cornell Medical College
Dave Chokshi, NYC Health + Hospitals
Henry Chung, Montefiore CMO
Kathy Ciccone, HANYS Benefit Services
Louise Cohen, Primary Care Development Corp.
Tara Cortes, Hartford Institute of Geriatric Nursing
Vito Grasso, NYS Academy of Family Physicians
Valerie Grey, HANYS
Mark Hannay, NY Health Care for All Campaign
Robert Hayes, Community Healthcare Network
Tim Johnson, GNYHA
Steven Kaplan, NewYork-Presbyterian Hospital
Munish Khaneja, Emblem Health
Hillary Kunins, NYC DOHMH
Linda Lambert, NYACP
Robert La Penna, Empire Blue Cross Blue Shield
Alan Mitchell, Primary Care Development Corp
Robert Morrow, Albert Einstein College of Medicine
Carla Nelson, GNYHA
Karen Nelson, Maimonides
Laurel Pickering, NEBGH
Arnold Saperstein, MetroPlus Health Plan
Alan Shapiro, Montefiore
Alan Silver, IPRO
William Streck, HANYS
Elizabeth Swain, CHCANYS
Salvatore Volpe, Staten Island PPS

Developing “Health Zones”



(1) Group communities into zones, using health indicators

- Burden of disease (Asthma, Hypertension, Diabetes, Obesity)
- Socio-demographic risk factors (Foreign-born, Limited English Proficiency, Black/Hispanic, Below FPL, Adults with Less than HS Diploma)
- “Preventable” utilization (Asthma, Hypertension, Diabetes)

(2) For ***each*** zone

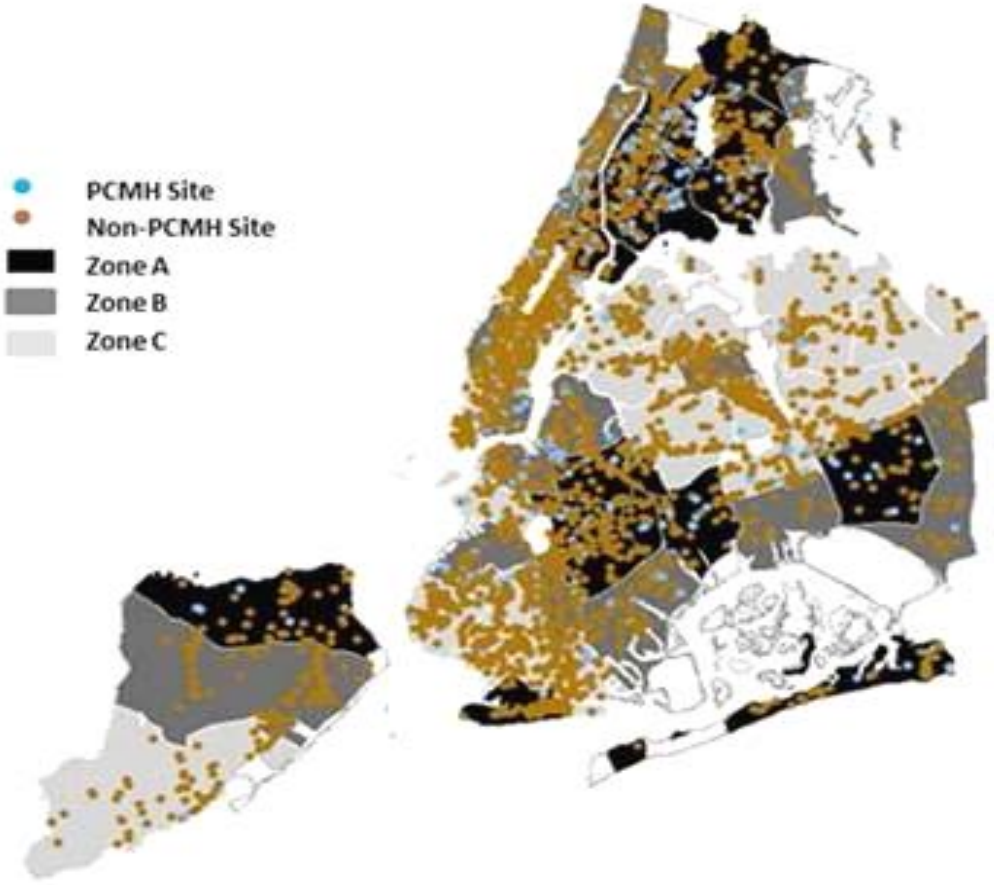
- Identify current base of primary care providers
- Assess current status of communities/cohorts relative to practice transformation
  - # with NCQA PCMH recognition, baseline
- Track involvement of communities/cohorts in efforts to achieve “medical home”
  - # receiving TA under various state and federally-funded initiatives

