NEW YORK STATE OF OPPORTUNITY. Department of Health

Workforce Workgroup

Meeting # 4

February 24, 2016

Welcome and Introductions

NEW YORK STATE OF OPPORTUNITY. Department of Health

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:00 – 10:10	Patrick Coonan & Wade Norwood, Co-Chairs
2	Subcommittee One Report Out	10:10 – 11:10	Wade Norwood
3	Update on New Committee Being Formed	11:10 – 11:20	Patrick Coonan
4	Subcommittee Report Out	11:20 – 12:20	Jean Moore
5	DSRIP Update	12:20 – 12:40	Peggy Chan
6	SIM Update	12:40 – 1:00	Hope Plavin

Subcommittee Report Out

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Care Coordination Subcommittees of DSRIP/SHIP Workforce Workgroup

Workgroup survey found consensus on need to "develop core competencies and/or training standards for workers in care coordination titles"

Three subcommittees convened to focus on different aspects of effective care coordination

- **Subcommittee 1**: Identification of core competencies and functions and regulatory barriers that could impede effective care coordination
- **Subcommittee 2:** Identification of curricular content for educating the health workforce on core concepts in care coordination (embedded in health professions education curricula and to use for continuing education)
- **Subcommittee 3:** Identification of recommended core curriculum for training workers in care coordination titles

Subcommittee One

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Subcommittee One Charge:

Advance Workgroup goals by:

- Delineating key care coordination competencies and functions;
- Maintaining a commitment to warranted variations based on patient population, clinical service lines and differing staffing patterns; and
- Identifying statutory/regulatory barriers that could impede the provision of care coordination services

Subcommittee One Membership

Chairs: Wade Norwood & Doug Lentivech

- Lloyd Sederer (OMH)
- Tim Johnson (GNYHA)
- Robin Frank (HANYS)
- Katie Gordon (HANYS)
- Gary Fitzgerald (Iroquois)
- John August (Cornell)
- Helen Schaub (1199)
- Sergio Matos (CHW of NY)
- Karen Nelson (Maimonides)
- Judith Mazza (HEALTH)
- Bill Ebenstein (CUNY)
- Nicole Haggerty (OMH)
- Melissa Harshbarger (OMH)

What Have We Done So Far?

Subcommittee Teleconference #1: Level set charge and define terms

Offline Coordination Teleconference #1: Build a common set of functions to be used by all 3 subcommittees

Subcommittee Teleconference #2: Discuss preliminary set of functions and preliminary set of licensed titles

Offline Coordination Teleconference #2: Engage relevant NYSED Board Secretaries to build a common vision

Our Operational Definitions

Title - Signifies an official position or a professional or academic qualification.

We propose using the terms “Licensed,” “Certified” and “Lay” to describe the different types of health workers that could, with varying degrees of supervision, be involved in effective care coordination

Function – A category or group of logically associated tasks that are carried out by one or more professions, titles and/or roles (e.g., Diagnose)

Task – A defined piece of work associated with a function (e.g., Blood Test)

Current Set of Functions

Make appointment reminder calls to patients or oversee automated process
Lead daily huddles
Provide information via portal
Review appointment history and follow up as needed
Document preventive / chronic care services since last visit
Verify and update missing preventive / chronic care services
Update social history
Verify and update demographic information (address, phone, etc.)
Verify and update insurance information
Verify information in referrals and test requisitions (insurance coverage, address, phone, etc.)
Assist with visit documentation
Assist patient in preparing questions for clinician
Gather history during visit
Document history
Interpretation for patient
Ensure Patient Compliance
Patient education/health coaching/patient self-management
Review clinician recommendations with patient
Track and follow up on completion of referral visits, tests & procedures
Set up next office visit appointment for patient
Make appointments with specialists or for procedures for patient
Make follow up care coordination phone calls
Transmit documents to specialists or facilities
Communicate with external case / disease managers
Teach-back to ensure patient learning
Scan documents into EHR
Complete orders and document
Update structured data in EHR
Communications (contact with patients via calls/emails, route patient calls/emails to appropriate staff, review communications from facilities in re patients, track time in establishing appointments)
Complete/document review of systems (update patient registry)
Population Management (data reports based on patient registry, mail relevant information to patients, outreach with no-show appointments, review reports in re unfilled patient prescriptions)

Early Lessons Learned

The set of functions selected is somewhat arbitrary – we had to start with something.

The difference between a function and a task is just as debatable; as a result, we stopped debating it.

We are well served by “eating the elephant one bite at a time.” We will start with the Licensed health workers but will identify barriers the impede effective care coordination by Certified and Lay workers.

