NYS Statewide Health Innovation Council

October 9, 2018

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 – 10:45	Paul Francis Dr. Howard Zucker
2	Review of SHIP Progress and Challenges	10:45 – 11:00	Paul Francis
3	SHIP Transformation Initiatives in NYS: Strengthening Primary Care and reducing avoidable hospital use ▪ State Innovation Model (SIM) ▪ Delivery System Reform Incentive Payment (DSRIP) ▪ Workforce Successes and Challenges	11:00 – 12:15	Dr. Marcus Friedrich Greg Allen Dr. Gene Heslin
4	Working Lunch ▪ Health Information Technology Successes and Challenges	12:15 – 12:35	Jim Kirkwood
5	Observations on the State Innovation Plan by Commissioner Dr. Howard Zucker	12:35 – 12:45	Dr. Howard Zucker
6	Emerging New VBP Models and Networks ▪ Creating sustainable VBP models comprised of integrated networks that include hospitals	12:45 – 1:15	Ryan Ashe Dr. Gene Heslin
7	Open Discussion ▪ Building on successes – alignment of primary care standards and quality measures ▪ Exploring promising ideas – leveraging new community partnerships, expanded care teams ▪ Addressing Challenges – provider engagement in transformation and VBP, small practices	1:15 – 2:15	Paul Francis
8	Closing Comments & Next Steps	2:15 - 2:30	Paul Francis Dr. Howard Zucker

Review of State Health Capitalization Plan Progress and Challenges

NEW YORK STATE OF OPPORTUNITY. Department of Health

State Health Innovation Plan Goals Set in 2014

New York State will achieve the Triple Aim within 5 years

	Goal
Improved health	*Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement.*
Better health care and consumer experience	*Achieve high standards for quality and patient experience, including at least a 20 percent reduction in avoidable hospital admissions and readmissions.*
Lower costs	*Generate $5-to-10 billion in cumulative savings by reducing unnecessary care, shifting care to appropriate settings, and curbing increases in unit prices for health care products and services that are not tied to quality.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

State Innovation Model
Health Care Delivery: Primary Care Transformation

Main CMS Demonstration Programs in NY State:

DSRIP	SIM/APC
Health system transformation, including primary care transformation	Primary care transformation
Medicaid, Managed Medicaid	Commercial Multi-payer approach, including other lines of business
Overall goal: 25% reduction in avoidable hospital use	Overall goal: improve primary care outcomes for New Yorkers
Funding: $7.3 billion	$100 Million
Main driver for transformation: PPS	Transformation agent vendors & Primary Care Practices
Primary Care Model: NCQA PCMH/recognition of APC Gate 2	Advanced primary care (APC)

Why create a distinct "NYS PCMH"?

- A NYS PCMH program considers several state-specific components including investments in Health IT, Behavior Health integration, rigorous Care Coordination, Population Health, and the potential for multi-payer support
- Accelerating the transition toward value-based payment and succeeding in new payment models for all practices in NY State is a priority for NY
- Align Medicaid and SIM/APC around one common practice transformation program

…and continue other successful SIM elements:

- Payment of practice transformation by practice transformation agents
- Regional Oversight Management Committees (ROMC)
- SIM funding for HIT
- SIM funding for practice enrollment fees

NEW YORK STATE OF OPPORTUNITY. Department of Health

NYS PCMH aligns largely with the NCQA program, with several targeted revisions

Key differences

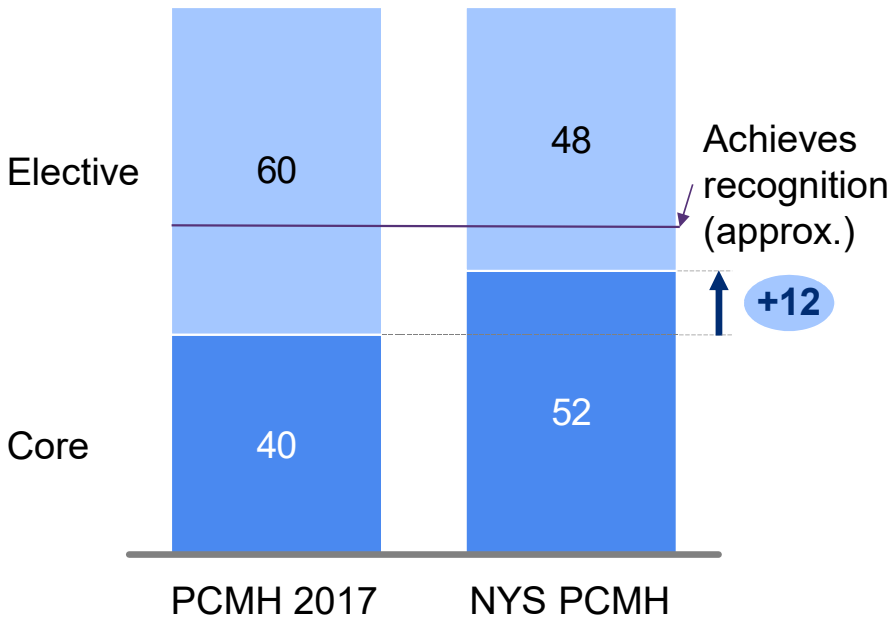
	From: NCQA PCMH 2017	To: NYS PCMH
Phases of transformation	1. Commit 2. Transform 3. Succeed	▪ Same- in the spirit of simplification, the current NCQA PCMH phases and assessment model would fully replace APC Gates
Requirements	1. Commit, self-assess, plan 2. Develop and document PCMH capabilities 3. Re-certify on an annual basis	1. Same, **plus commitment to adopt VBP** 2. **Additionally require 12 NCQA-elective Behavioral Health, Care management, Population Health, and Health IT capabilities as "Core"[1]** 3. Same
Recognition	▪ Recognition by NCQA as a PCMH 2017 practice	▪ Recognition by NYS and NCQA as an **NYS PCMH 2017** practice
State-funded Technical Assistance (TA)	▪ None	▪ **State-funded TA** to achieve NYS PCMH recognition (with minimal to no need for changes in curriculum), contingent on continued participation for up to 2 years
Medicaid support	▪ Incentive payment upon achieving PMCH 2017 recognition	▪ PMPM payment upon reaching NYS PCMH recognition

1 The 12 additional core criteria for NYS PCMH represent up to 18 elective credits in NCQA PCMH- so NYS PCMH practices would need to complete only an additional 7 credits of electives to achieve recognition

NEW YORK STATE OF OPPORTUNITY. Department of Health

NYS PCMH builds on APC/PCMH 2017 by converting 12 Electives into Core without asking the practices to do more

NYS PCMH criteria compared to PCMH 2017



Changes compared to NCQA PCMH 2017

- **12 Additional Core criteria*** represent fundamental building blocks in the areas of:
  - Behavioral Health integration
  - More rigorous Care Coordination
  - Health IT capabilities
  - VBP arrangements
  - Population Health
- Providers would then complete **elective criteria to earn 6-9 additional credits**
- **Continuation of TA vendor activities**

* See Appendix for specific standards that were added as core to NYS PCMH

NEW YORK STATE | Department of Health

Progress: Current Program Participation: August 2018

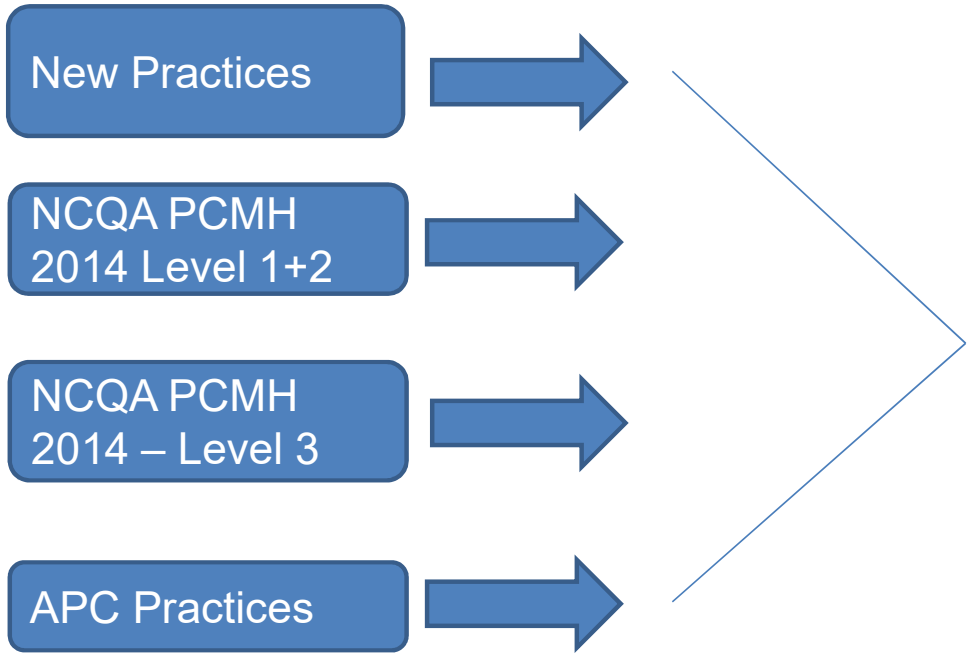
	PCMH 2014	NYS PCMH
Number of practices:	2,376	1,269
Number of physicians:	8,893	~4,500