(3) Identify gaps for reaching 80% APC goal by

- Geographical areas
- Types of sites

Establishing a Baseline: NYC's Primary Care Landscape

	Zone A	Zone B	Zone C	Citywide
Population	2,953,451	2,214,296	3,234,545	8,402,292
Primary Care Providers	3,932	2,847	4,655	10,171
PCPs who are PCMH	1,100 (28%)	600 (21%)	609 (13%)	2,333
PCMH Sites by # of PCPs at Site				
1 -2	65 (10%)	59 (9%)	52 (4%)	176
3 – 5	45 (30%)	28 (21%)	38 (16%)	111
6 – 15	40 (42%)	24 (35%)	22 (20%)	86
16 +	22 (37%)	9 (23%)	7 (15%)	38



Consumer Focus Groups

Why

- Test current perceptions of primary care performance
- Probe for importance of APC/Medical Home attributes

Who

- 5 focus groups (one/borough) in “Zone A” communities
- 10-15 per group, ages 18+
- Partnered with CBOs to organize/arrange
- Focus groups run and analyzed by staff from NYAM

How

- Conducted between November 2015 and January 2016 (N=64)
- Held at community-based sites
- 2-hour sessions, with expert facilitation

Consumer Focus Groups - Themes

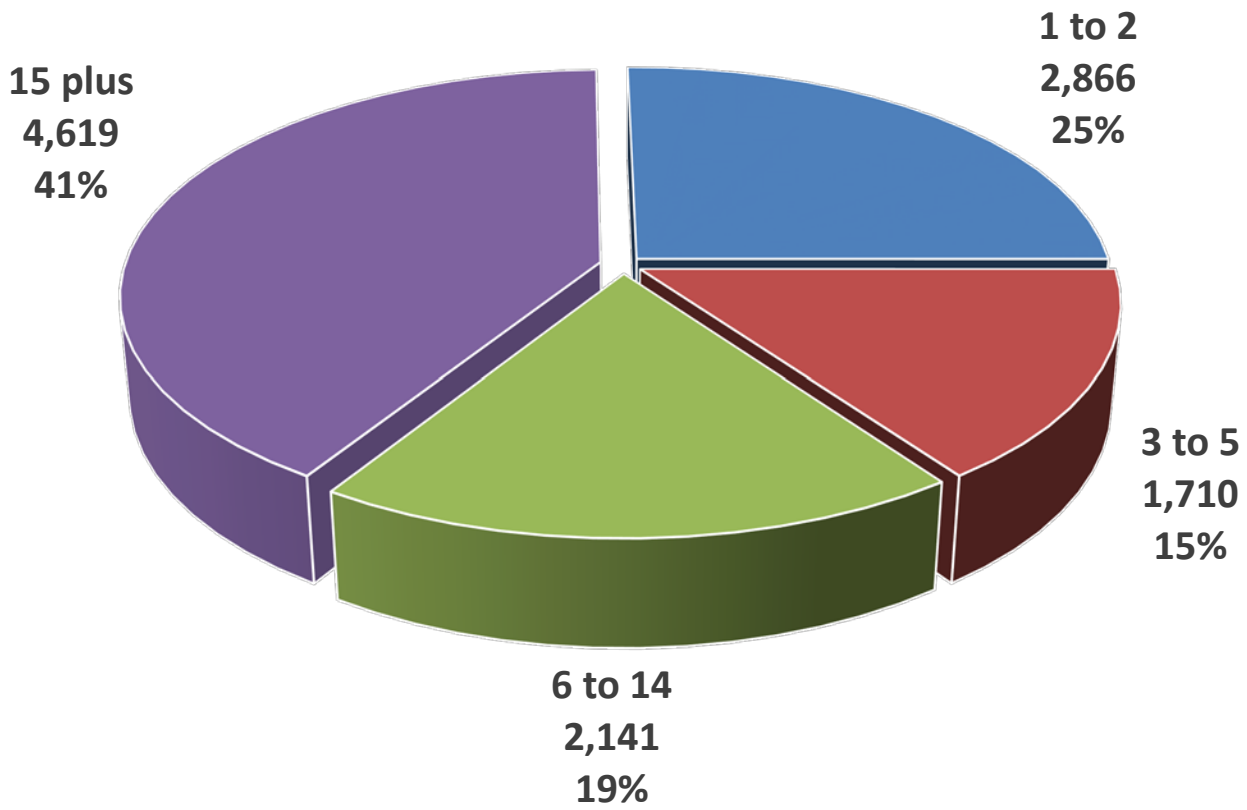
1. Dissatisfaction with performance of current primary care system
2. Strong support among participants for APC-like patient-centered care
3. High-value attributes included:
   - Improved access and availability
   - Culturally and linguistically appropriate care
   - Respectful interpersonal interactions
   - Efficient referral systems, more care coordination, information sharing
   - Access to health information, integration with non-medical services in their communities, both for health promotion and in relationship to individual care
   - Improved communication between patient and provider, including clear explanation to participants regarding their role, protocol and procedures

Strategic Plan: The Opportunities

1. Prioritize increasing medical home adoption in communities with the greatest health disparities and inequities.
2. Ensure opportunities for medical home transformation are accessible and sustainable for small practices.
3. Support integration of behavioral health care as part of the medical home.
4. Build on and better coordinate the various medical home initiatives under way across New York State.
5. Achieve multi-payer support to sustain medical home models.