This is not an easy task for the subcommittee and we expect our need for full Workgroup engagement will be around “the very not easy tasks.”

Scope of Licensed Titles

Medicine
. Physicians
. Physician Assistants
. Specialist Assistants

Midwifery

Nursing
. Registered Professional Nurses
. Nurse Practitioners
. Clinical Nurse Specialists
. Licensed Practical Nurses

Social Work
. Licensed Master Social Worker (LMSW)
. Licensed Clinical Social Worker (LCSW)

Next Steps

Report Statutory/Regulatory Barriers for Licensed Titled workers to Subcommittee

Determine Scope of Certified and Lay Titled workers for Analysis

Report Statutory/Regulatory Barriers Certified and Lay Titled workers to Subcommittee

Deliver Subcommittee report on Statutory/Regulatory Barriers for all “in-scope workers” to full Workgroup for review and refinement

Receive and, as needed, incorporate recommendations from other subcommittees with regard to workforce preparation and/or on-going development

Subcommittee Two

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Subcommittee Two

Chaired by: Patrick R. Coonan, EdD, RN, NEA-BC, FACHE

Focus: Identification of curricular content for educating the health workforce in core concepts in care coordination (embedded in health professions education curricula and for continuing education of existing health care professionals).

Goal: To describe the recommended curriculum to use for educating health professions students and the existing health workforce in the core concepts of care coordination. The curriculum should be designed to provide a basic understanding of what care coordination is and the roles that health workers can play to support effective care coordination in their patient population. The initial focus will be on the following health professions: registered nurses, physicians, physician assistants and nurse practitioners. Subsequently, strategies for training other professions and occupations will be considered, including social workers, pharmacists, and medical assistants, among others.

Status: The committee will be convened to include members of the Workforce Workgroup as well as non-members from representative educational institutions and societies from across the state. Targeting a meeting in late March 2016.

Subcommittee Three

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Care Coordination Subcommittees of DSRIP/SHIP Workforce Workgroup

Workgroup survey found consensus on need to "develop core competencies and/or training standards for workers in care coordination titles"

- Three subcommittees convened to focus on different aspects of effective care coordination
  - Subcommittee 1: Identification of core competencies and functions and regulatory barriers that could impede effective care coordination
  - Subcommittee 2: Identification of curricular content for educating the health workforce on core concepts in care coordination (embedded in health professions education curricula and to use for continuing education)
  - **Subcommittee 3: Identification of recommended core curriculum for training workers in care coordination titles**

Subcommittee Three Charge

- To review curricula used by groups across the state for training workers in care coordination titles
- To examine overlap in core content of these training programs
- To identify key curricular components to include in all basic training programs for workers in care coordination titles

Subcommittee Members

- Heather Eichen, State University of New York
- Shawna Trager, New York Alliance for Careers in Healthcare
- Sandi Vito, 1199SEIU/League Training & Upgrading Fund
- Tracey Leonard, Fort Drum Regional Health Planning Organization
- Bill Ebenstein, City University of New York
- Jean Moore, Center for Health Workforce Studies
- Carol Rodat, Paraprofessional Healthcare Institute
- Johney Barnes, Office of Mental Health
- Alexandra Blais, Home Care Association of NYS

Care Coordination Curricular Review Process

- Primary focus of curricula review:
  - CUNY Credited Course Sequence in Care Coordination and Health Coaching
  - New York Alliance for Careers in Healthcare Training
  - North Country Care Coordination Certificate Program
  - 1199SEIU Care Coordination Fundamentals
- National literature searches on care coordination training were conducted as these curricula were being developed
- The review found a great deal of consistency in content across the different training curricula

Core Curriculum Guidelines Developed

- Consists of 9 modules
- Modules include topics, learning objectives and resources
- Estimated time to complete modules is between 36-45 hours
- Considered the ‘starting point’
- Designed to be adapted to fit local circumstances
  - Could be embedded in medical assistant or home health aide training
  - Could serve as a base for care coordination training worth college credit

Summary of Modules

- Introduction to New Models of Care and Health Care Trends
- Interdisciplinary Teams
- Person-Centeredness and Communication
- Chronic Disease and Social Determinants of Health
- Cultural Competence
- Ethics and Professional Boundaries
- Quality Improvement
- Community Orientation
- Health Information Technology, Documentation and Confidentiality

Reference Materials

- List of and links to (where available) all training programs reviewed
- Resources
  - Textbooks
  - Supplemental readings
  - Documentaries/programs
  - On-line resources

Questions and comments

For discussion

1. Feedback on content?
2. What strategies could support the adoption of these guidelines?
3. What are the best approaches to update the guidelines to reflect changes in care coordination functions?