About 15-20% of APC providers were already PCMH certified

*See Appendix for a map of NYS PCMH Enrolled Practices

NEW YORK STATE OF OPPORTUNITY. Department of Health

Costs of Transformation to NYS PCMH:



Costs for NYS PCMH recognition will be paid for by SIM grant

SIM grant funding will end February 2020

NEW YORK STATE OF OPPORTUNITY. Department of Health

Practice Transformation Challenges:

- Improvement of small practice operations
- Aggregation for measurement
- Communication about program
- Payment Adequacy: Reimbursement to the Primary Care sector

Payment for Practice Transformation

SIM Payment Approach

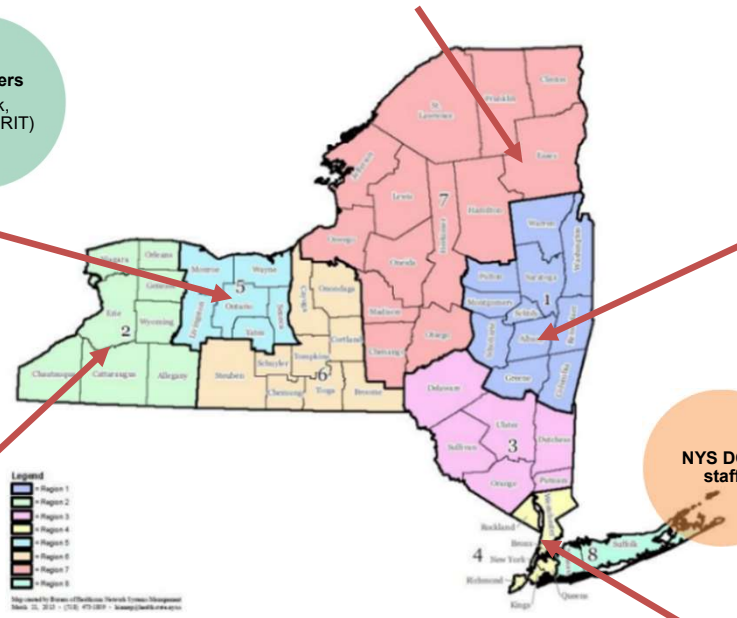
- "Critical mass" of VBP contracts in a practice offers more chances of transformation success
- Regional approach in discussions with payers to offer VBP contracts to practices who are not engaged in VBP
- Voluntary payer participation
- Payers decide what contracts to offer and to whom

Regional Oversight Management Committees (ROMC)

ADK Medical Home Initiative

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

- **Plans** (Aetna, Excellus BCBS, MVP, United Empire Plan)
- **TA Vendors** (Common Ground Health)
- **Employers** (Kodak, Paychex, RIT)
- **Consumers**
- **Providers** (ACOs, FQHC, Private Practice, Medical Society)



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)

Western Area:
Review of RFP applications

NEW YORK STATE OF OPPORTUNITY. Department of Health

ROMC Progress to Date

ROMC	Multi-payer model
ADK	7 commercial payers, Medicaid, 3 year agreement
Capital District/Hudson Valley	4 Commercial payers (some include all lines of business), agreement on model
New York City	6 Commercial payers, discussions ongoing
Rochester	4 Commercial payers, discussions ongoing
Western Region	TBA

Payment Challenges:

- Different regions have different challenges
- Payers are engaged in ROMC while managing their own VBP programs
- Agreed subset of practices to offer VBP might be smaller than expected

Questions?

NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

The Delivery System Reform Incentive Payment Program

Greg Allen
Division Director
Division of Program/Policy Development and Management

October 2018

DSRIP Key Goals

- Transform the health care safety net at both the system and state level.
- Reduce avoidable hospital use and improve other health and public health measures at both the system and state level.
- Ensure delivery system transformation continues beyond the waiver period through leveraging managed care payment reform.

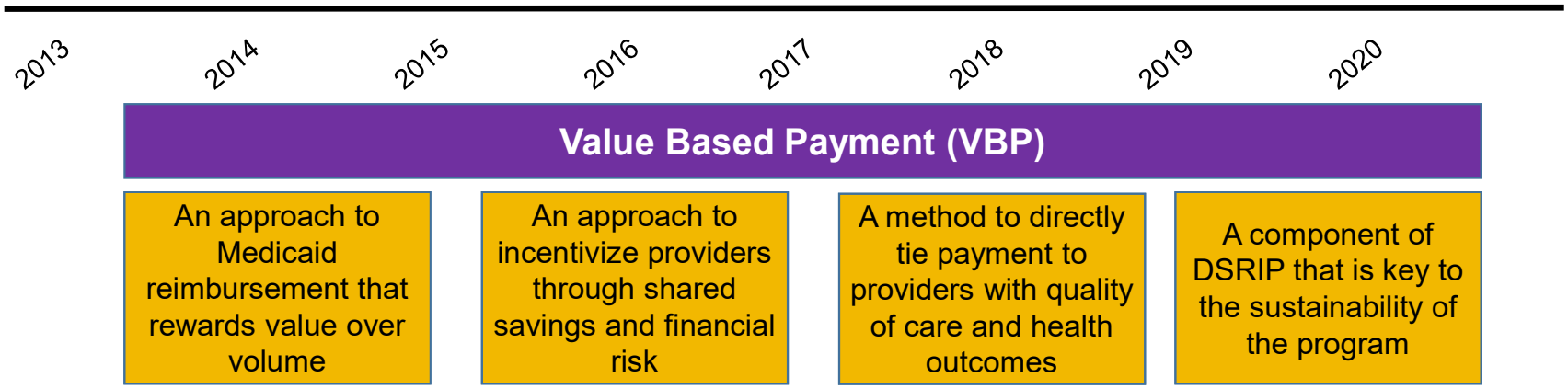
Better care, less cost– transforming today for a VBP tomorrow

Old world:
- FFS
- Individual provider was anchor for financing and quality measurement
- Volume over Value

DSRIP:

Restructuring effort to prepare for future success in changing environment

New world:
- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume

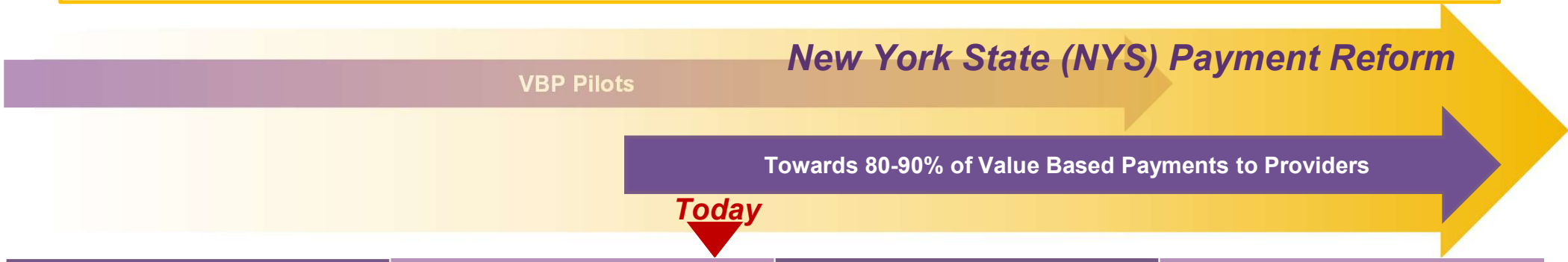


Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published June 2015.

NEW YORK STATE OF OPPORTUNITY. Department of Health

VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.