A Focus on Small Practices

Primary Care Providers in NYC
by Practice/Site Size



40 % of NYC's Primary Care Providers Work in Sites With ≤ 5 Providers

A Range of New Functions – Many Requiring Scale – Are Required for APC

Purpose	Services
Required to Develop/Implement a Shared Service Organization	"Convener"
	"Project Manager"
	Trusted Organization / "Host"
	"Trusted Physician /non-physician Leader"
Capacities needed to Function as a Medical Home (APC/TCPI/PCMH)	Care coordinator
	Care manager
	Consultation with Social Workers/Pharmacists
	Nutritionist, BH Specialist / Psychiatrist (?)
Required to Participate in VBP	Documentation
	Data Analytics
	Risk stratification
	Clinical Quality Monitoring
	Reporting on performance/outcomes
	Sufficient Scale / Aggregation - Larger Unit of Analysis for VBP
	Data aggregation (SHIN-NY, APD, MAPP)
	Data validation
Required Practice Infrastructure	EHR software adoption
	Assistance with EHR use
	Ongoing EHR maintenance
	Health Information Exchange
	Data Exchange
Business Operations	Payer negotiation/group purchasing
	Operational management
	Cost/Revenue cycle management

Small Practices

- Help independent providers better understand the business case for pursuing the medical home model.
- Develop a unified and targeted communication plan to help small practices identify and access practice transformation resources.
- Work with medical associations to convene listening sessions to gather input from primary care providers on approaches to, and potential benefits of sharing key services and infrastructure.
- Assess and test the feasibility of implementing shared services models for small practices in NYC.

Consumer Engagement Strategy

State-level Consumer Engagement Strategy for APC

Strategy	Methods of engagement
Community Outreach	• Regional stakeholder meetings organized with PHIPs (open to public, consumer organizations, community groups) • Coordinate process at state level to share insights • 11 meetings in Summer/Fall 2016 across PHIP regions
Awareness and communications	• SIM Newsletter • DOH Website • DOH social media • FAQs on SIM initiatives including APC FAQ for consumers • Posters, materials for APC provider offices • Online information about APC provider levels
Evaluation of APC	• Patient surveys and focus groups (detail TBD pending procurement)
APC Practice level - milestones	• Practices build and integrate patient engagement activities depending on Gate
Direct consumer engagement	• DOH to explore RFA/RFP based on advocate input and other SIM state best practices

Community Outreach

1. Community Outreach: Work with PHIPs as convener of consumers in regions – host listening sessions or focus groups
   - **Summer 2016:** Learn what consumers see as critical issues in primary care in their communities; generate awareness of SIM, APC goals and timelines, provide feedback on communications
   - **2017-2019:** To be developed; may include sessions to inform implementation/APC modifications and refinement

Awareness and Communications

Use of existing communication vehicles and developing new ones:

- SIM Newsletter
- DOH Website
- DOH social media
- FAQs on SIM initiatives including APC FAQ for consumers
- Posters, materials for APC provider offices
- Common materials/language for PT entities
- Online information about APC provider levels

Consumer meetings and forums can serve as sessions for input on communications.

Evaluation of APC and SIM

Independent evaluator of NY SIM procurement is underway

- Will include a robust evaluation of NY SIM goals, process and performance
- Patient focus groups may be part of contractor strategy; will provide input into success of APC model

APC Milestones: Patient Centered Care

The APC model explicitly includes patient engagement as a core responsibility as defined by:

- **Gate 2** – APC Milestone Technical Specifications require that practices build and integrate patient engagement activities through patient-family survey, Patient-Family Advisory Council (PFAC) or Focus Group at Gate 2.
- **Gate 3** – it is expected that practices will survey no less than semi-annually at least 8% of their total patient panel. If selecting a PFAC or Focus Group, quarterly material reporting is required.
- **Gate 3** – practices are expected to provide QI strategies that have resulted in meaningful change for patients and families.
- It is suggested that the practices 'take ownership' of this effort and that team participation/training is recommended.

Direct Consumer Engagement – RFA/RFP to be explored

Based on guidance and input from consumer representatives, as we transition from design to implementation, it is critical to engage consumers directly.