DSRIP Update

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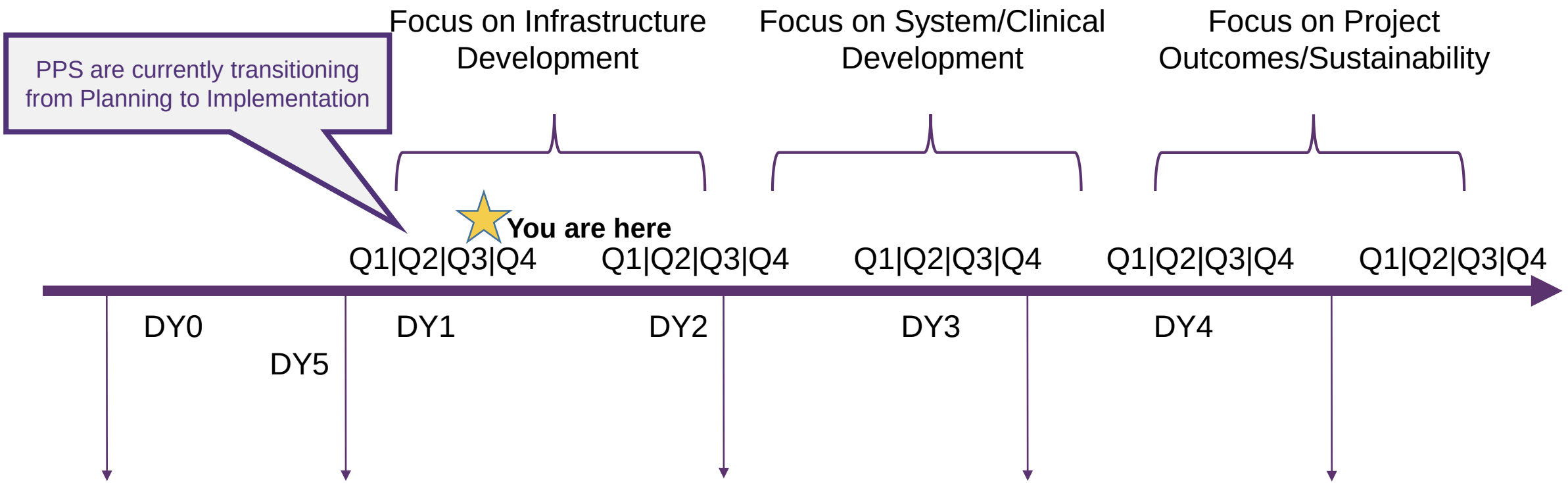
DSRIP Implementation Timeline and Key Benchmarks



- Submission/Approval of Project Plan

- PPS Project Plan Valuation
- PPS first DSRIP Payment
- PPS Submission and approval of Implementation Plan
- PPS Submission of First Quarterly Report

Domain 3: Clinical Improvement P4P Performance Measures begin

Domain 2: System Transformation P4P Performance Measures begin

Domains 2 & 3 are completely P4P

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Workforce Deliverables, Achievement Values, & Deadlines

Milestone / Deliverable	AV Driving?	Prescribed Reporting / Completion Date
Workforce Strategy Spending	Yes	Baselines: DY1, Q4 Actuals: DY1, Q4 and subsequent Q2 and Q4
Workforce Staff Impact Analysis (Redeployment/Retraining)	Yes	Baselines: DY2, Q1 Actuals: DY2, Q2 and subsequent Q2 and Q4
Workforce New Hire Analysis	Yes	Baselines: DY2, Q1 Actuals: DY2, Q2 and subsequent Q2 and Q4
Milestone #4: Produce a Compensation and Benefits Analysis	Yes	DY1: DY2, Q1 DY3: DY3, Q4 DY5: DY5, Q4
Milestone #1: Define target workforce state (in line with DSRIP program's goals)	No	None – Suggested completion date of DY2, Q1
Milestone #2: Create a workforce transition roadmap for achieving your defined target workforce state.	No	None – Suggested completion date of DY2, Q2
Milestone #3: Perform detailed gap analysis between current state assessment of workforce and projected state.	No	None – Suggested completion date of DY2, Q2
Milestone #5: Develop training strategy.	No	None – Suggested completion date of DY2, Q2

Workforce Achievement Values

- Domain 1 Organizational AVs are based on the completion of Current period milestones and updates on milestones to be completed or already completed
- Each of the four Domain 1 Organizational AVs related to the Workforce section of the Quarterly Report can be earned by completing the following:

Workforce Strategy Budget Updates

Based on the Workforce Strategy Budget commitment made in the Project Plan Application (*semi-annual Q2 & Q4 reporting*)

Workforce Impact Analysis and Updates

Provides details on the workforce impact and placement impact for redeployed, retrained and newly hired staff (semi-annual Q2 & Q4 reporting)

New Hire Employment Analysis and Updates

Provides details on the number and types of new hires (semi-annual Q2 & Q4 reporting)

Compensation & Benefits Analysis

Captures a snapshot in time and examines workforce trends within each PPS (DY2 Q1, DY3 Q4, DY5 Q4)

DSRIP PPS Workforce Budget Overview

- Each PPS submitted a Workforce Budget as part of their PPS application.
- The Workforce Budget commitments were part of the application scoring which drove the total potential PPS award.
- The Workforce Budget commitment made by each PPS is binding and is tied to Achievement Values that govern semi-annual payment amounts.
- PPSs are to expend for workforce analyses, training/retraining, redeployment, and recruitment.
- Adjustments have been made to allow PPSs more flexibility in timeframes for expenditures so long as 90% of total budget is accounted for by the end of DY4.

DSRIP Year	Spending Requirement
DY1	80% of DY1 spending commitment**
DY2	80% of cumulative DY1 + DY2 spending commitment
DY3	85% of cumulative DY1 + DY2 + DY3 spending commitment
DY4	90% of total spending commitment

DSRIP Staff Impact and New Hire Analysis Overview

- PPS are required to provide details on annual staffing impact resulting from DSRIP project implementation.
  - Baselines: DY2, Q1
  - Actuals: DY2, Q2 and subsequent Q2 and Q4

- Staff Impact reporting will be entered into a matrix of Job Titles vs. Facility Types.
- These tables will be built into MAPP for PPS reporting.

Required data elements for measuring and reporting Staff Impact

Year	Facility Type (defined list)	Job category (defined list)	New hires, #	Redeployed, #	Retrained, #	Other, #	Full placement (≥95% comp.), #	Partial placement (≥75% and <95% comp.), #
DY1	Inpatient	Nurse practitioners	6	14	3	2	4	15
		Registered nurses	17	83	24	12	30	84
DY1	Hospital Article 28 Outpatient Clinic	Nurse practitioners	2	3	3	1	4	3
		Registered nurses	4	16	5	7	8	20

all numbers and data elements in this table are intended for illustrative purposes only

All DSRIP years

Reporting for all defined Facility Types

Reporting for all defined Job Titles

Job Titles and Facility Types

Where possible, job titles crosswalk to 2010 Standard Occupational Classification *(see Appendix for full list)*

Physicians
Primary Care
Other Specialties (Except Psychiatrists)
Physician Assistants
Primary Care
Other Specialties
Nurse Practitioners
Primary Care
Other Specialties (Except Psychiatric NPs)
Midwives
Nursing
Nurse Managers/Supervisors
Staff Registered Nurses
Other Registered Nurses (Utilization Review, Staff Development, etc.)
LPNs
Other
Behavioral Health (Except Social Workers providing Case/Care Management, etc.)
Psychiatrists
Psychologists
Psychiatric Nurse Practitioners

Behavioral Health (Except Social Workers providing Case/Care Management, etc.) (cont'd)
Licensed Clinical Social Workers
Substance Abuse and Behavioral Disorder Counselors
Other Mental Health/Substance Abuse Titles Requiring Certification
Social and Human Service Assistants
Psychiatric Aides/Techs
Other
Nursing Care Managers/ Coordinators/Navigators/Coaches
RN Care Coordinators/Case Managers/Care Transitions
LPN Care Coordinators/Case Managers
Social Worker Case Management/ Care Management
Bachelor's Social Work
Licensed Masters Social Workers
Social Worker Care Coordinators/Case Managers/Care Transition
Other

For each job title, workforce impact will be reported against the most appropriate Facility Type below:

- **Outpatient Behavioral Health (Article 31 & Article 32)**
- **Article 28 Diagnostic & Treatment Centers**
- **Article 16 Clinics (OPWDD)**
- **Home Care Agency**
- **Hospital Article 28 Outpatient Clinics**
- **Inpatient**
- **Non-licensed CBO**
- **Nursing Home/SNF**
- **Private Provider Practice**