April 2017

Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP

☑

April 2018

≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above

☑

April 2019

≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher *

April 2020

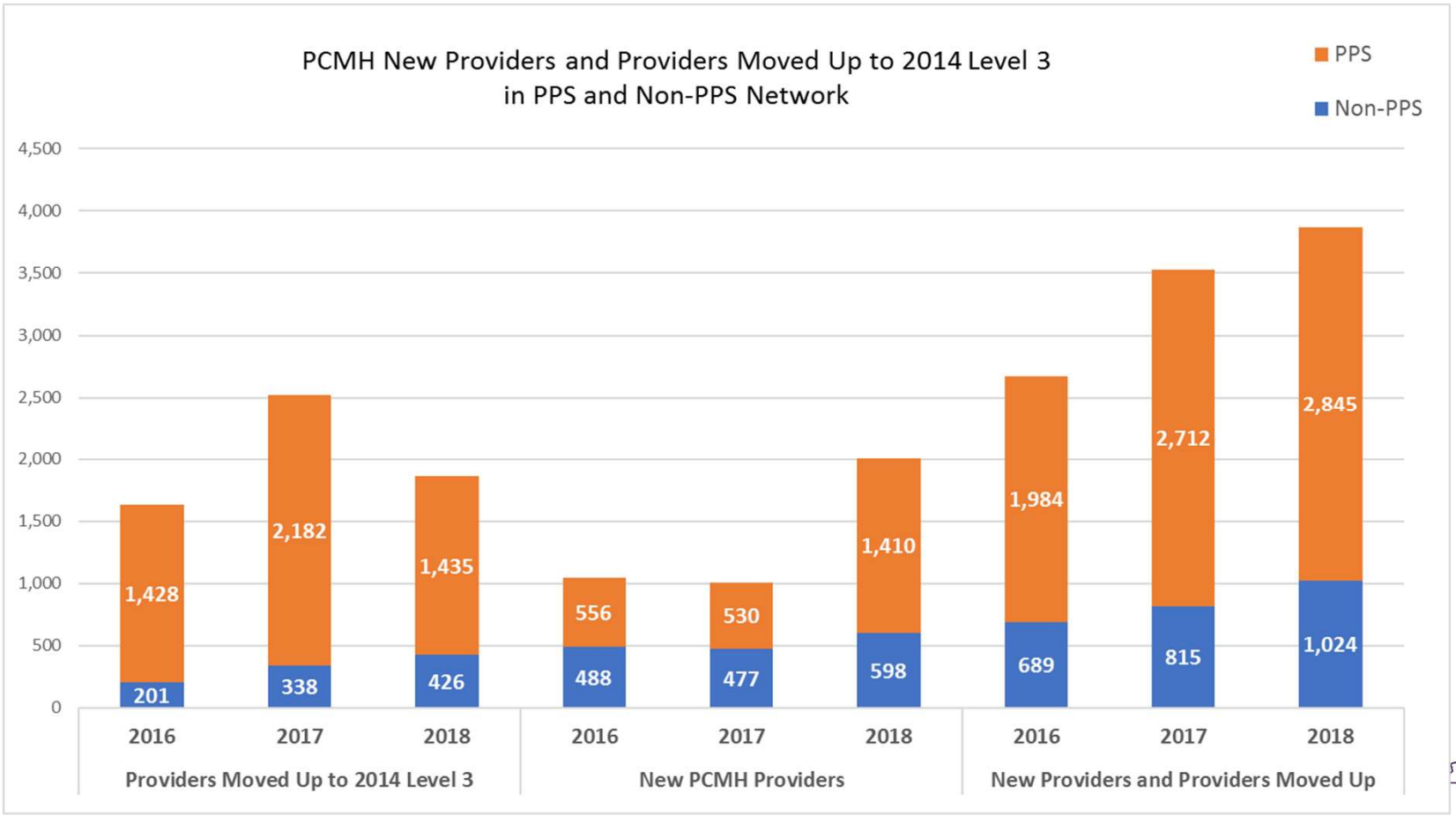
80-90% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher *

* For goals relating to VBP level 2 and higher, calculation excludes partial capitation plans such as MLTC from this minimum target.

NEW YORK STATE OF OPPORTUNITY. Department of Health

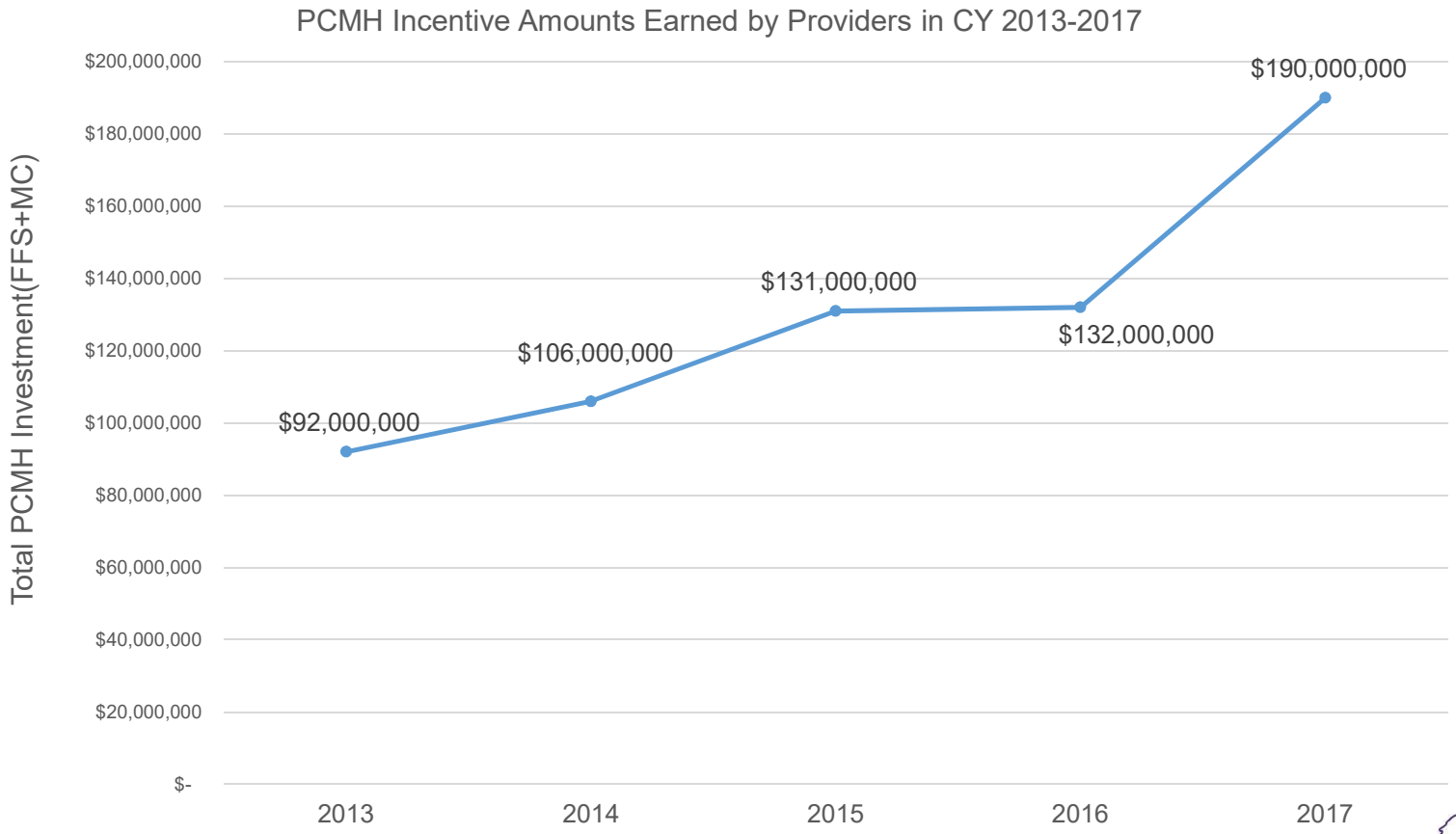
PCMH/ APC – DSRIP Effect

DSRIP Increasing # of Advanced Primary Care Practices



NEW YORK STATE OF OPPORTUNITY. Department of Health

Investment in PCMH incentive

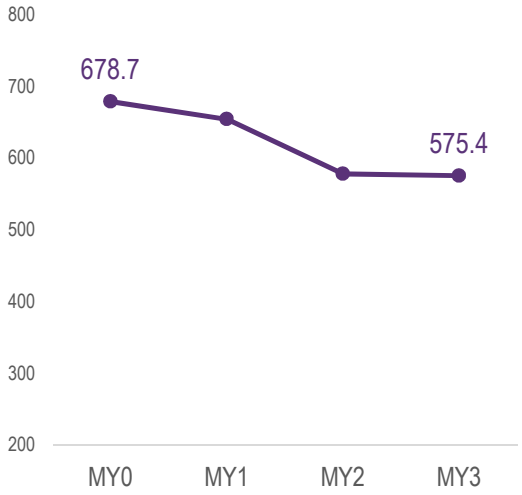


NEW YORK STATE OF OPPORTUNITY. Department of Health

Preventable Hospital Use Measurement Years 2014 - 2017

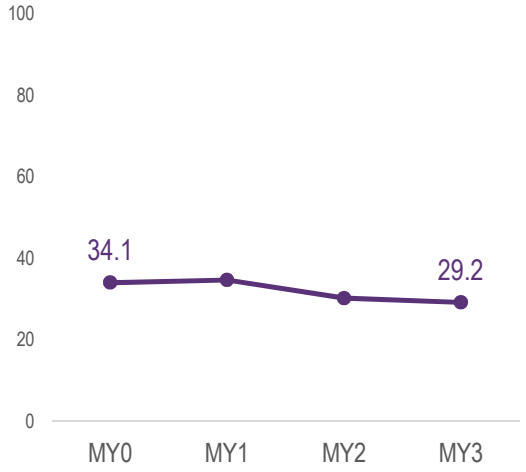
Preventable Hospital Use Continues to Decline

Preventable Readmissions
(per 100,000 Medicaid members)