Goal: To ensure that the guidance we provide at the outset, and on an ongoing basis, to transformation agents ensures the best possible implementation of the APC model; one that incorporates key learnings from the patient perspective.

Explore and develop RFP/RFA:

- To ensure success on consumer engagement
- Solicit guidance from patients, consumers, and caregivers and to share learnings with the PT entities and APC practices

Next Steps:

- Discuss with CMMI for approval of concept
- Additional guidance needed; will schedule a conference call and invite ICWG members and other stakeholders to ensure a robust plan for ensuring meaningful consumer guidance as the APC model is implemented

APC Score Card Update

Principles Moving Forward for APC Core Measure Set

- **Use a phase-in approach to the APC Core Measure Set**
  - Start with a Version 1 that comprises measures that are easy to collect/report
  - Observe implementation of the APC Core Set and the CMS Primary Care Set over 18 months – payer and provider experiences will guide evolution, revisions and updates of the APC Core Set
  - Keep an eye out for the forthcoming CMS Pediatric Set – assess opportunity for alignment
  - Understand and facilitate APC providers' abilities to collect and report clinical measures (for Version 2)

Proposed Next Steps for APC Measure Set

- **Proposed action**:
  - Add all of the CMS measures to the APC set except -
    - Non-recommended cervical cancer screening for adolescents
    - Two depression remission measures
  - Keep APC child and adolescent measures
  - Keep APC prevention measures
- **Implications**: Assuming payers/providers will have to report on the CMS measures eventually, an integrated CMS-APC set would differ from a CMS-only set in the following ways:
  - Five additional child/adolescent and prevention measures
  - Three additional behavioral health measures

New APC Set - with CMS Alignment

28 measures total - 20 measures in Version 1 (claims-only measures)

Domains	NQF #/Developer	Version 1/Data Source	Measures	Version 1
Prevention	32/HEDIS	Claims/EHR. Claims-only possible.	**Cervical Cancer Screening**	✓
	2372/HEDIS	Claims/EHR. Claims-only possible.	**Breast Cancer Screening**	✓
	34/HEDIS	Claims/EHR	**Colorectal Cancer Screening**	
	33/HEDIS	Claims/EHR. Claims-only possible	**Chlamydia Screening**	✓
	41/AMA	Claims/EHR/Survey. Claims-only possible.	**Influenza Immunization - all ages**	
	38/HEDIS	Claims/EHR/Survey. Claims-only possible.	**Childhood Immunization (status)**	✓
	2528/ADA	Claims	**Fluoride Varnish Application**	✓
Chronic Disease	28/AMA	Claims/EHR	**Tobacco Use Screening and Intervention**	
	18/HEDIS	Claims/EHR	**Controlling High Blood Pressure**	
	59/HEDIS	Claims/EHR	**Comprehensive Diabetes Care: HbA1C Poor Control**	
	57/HEDIS	Claims	**Comprehensive Diabetes Care: HbA1C Testing**	✓
	55/HEDIS	Claims	**Comprehensive Diabetes Care: Eye Exam**	✓
	56/HEDIS	Claims	**Comprehensive Diabetes Care: Foot Exam**	
	62/HEDIS	Claims	**Comprehensive Diabetes Care: Medical Attention for Nephropathy**	✓
	71/HEDIS	Claims/EHR	**Persistent Beta Blocker Treatment after Heart Attack**	✓
	1799/HEDIS	Claims/EHR. Claims-only possible.	**Medication Management for People With Asthma**	✓
	24/HEDIS	Claims/EHR	**[Combined obesity measure] Weight Assessment and Counseling for nutrition and physical activity for children and adolescents**	
	421/CMS	Claims/EHR	**[Combined obesity measure] Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**	
Behavioral Health/ Substance Use	418/CMS	Claims/EHR	**Screening for Clinical Depression and Follow-up Plan**	
	4/HEDIS	Claims	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	✓
	105/HEDIS	Claims/EHR	**Antidepressant Medication Management**	✓
Patient-Reported	326/HEDIS	Claims/EHR	**Advance Care Plan**	
	5/AHRQ	Survey	**CAHPS Access to Care, Getting Care Quickly**	
Appropriate Use	52/HEDIS	Claims	**Use of Imaging Studies for Low Back Pain**	✓
	58/HEDIS	Claims	**Avoidance of Antibiotic Treatment in adults with acute bronchitis**	✓
	--/HEDIS	Claims	**Inpatient Hospital Utilization (HEDIS)**	✓
	1768/HEDIS	Claims	**All-Cause Readmissions**	✓
	--/HEDIS	Claims	**Emergency Department Utilization**	✓
Cost	--	Claims	**Total Cost Per Member Per Month**	✓

Closing Remarks