DSRIP Compensation and Benefits Analysis Overview

- The purpose of the Compensation & Benefits Survey is to capture a *snapshot in time* and examine workforce trends within each PPS in order to:
  - Inform education and training requirements for PPSs and their partners,
  - Guide retraining for redeployed workers and employee support programs, and
  - Advance health care workforce research and policy development while demonstrating DSRIP impact.
- PPS are required to complete this analysis for DY1, DY3, and DY5 (i.e., start, mid-point, and end of DSRIP)
- A sample data grid is shown here for collecting information about all Job Titles of workers at each facility:

Facility code	Facility Type (select from defined list)	Job category (select from defined list)	Individuals Employed, #	Vacancies/ Intend to fill, #	Average cash compensation rate, $	Benefits, as a percentage of compensation	CBA* Status, Y or N
Hospital A123	Inpatient	Nurse practitioners	88	4	$48.56	27%	N
		Registered nurses	1,263	163	$37.98	27%	Y
Hospital B123	Hospital Article 28 Outpatient Clinic	Nurse practitioners	44	6	$45.19	29%	N
		Registered nurses	767	21	$33.13	29%	N

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**CBA = Collective Bargaining Agreement*

The required set of data elements to be collected and reported by all PPS can be found in the appendix.

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Example Table for Compensation and Benefits Analysis

- A sample data grid is shown here for Aggregating collected data by Job Title

Job Title: Registered Nurse										
Organization Category	Number organizations	Number CBA* organizations	Number employees	Number of vacancies	Position vacancy rate	25th percentile average cash comp. rate, $	Mean average cash comp. rate, $	Median average cash comp. rate, $	75th percentile average cash comp. rate, $	Benefits, as % of average comp.
All organizations	124	14	1797	107	5.95%	$30.23	$36.92	$37.31	$39.24	26%
Outpatient Behavioral Health (Article 31 & 32)	15	2	31	6	1.94%	$30.51	$28.97	$29.78	$29.58	22%
Article 28 Diagnostic & Treatment Centers	33	2	423	10	2.36%	$29.34	$29.01	$31.20	$29.88	24%
Article 16 Clinics (OPWDD)	7	1	29	3	10.34%	$30.61	$30.65	$30.99	$29.93	27%
Home Care Agency	6	2	18	2	11.11%	$30.44	$31.46	$31.58	$30.39	25%
Hospital Article 28 Outpatient Clinics	19	2	79	29	36.71%	$31.31	$29.62	$29.73	$31.26	27%
Inpatient	6	3	1057	51	4.82%	$28.77	$29.57	$29.45	$30.23	28%
Non-licensed CBO	9	0	22	2	9.09%	$30.52	$31.18	$28.91	$31.60	24%
Nursing Home/SNF	7	4	109	3	2.75%	$30.37	$30.39	$30.43	$30.06	26%
Private Provider Practice	27	0	29	1	3.45%	$29.72	$31.30	$31.15	$29.12	28%

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Examples of PPS Collaboration on Workforce

PPS	Initiative	Impact	Next Steps
Maimonides Medical Center, NYU Lutheran Medical Center, St Barnabas Hospital and New York City Health and Hospital's Corporation (HHC)	PPSs met to discuss workforce assessment strategy and created a single workforce survey through a joint vendor contract	Intend to streamline data collection across overlapping partners and reduce cost through a city-wide approach on workforce current state	Challenges include high cost, limited on-the-ground vendor support, difficulty in identifying PPS-specific impacts, and citywide needs of New York City Health and Hospital's Corporation.
Adirondack Health Institute, Inc.	Partnered with SUNY, the Center for Health Workforce Studies, the Hudson Mohawk Area Health Education Center, and the Northern Area Health Education Committee for a program called RP2. RP2 is designed to address current health workforce gaps and meet future needs through the creation of regional workforce groups that include educators, employers and others	The initiative resulted in a regional training resource directory that will be updated by the PPS Workforce Committee. In addition, a standardized Care Management/Coordination curriculum with credentialing/certificate provision is being considered for the region. Individuals who participated in the RP2 meetings were invited to participate in AHI PPS workforce efforts by joining the Workforce Advisory Council.	The Workforce Advisory Council meets quarterly with meetings planned for March, June, September and December generally via webinar. In addition, AHI, SUNY, Center for Health Workforce Studies, Hudson Mohawk Area Health Education Center and Northern Area Health Education Center meet quarterly with other upstate PPS workforce representatives to share information and identify other means to collaborate.
Maimonides Medical Center, New York and Presbyterian Hospital, Bronx-Lebanon Hospital Center, St Barnabas Hospital, Advocate Community Partners and New York Health and Hospital's Corporation (HHC)	Participated in multi-PPS meetings to discuss workforce assessment strategy and the possibility of creating a single workforce survey to be administered by a preferred vendor(s) identified through a collaborative RFP / proposal review process.	Streamlined data collection across overlapping partners and reduction in cost with borough-wide (e.g., one approach in Brooklyn) approach to assessment of current workforce state.	Developing follow up plans to address challenges, including high cost, limited on-the-ground vendor support, difficulty in identifying PPS-specific impacts, and citywide needs of New York City Health and Hospital's Corporation (HHC) PPS and Advocate Community Partners PPS

Questions?