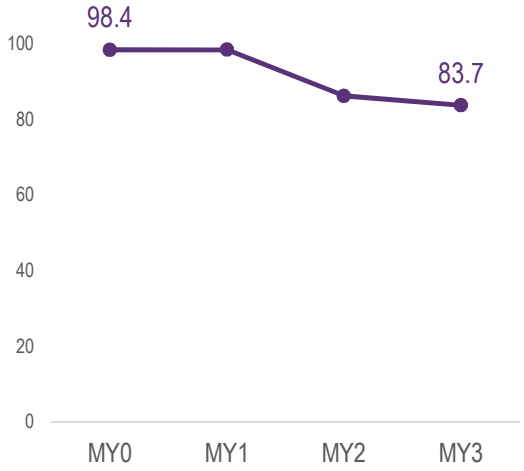
All PPS rate change since baseline: **15.2%**

Preventable ED Visits
(per 100 Medicaid members)



All PPS rate change since baseline: **14.3%**

Preventable ED Visits (BH Population)
(per 100 Medicaid members)



All PPS rate change since baseline: **14.9%**

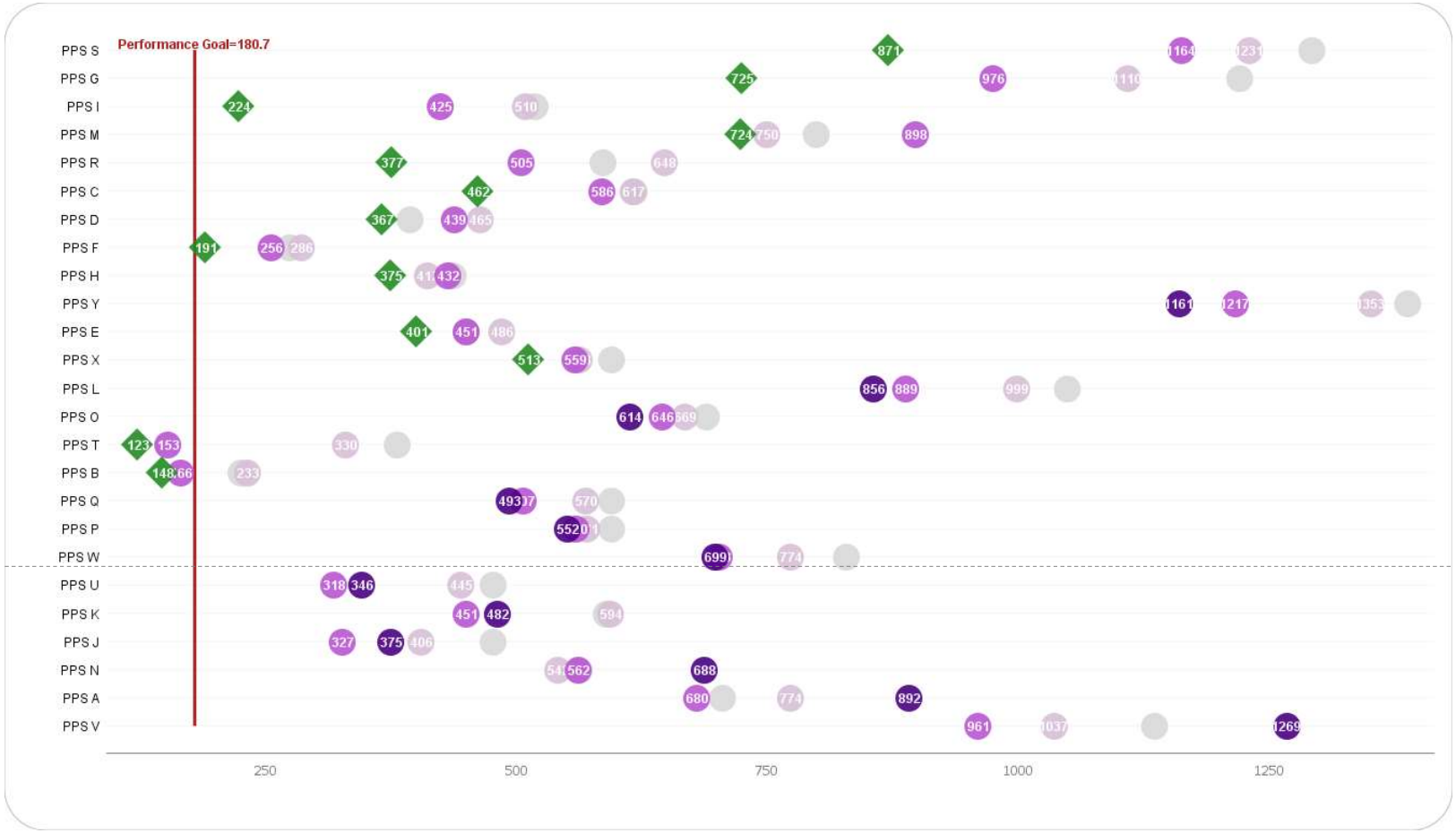
Data Source: All PPS rate

NEW YORK STATE OF OPPORTUNITY. Department of Health

Potentially Preventable Readmissions ±

19 PPS Improve, 13 Meet Annual Improvement Target

± A lower rate is desirable



MY3 P4P Funds Earned
$24,920,036 + HPF

MY0 MY1 MY2 MY3 PPS Result

= MY3 result met the AIT

Improving ←

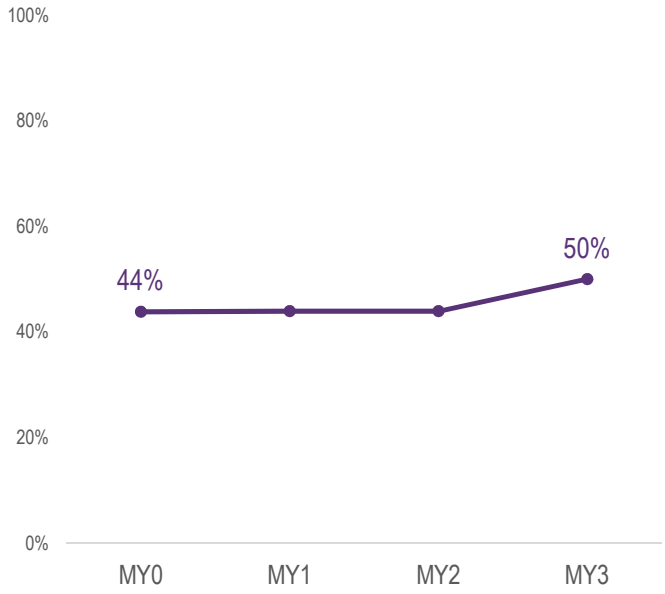
Not Improving →

NEW YORK STATE OF OPPORTUNITY. Department of Health

BH Integration

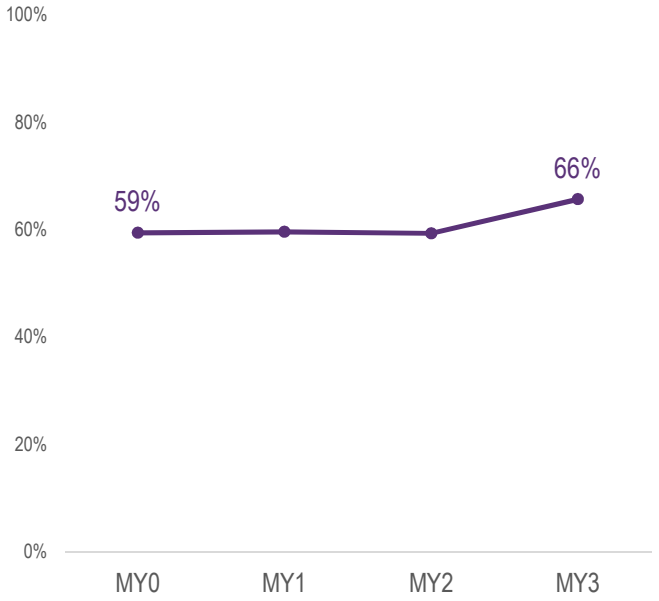
Behavioral Health Measures: Mental Illness

Follow-up After Hospitalization for Mental Illness Within 7 Days



All PPS rate change since baseline: **14.1%**

Follow-up After Hospitalization for Mental Illness Within 30 Days



All PPS rate change since baseline: **10.6%**

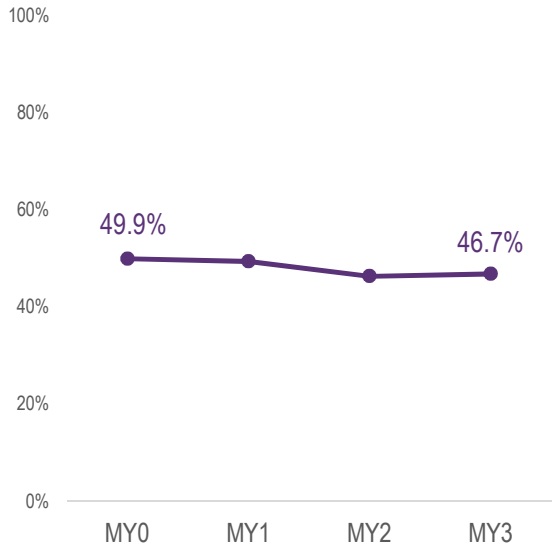
Data Source: All PPS rate

NEW YORK STATE OF OPPORTUNITY. Department of Health

Challenges – SUD Population/Data Sharing

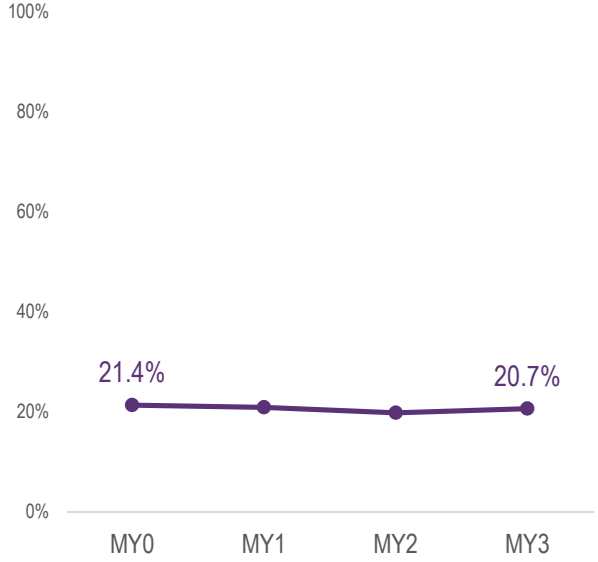
Behavioral Health Measures: Substance Use

Alcohol & Other Drug Dependence Treatment (1 visit within 14 days)



All PPS rate change since baseline: **-6.3%**

Alcohol & Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)



All PPS rate change since baseline: **-3.4%**

Data Source: All PPS rate

NEW YORK STATE OF OPPORTUNITY. Department of Health

Statewide Accountability Milestones (SWAM)

The 1st test on the four measures of statewide performance was completed for DY3, and:

Statewide Milestone	Performance Goal	
1. Statewide metrics performance	At least 50% of measures are improving/maintaining vs. worsening (minimum of 9 out of 16 measures)	**PASS!**
2. Success of projects statewide[2]	At least 50% of eligible measures trigger an award (minimum of 1,352 out of 2,702 measures)	**PASS!**
3. Total Medicaid spending[3]	Total Statewide IP and ER Spending < $154.70 PMPM	**PASS!**
4. Managed care plan	At least 10% of total MCO expenditures are captured in Level 1 or above.	**PASS!**
Statewide Performance	**Must pass all four milestones**	

DSRIP:
Beyond the Measures

Health Pulse

April 27, 2018

Nassau Queens PPS lowers emergency room visits from Creedmoor campus

When the partners of Nassau Queens Performing Provider System considered how to lower emergency room visits for their patients, they developed a heat map showing where residents were more likely to end up in the ER or hospital. One hot spot: the campus of Creedmoor Psychiatric Center, where outpatients who receive treatment or live in community residences on campus are responsible for an outsize number of ER visits. Most frequently they are taken to Zucker Hillside Hospital in Glen Oaks and Long Island Jewish Medical Center, a partner in Nassau Queens PPS, in New Hyde Park.

To tackle the problem, Nassau Queens PPS, the DSRIP network led by Nassau University Medical Center, Catholic Health Services of Long Island and Northwell Health's LIJ, created a Local Emergency Assistance and Diversion team in July to intervene when an individual on the campus was in crisis.

The program has made 211 visits to clients from July to January 2018, and in 205 cases it was able to de-escalate the situation without a trip to the emergency room. Of course, that doesn't take into account the ER visits that occurred when the LEAD team wasn't called. That's why the group is trying to increase awareness about the option.

"The key to me for this whole thing is the use of the peer—that's somec
Javis, director of behavioral health at Nassau Queens PPS. "It's been fo
noted that the peer workers can discuss their own strategies for dealin
clients to take their medication and participate in group counseling.

Bronx nursing home using telemedicine to prevent ER trips

Providence Rest, a nonprofit Bronx nursing home, has started working with StationMD, a Scotch Plains, N.J.-based telemedicine company to reduce unnecessary emergency room visits by its patients.

The six-month pilot is funded by an innovation grant from Bronx Partners for Healthy Communities, a Performing Provider System participating in the state Delivery System Reform Incentive Payment program. The goal of the pilot is to reduce hospital readmissions for medically frail patients.

Jean Bartley-Christie, director of nursing at 200-bed Providence Rest, said the service is most useful on nights and weekends when the nursing home has less physician coverage. On-call physicians or nurse practitioners during those times are less likely to know the patient and might not have access to patients' medical records.

The Leader-Herald

May 10, 2018 | Today's Paper | Submit News | Subscribe Today

Fulton County telehealth initiative moves forward

LOCAL NEWS

FEB 7, 2017

JOHNSTOWN — Fulton County supervisors last week authorized acceptance of nearly $17,000 in state funds for county Public Health Department's new telehealth pilot initiative.

The Board of Supervisors' Human Services Committee voted Tuesday to accept $16,900 in funding through the North Country Delivery System Reform Incentive Payment, or DSRIP Program. An agreement is proposed for five years. The full board will vote Feb. 13 on the final resolution.

@crainshealth

POLITICO

Health Care | Real Estate | Newsletters | Trackers | Document Drawer

By DAN GOLDBERG | 05/03/2018 08:50 AM EDT

WHAT INTEGRATION LOOKS LIKE — It isn't easy for Angela to talk about last July 19. That's the day a man jumped out from the bushes outside her Staten Island home and attacked her. Her ribs were broken, as were several blood vessels in her face. There were other wounds, too, but they are not visible. Angela, who asked that her last name not be used to protect her privacy, spoke to POLITICO following an appointment with a psychiatrist at The Center for Integrative

Watertown Daily Times

Serving the communities of Jefferson, St. Lawrence and Lewis counties, New York

In print daily. Online always.

Seeing results: Implementing DSRIP program has benefited north country

PUBLISHED: MONDAY, APRIL 30, 2018 AT 5:15 AM

◄ PREV Item 1 of 2 NEXT ►

WATERTOWN DAILY TIMES

holds her child, Izabella, while licensed practical nurse Steve Young listens to her heartbeat ck-up at the North County Family Health Center in Watertown in 2015.

Like 0 Share Tweet

alfway through their timeline, those the goals of the Delivery System ntive Payment program in Northern ve made steady progress.

15, DSRIP is a five-year plan to health care services are delivered to use Medicaid. It seeks to reduce ospital visits by 25 percent during

Ad closed by Google

Report this ad

Why this ad? ▷

NEW YORK STATE OF OPPORTUNITY. Department of Health

Making a Difference In Patients' Lives

Patient "D"

- 22 emergency room visits in five years
- 20 inpatient hospitalizations, six of which were crisis situations.

DSRIP Intervention:

- With guidance and support from a PCP Care Manager, a collaborative care plan was designed to address patient's social and medical needs
- Introduced to a Certified Diabetes Educator and nutritionist
- Introduced to new strategies for weight loss and management (DSRIP project (3.c.i)
- Received options for getting medical advice after-hours that did not include ER utilization.

Result:

- Since enrolling in care management, the patient has not had any hospitalizations or emergency room visits.

Making a Difference In Patients' Lives

"Y" and 7 year-old son

- 8 ER visits for son's asthma in 12 months
- 20 inpatient hospitalizations, six of which were crisis situations.

DSRIP Intervention:

- Meets with Spanish speaking Community Health Workers in ER
- Mom has trouble managing son's medicine – connected with Certified Asthma Educator
- Rescheduled missed appointments; reminders and escorts to appointments
- CHW coordinates meetings with school counselors
- Obtains nutritional services
- Initiatives children's health home services

Result:

- Keeping appointments; reduced ER visits Since enrolling in care management, the patient has not had any hospitalizations or emergency room visits.