DSRIP e-mail:
dsrip@health.ny.gov

SIM Update

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New York State Health Innovation Plan (SHIP)

Goal	**Delivering the Triple Aim –** *Healthier people, better care and individual experience, smarter spending*		
Pillars	**Improve access to care for all New Yorkers, without disparity** Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	**Integrate care to address patient needs seamlessly** Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it	**Make the cost and quality of care transparent to empower decision making** Information to enable individuals and providers to make better decisions at enrollment and at the point of care
	Pay for health care value, not volume Rewards for providers who achieve high standards for quality and individual experience while controlling costs	**Promote population health** Improved screening and prevention through closer linkages between primary care, public health, and community- based supports	
Enablers	**Workforce strategy**	**A**	Matching the capacity and skills of our health care workforce to the evolving needs of our communities
	Health information technology	**B**	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation
	Performance measurement & evaluation	**C**	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation

State Health Innovation Plan/State Innovation Model

Advanced Primary Care

- Goal is a multipayer approach to aligned care/payment reform focused on primary care that:
  - Achieves (works to achieve) triple aim goals
  - Engages practices, patients, and payers
  - Builds on evidence, experience, existing demonstrations, PCMH
  - Is sustainable
    - Not ‘just’ a grant program
  - Is supported by HIT/HIE, workforce, access
  - Is statewide
  - Combines care and payment reform

Progress: Thanks to our Integrated Care Workgroup and Stakeholder Inputs

- Broad consensus on practice capabilities (and approach to measure/determine)

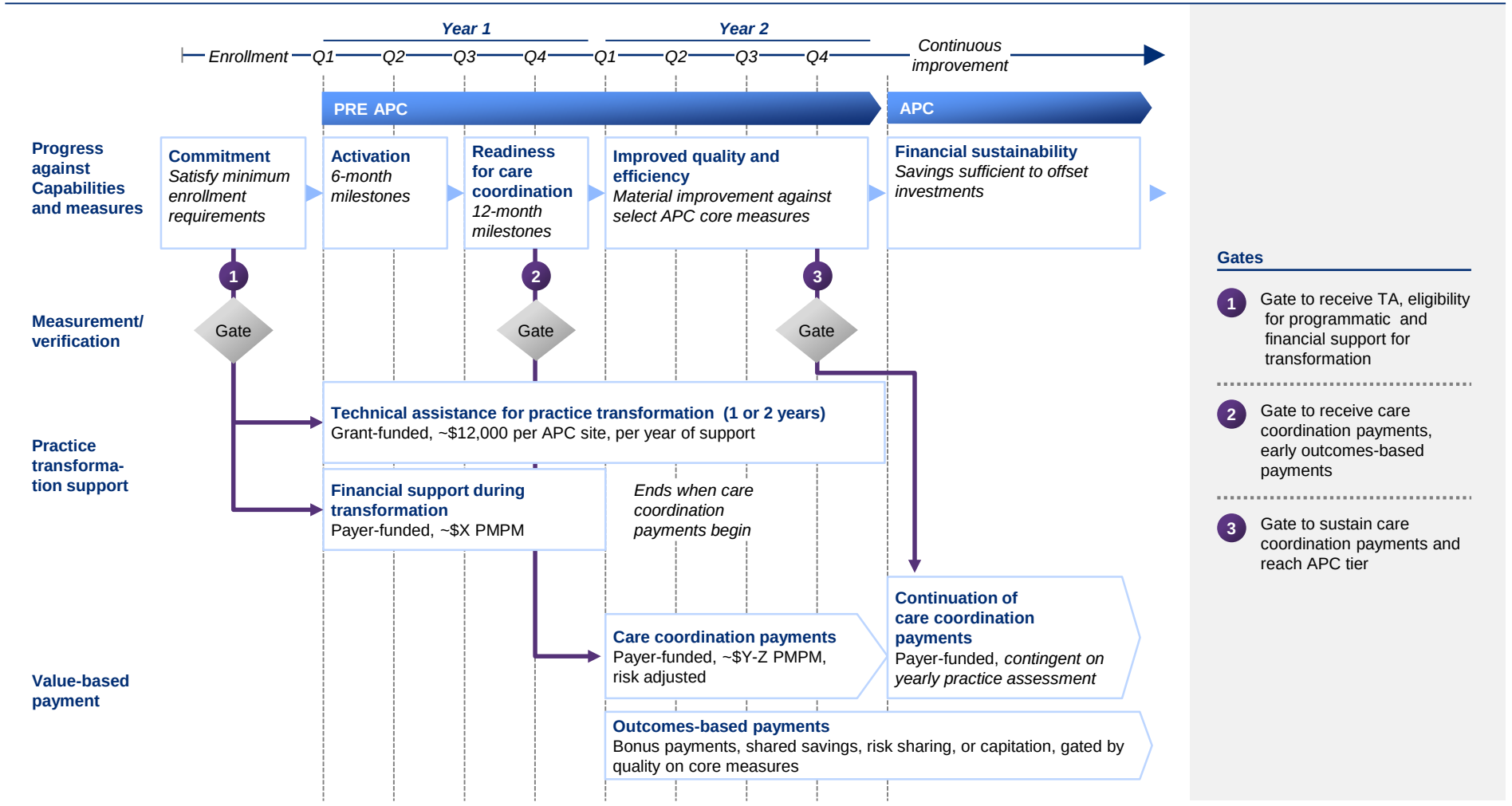
- Finite set of shared ‘core’ measures (currently ~20)
  - Non-FFS payments depend on measures/performance

Approach to aligned payment support
- technical support to practices
- care management support from payers
- value/outcome based payments

APC Capabilities

Category	Description
Patient-centered care	▪ Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
Population Health	▪ Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment
Care management/ coordination	▪ Manage and coordinate care across multiple providers and settings by actively tracking the sickest patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and tracking and optimizing transitions of care
Access to care	▪ Promote access as defined by affordability, availability, accessibility, and acceptability of care across all patient populations
HIT	▪ Use health information technology to deliver better care that is evidence-based, coordinated, and efficient
Payment model	▪ Participate in outcomes-based payment models, based on quality and cost performance, for over 60% of the practice's patient panel
Quality and performance	▪ Measure and actively improve quality, experience, and cost outcomes as described by the APC core measures in the primary care panel

Updated path to APC over time for practices starting out



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APC structural milestones

DRAFT

	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 >50 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 Prevention Agenda ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to self-management programs
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
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[2] contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing3 contracts with APC-participating payers representing 60% of panel

Technical specifications can be found in pre-read

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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

11 measures are proposed for inclusion in our V1.0 scorecard (target launch July 2016)

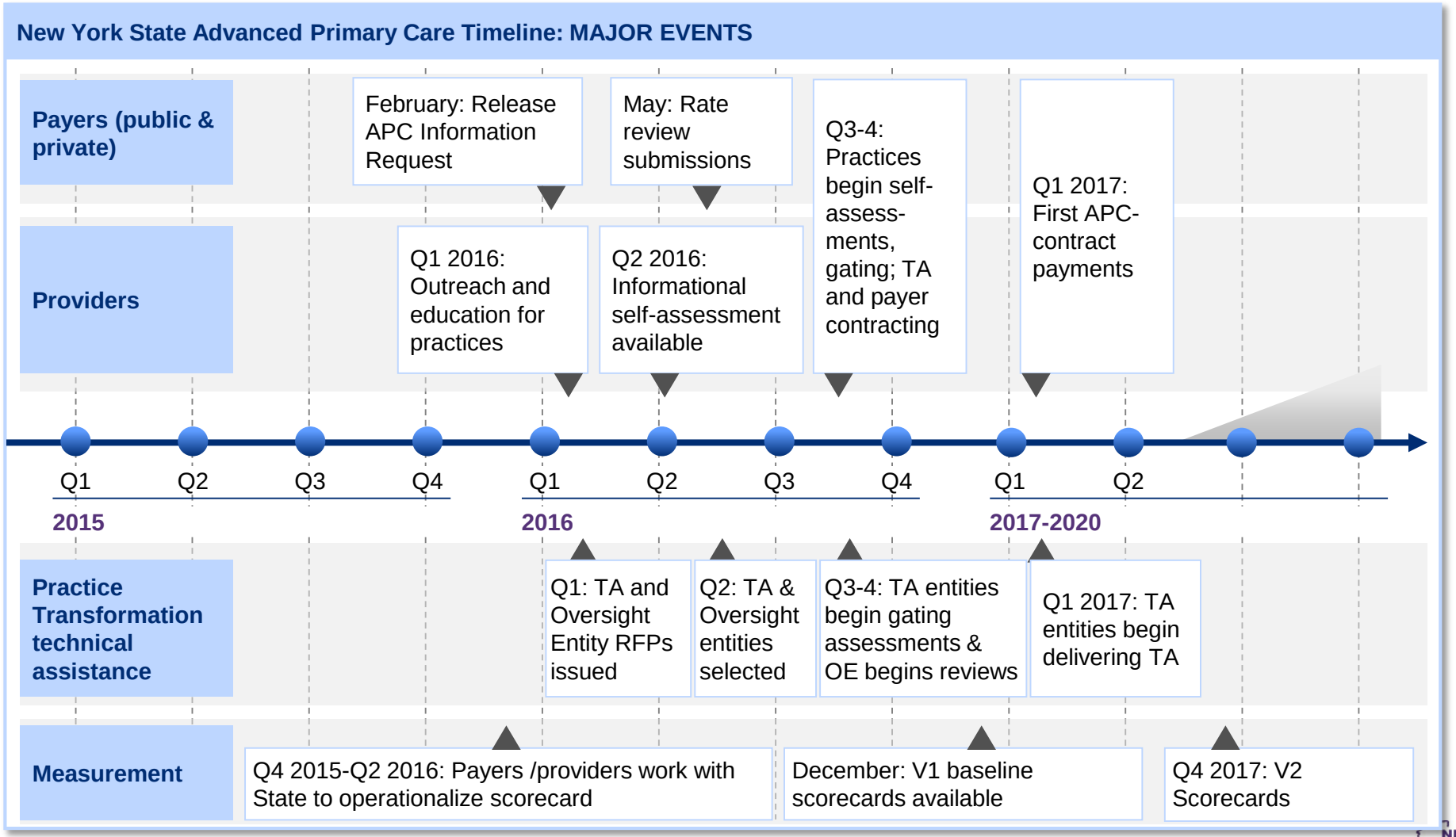
(#) Current V1.0 candidates

✓ Claims-only is possible

Categories	Measures	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	✓	✓	
	2 Chlamydia Screening	✓	✓	
	3 Influenza Immunization - all ages	✓	✓	✓