Medicaid Accelerated eXchange (MAX)

The MAX Series and Community Partnerships

To create an integrated delivery system capable of achieving DSRIP goals, providers across the full continuum of care, social and behavior services must work together

MAX is the link between policy and practice

Sample List of a MAX Action Team

- ED Physician
- Primary Care Physician
- Nurses
- Care Managers
- Social Worker
- Behavioral Health Counsellor / Psychiatry Liaison
- Manager
- Other representatives that can be key to providing care for this patient population

NEW YORK STATE OF OPPORTUNITY. Department of Health

The MAX Series is a rapid cycle continuous improvement program that brings together frontline providers to redesign the way care is delivered

MAX Series Core Elements

- Leveraging a **highly structured methodology**, approach and coaching

- Putting **frontline providers in the lead**

- Facilitating **system integration** by breaking down silos and bringing together multi-disciplinary providers

- Utilizing **data** to measure and drive performance

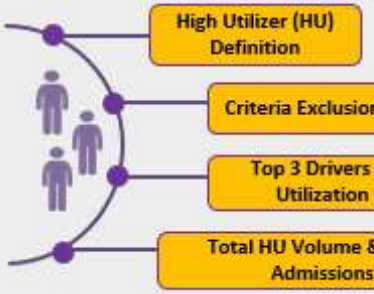
Program Objectives

1. Improve patient outcomes and key metrics
2. Improve provider quality of life
3. Increase integration across the care delivery system
4. Develop and build rapid cycle continuous improvement capability

NEW YORK STATE OF OPPORTUNITY. Department of Health

New York Presbyterian, Weill Cornell Medical Center

Our High Utilizer Population



High Utilizer (HU) Definition	4 or more inpatient admissions in the past 12 months
Criteria Exclusions	Planned obstetrics, chemotherapy, pediatric admissions, patients discharged to SNFs, and patients on a left ventricular assist device (LVAD)
Top 3 Drivers of Utilization	Psychosocial issues, housing insecurity, substance use disorder
Total HU Volume & HU IP Admissions	652 unique high utilizers (1,507 inpatient admissions)

Our Actions

HU Care Pathway

Identify
- Real-time ID of HUs through Tableau dashboard.
- Transitional Care Manager (TCM) and Ambulatory Care Nurse (ACN) are notified of admitted HU.

Assess
- TCM or ACN conducts Driver of Utilization (DOU) assessment.
- Daily HU huddle with care team.

Link
- DOU assessment leveraged to link HU to services.
- TCM bedside warm handoff to Health Home, Community Health Worker (CHW) or ACN.

Manage
- Daily case conferences on high utilizer cases.
- Integration of Health Home and Community Health Worker follow-up into daily huddle.

Success Story

Older male with four admissions in 12 months. Patient has chronic osteomyelitis, diabetes mellitus and lymphoma.

Driver of Utilization:

Lack of transportation, physical limitations in his home environment (i.e. stairs), inadequate living conditions – crowded basement with wife and disabled son, and food insecurity.

How we the Action Team addressed the DOUs:

- The Action Team connected the patient to a home visiting PCP and set him up with in-home IV infusion.
- CHWs conducted an in-home assessment, filled out a "Access-a-ride" application, and linked the patient to housing applications.
- The Action Team provided the family with referrals for food stamps, God's Love We Deliver meal delivery, and a Health Home Care Manager.

Impact to date:

- The patient has not been back since June 3rd for an admission or ER visit.

Our Impact

Partnerships

1. **God's Love We Deliver:** For high utilizers living with food insecurity and inadequate housing, this partnership serves to address these needs.
2. **The Bridge:** Provides housing, services for behavioral health, and substance abuse treatment, all of these which are common drivers of utilization at NYPH.

Unique Accomplishment

Dedicated Transitional Care Nurses (2 – 3) immediately respond upon receiving HU admission alert, to perform DOU interview at bedside.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
1,437	491	-66%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post-Hospital Utilization
(February - April 2017)

66%*
Decrease in inpatient HU admissions

N = 295 HUs

NEW YORK STATE OF OPPORTUNITY. Department of Health

Department of Health

MAD MAX

Care Compass Network, Cortland Regional Medical Center

Our High Utilizer Population

High Utilizer (HU) Definition — 4 or more inpatient admissions in the past 12 months

Criteria Exclusions — Planned obstetrics, chemotherapy, and pediatric patients

Top 3 Drivers of Utilization — End of life, lack of community-based behavioral health services, lack social support (social isolation, housing, transportation)

Total HU Volume & HU IP Admissions — 119 HUs (596 IP admissions)

**Data reflects rolling average from January 2015-December 2016*

Our Actions

HU Care Pathway

Identify
- Automated daily high utilizer census list in IP and ED.
- Developed 30-day readmission flag in EMR.
- Share list of high utilizers in daily huddles.

Assess
- Discuss admitted high utilizers in daily huddles and review prior utilization.
- Complete driver of utilization assessment.
- Complete palliative care assessment and link positive screens for bedside palliative care consults.

Link
- Link high utilizers to Hospicare for ongoing palliative care services.
- Weekly interagency meeting with community based organizations (CBOs) for care collaboration and warm handoffs.

Manage
- Weekly multidisciplinary high utilizer case conferences.
- Post-discharge telephonic follow-up within 24-48 hours.
- SNF closed-feedback loop for care coordination.
- High utilizer operational improvement dashboard tracking service provisions for stabilization.

Success Story

Elderly male; admitted to inpatient setting in mid-May.

Driver of Utilization:
Patient unable to self-manage recurrent symptoms due to cognitive deficits (lack of mental functions).

How we addressed DOUs:
- Enrolled patient in Care Transitions Program, provides 30 day post-discharge follow-up and linkages to community resources/support services.
- Provided care management to assist patient with low sodium diet to reduce high blood pressure and other cardiac complications.
- Care Transitions Manager assisted patient with appointment adherence telephonic reminder phone calls.

Impact to date:
- Patient utilization has decreased from five admissions over a 10 month period, to zero ED presentations or IP admission since being engaged in high utilizer program.

Our Impact

Partnerships

1. **Hospicare & Palliative Care Services:** Provide bedside palliative care consults for high utilizer with positive assessment outcomes.
2. **Cortland County Area Agency on Aging:** Provide post-discharge community care coordination services.

Unique Accomplishment

Developed formal process with external palliative care provider (Hospicare) to perform bedside consults and link patients for ongoing care through PATH program.

Outcome Metrics

90 Days Pre vs. Post Index Visit Hospital Utilization		
90 Days Pre-Index Visit Admissions	90 Days Post-Index Visit Admissions	% Change
139	40	-71%

The index admission is the first admission for each HU after the program start date that meets HU criteria (e.g. fourth or higher admission).

High Utilizer 90-Day Pre- vs. Post- Hospital Utilization (March - June 2017)

71%*

Decrease in inpatient HU admissions

N = 65 HUs

NEW YORK STATE OF OPPORTUNITY. Department of Health

MAX Series program achieving tremendous results

Engaged **87 Action Teams** from **68 hospitals**,

with almost **900 Staff** from health care facilities, behavioral health providers, and community-based organizations

who each attended a total of 3 full day workshops over 7 cycles, for a total of **21 Workshops**,

and committed to **558 Action Plans**, focused on improving care for their patients.

At the final Workshop of the MAX Series, **100% of individuals would recommend the program**

Action Teams reported **decreased overall hospital utilization between 20% and 74%***

NYS has invested and trained another **70 MAX facilitators from PPS** to continue the work.

** Decrease does not account for the historical regression to the mean*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Find Out More about MAX

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/max.htm

NEW YORK STATE OF OPPORTUNITY. Department of Health

Workforce Successes and Challenges

Workforce Challenges

- Primary care practitioners are not sufficiently distributed throughout the state
- Direct care workers are in increasing demand
- Efforts to attract and retain workers in underserved areas and sectors involve multiple considerations including compensation, career mobility, and geographic preferences
- Practitioners need more training and education in team-based care
- Efforts to integrate physical and behavioral health care require an appropriately skilled workforce
- More data is needed to address issues of maldistribution and shortages of health and behavioral health care practitioners
- Developing initiatives to address the foregoing challenges requires sustainable tools

Workgroup Accomplishments

- In support of the priority areas of focus, the Workgroup:
  - Reviewed the scope of practice for licensed professionals and determined that they generally do not preclude the performance of tasks related to care coordination
  - Identified a limited number of barriers that may prevent providers from fully realizing the potential of patient-centered, team-based care, which are under discussion
  - Developed and disseminated care coordination guidelines for health care workers and shortly will issue similar guidelines for educational curricula
  - Recommended legislative changes to expand access to data about health and behavioral health care practitioners
  - Served as a forum for sharing information about innovative models and practices, including DSRIP workforce initiatives, value-based purchasing, the SIM Rural Residency Program, and peer support programs

Next Phase

- For its next phase, the Workgroup will develop a compendium of best practices and resource guides – a sustainable tool that stakeholders can use to develop their own approaches to workforce challenges – by:
  - Defining the overall characteristics of what makes something a “best practice” (e.g., replicable, scalable, flexible, evidence-based)
  - Identifying a series of best practices (e.g., including community health workers in team-based care, developing recruitment and retention programs)
  - Providing examples of successful approaches used by other stakeholders in each best practice area, including details on how each example was implemented
  - Compiling information and materials for each example into a resource guide
- The compendium will allow stakeholders to replicate, modify, and scale their own initiatives as needed to address workforce challenges

NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE OF OPPORTUNITY. Department of Health

Working Lunch:
Health Information Technology Successes and Challenges

SHIN-NY Participation

- 99% of Hospitals
- 65% of Diagnostic and Treatment Centers
- 52% of Physician Practice Sites
- 76% of Certified Home Health Agency*
- 89% of Long Term Home Healthcare Program*
- 77% of Residential Healthcare Facility – SNF*
- 75% of Hospice*

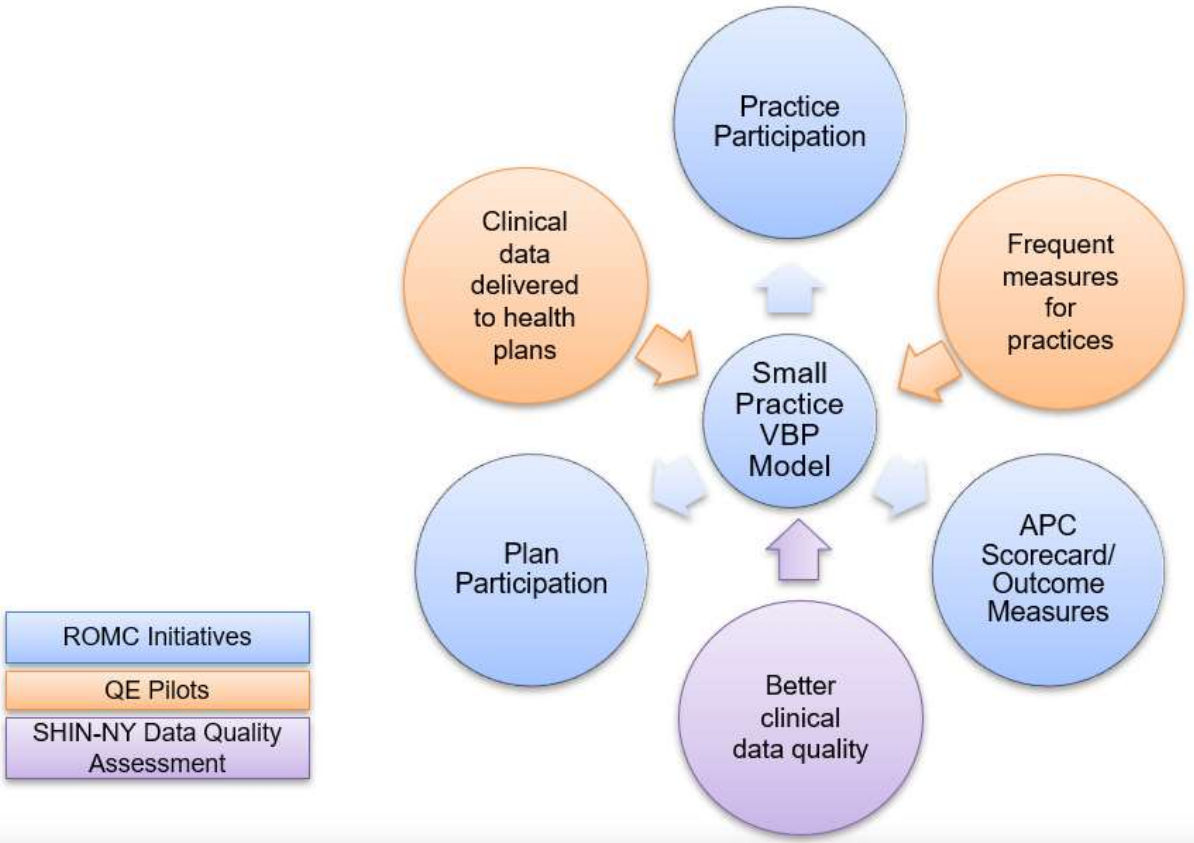
*Minimal data contribution due to not being traditional Meaningful Use providers; vast majority only have access to clinical viewer

NEW YORK STATE OF OPPORTUNITY. Department of Health

SHIN-NY Supporting Health Transformation

- Increasing security
  - HITRUST recognition a component of QE Certification
- Technology enhancements
  - Cross-QE alerts and query
- Policy Changes
  - Alerts based on a treatment relationship
- Increasing SHIN-NY data quality

Initiatives to support small practice ROMC Model



NEW YORK STATE OF OPPORTUNITY. Department of Health

QE Quality Measurement Pilot

Goals:

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

Key Activities:

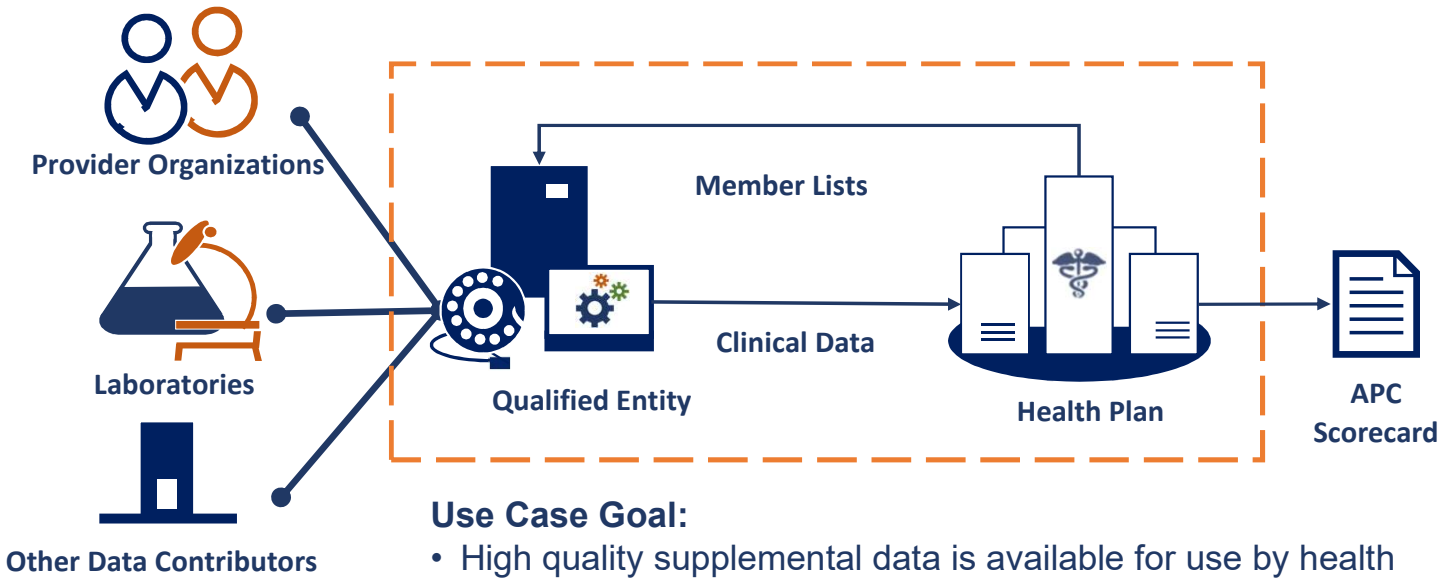
- QEs will design, implement and test capabilities to deliver electronic clinical data to health plans
- QEs will generate and share quality measures with PCMH practices
- Document data standards, data quality and other lessons learned

Outcomes:

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

NEW YORK STATE OF OPPORTUNITY. Department of Health

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

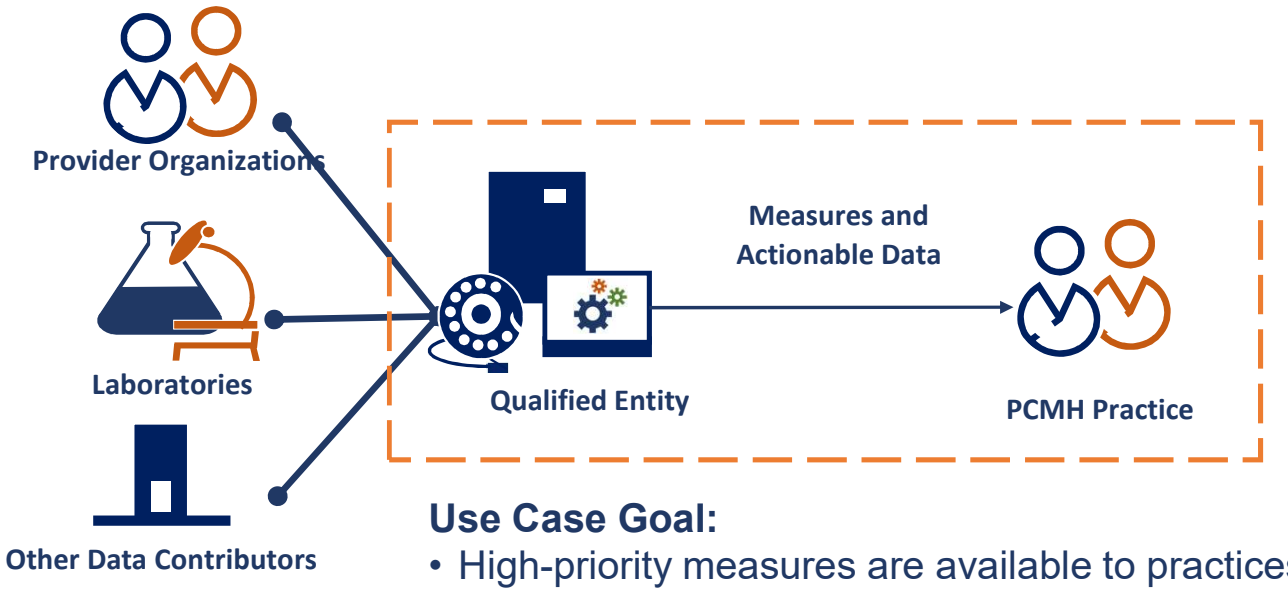


Use Case Goal:

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

NEW YORK STATE OF OPPORTUNITY. Department of Health

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



Use Case Goal:

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

NEW YORK STATE OF OPPORTUNITY. Department of Health

SHIN-NY Use Cases Supporting VBP

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

Dynamic SHIN-NY Landscape

NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE OF OPPORTUNITY. Department of Health

Observations on the State Innovation Plan by Commissioner Dr. Howard Zucker

NEW YORK STATE OF OPPORTUNITY. Department of Health

Emerging New VBP Models and Networks

- Review of key topics & priorities in VBP
- Network Integration in the context of VBP

Review of priorities & key topics in payment reform

1. A. Quality measure alignment
   - Multiple business lines across commercial, Medicare and Medicaid
   - Multiple programs that may exist within business line
     - For example, VBP, DSRIP in Medicaid
     - MIPS, APM in Medicare

   B. Development of new quality measures to support specific subpopulations
     - Behavioral health
     - Intellectual & developmentally disabled
2. Virtual aggregation models to support VBP
   - MCOs aggregate independent practices with low volume to support virtual value based payment arrangements
   - May build on top of existing quality bonus programs
   - Bases distribution of shared savings on efficiency, quality and volume of members attributed to a single practice

NEW YORK STATE OF OPPORTUNITY. Department of Health

Review of priorities & key topics in payment reform

3. Rise in “health innovation funds” seeking to support population health within value based payment
   - Town Hall Ventures
   - Wellthapp
   - Onecity Health

4. Transforming relationship between community-based organizations (CBOs), insurers and providers
   - CBOs refining their approach to payment and contracting
   - CBO hub model concept

Review of priorities & key topics in payment reform

5. Creating sustainable provider networks that may support VBP
   - Care coordination, network integration, population health are goals of payment reform
   - Robust provider networks that include primary care, behavioral health and hospitals for example, are better positioned to succeed in VBP
   - Quality and efficiency improvement in care will be supported by, for example:
     - Referral, discharge and coordination patterns between hospitals and primary care and specialty providers
     - Warm vs cold handoffs between physical and behavioral health providers
     - Colocation of providers
   - Innovator program for context:
     - Maintains membership volume requirements
     - Maintains network adequacy requirements
     - Maintains financial solvency requirements

Discussion

- Discussion:
- How do we build upon the existing framework, to achieve improved population health outcomes within integrated networks?
- How do we strengthen integration between PCP, behavioral health & specialty care?

NEW YORK STATE OF OPPORTUNITY. Department of Health

Open Discussion

- Building on successes
- Exploring promising ideas
- Addressing Challenges

Building on Successes

- Standards for Primary Care aligned across State programs and map well to federal program requirements
- Quality measure alignment across payers and programs continuing
- Infrastructure and policies supporting HIE enabled quality measurement developing

Questions for Discussion

- Are there opportunities to build on successes working with other providers?
- Are there ideas to scale or accelerate practices involved in transformation? Ways to encourage more providers to join in transformation?
- Are there populations or types of providers that may be helpful to address more specifically?

Growing Promising Ideas

- Community partnerships, community based organizations, expanded care teams
- Regional models and adaptations
- Integration of behavioral health

Questions for Discussion

- What ideas could be applied to address similar needs, such as social determinants of health?
- How would we expand promising ideas to test if they would be able to be scaled or further developed for other populations or medical neighborhoods?
- What benefit would there be in leveraging regional health care groups to set priorities for care in their region? What would be necessary for that model to work?

Addressing Challenges

- Provider engagement in transformation that will support success in VBP arrangements, such as small practices
- Inclusion of hospitals in arrangements

Questions for Discussion

- How prepared are providers for value-based arrangements?
- Are there early models with lessons learned that could inform New York?

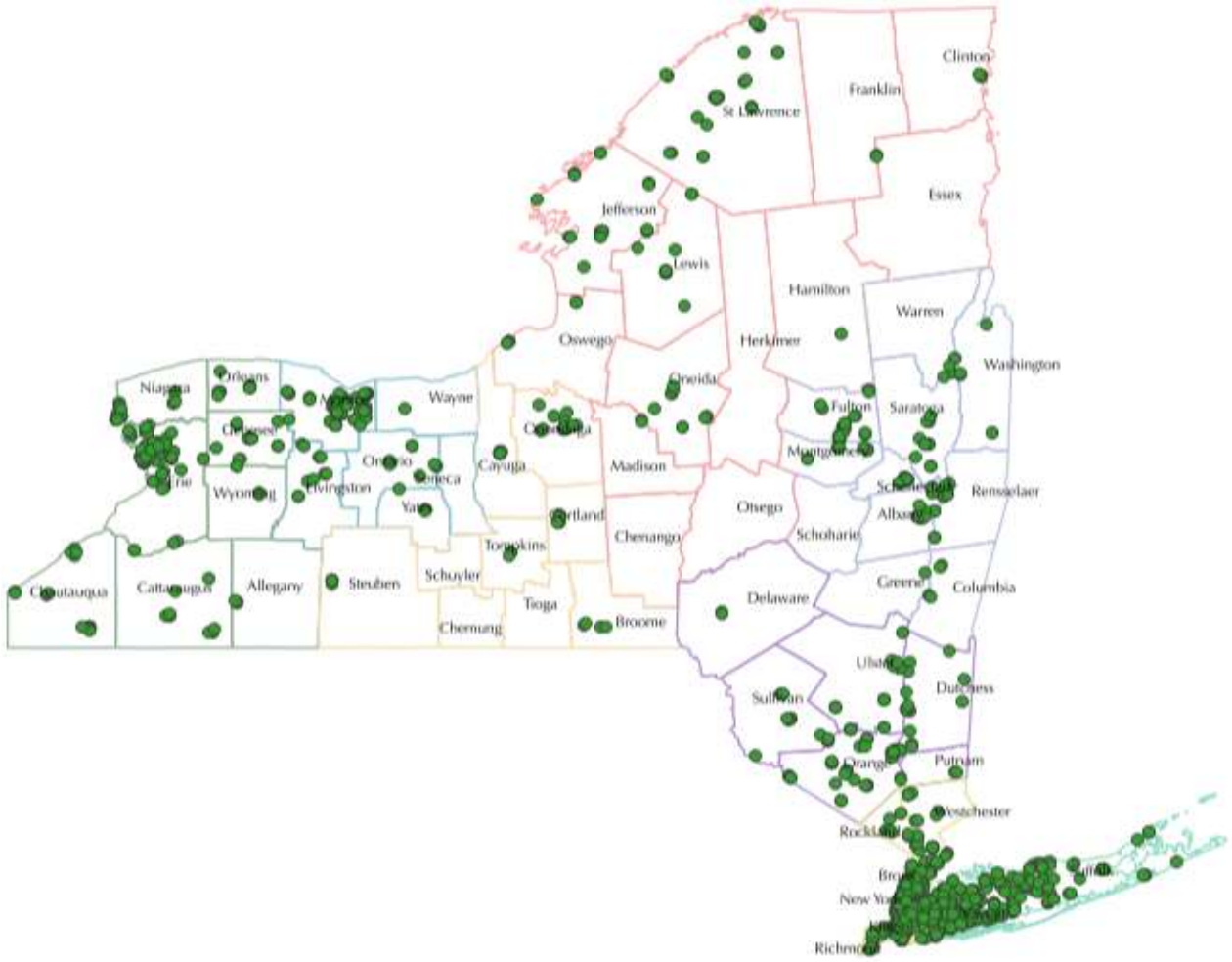
Appendix

Detail: NYS PCMH 12 new "core" criteria

	Code	Criteria
Behavioral health	CC9	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
	KM4	Conducts BH screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety B. Alcohol Use Disorder C. Substance Use Disorder D. Pediatric Behavioral Health Screening E. PTSD F. ADHD G. Postpartum Depression
Care management and coordination	CM3	Applies a comprehensive risk - stratification process to entire patient panel in order to identify and direct resources appropriately
	CC8	Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care
	CM9	Care plan is integrated and accessible across settings of care
	CC19	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
	KM11	Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2) A. Target pop. health mgmt. on disparities in care B. Address health literacy of the practice C. Educate staff in cultural competence
Health IT	AC8	Has a secure electronic system for two-way communication to provide timely clinical advice
	AC12	Provides continuity of medical record information for care and advice when the office is closed
	CC21	Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): RHIO, Immunization Registry, Summary of care record to other providers or care facilities for care transitions
	TC5	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies
VBP	QI19	The practice is engaged in Value-Based Contract Agreement[1].

1 A value-based program where the clinician/practice receives an incentive for meeting performance expectations but do not share losses if costs exceed targets.

NYS PCMH Enrollment Status – September 2018



DFS Regions

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

NEW YORK STATE OF OPPORTUNITY. Department of Health