	4 Childhood Immunization (status)	✓	✓	
	5 Fluoride Varnish Application	✓		
Chronic disease	6 Tobacco Use Screening and Intervention	✓	✓	
	7 Controlling High Blood Pressure	✓	✓	
	8 Diabetes A1C Poor Control	✓	✓	
	9 Medication Management for People with Asthma	✓	✓	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	✓	✓	
BH / Substance abuse	11 Depression screening and management	✓	✓	
	12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓		
Patient reported	13 Record Advance Directives for 65 and older	✓	✓	
	14 CAHPS Access to Care, Getting Care Quickly			✓
Appropriate use	15 Use of Imaging Studies for Low Back Pain	✓		
	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
	17 Avoidable Hospitalization	✓		
	18 Avoidable readmission	✓		
	19 Emergency Dept. Utilization	✓		
Cost	20 Total Cost Per Member Per Month	✓		

NEW YORK STATE OF OPPORTUNITY. Department of Health

Overview of 2016 major events leading to full Jan 2017 implementation



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Questions and Discussion

For additional information on SIM, SHIP, and APC:

- SHIP/SIM website: https://www.health.ny.gov/technology/innovation_plan_initiative/
- APC materials -- under Integrated Care Workgroup: https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm
- SIM inbox: sim@health.ny.gov

DSRIP Appendices

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Appendix: Full List of Job Titles

- Where possible, job titles crosswalk to 2010 Standard Occupational Classification

Physicians
Primary Care
Other Specialties (Except Psychiatrists)
Physician Assistants
Primary Care
Other Specialties
Nurse Practitioners
Primary Care
Other Specialties (Except Psychiatric NPs)
Midwives
Nursing
Nurse Managers/Supervisors
Staff Registered Nurses
Other Registered Nurses (Utilization Review, Staff Development, etc.)
LPNs
Other
Clinical Support
Medical Assistants
Nurse Aides/Assistants
Patient Care Techs
Clinical Laboratory Technologists and Technicians
Other
Behavioral Health (Except Social Workers providing Case/Care Management, etc.)
Psychiatrists
Psychologists
Psychiatric Nurse Practitioners

Behavioral Health (Except Social Workers providing Case/Care Management, etc.) (cont'd)
Licensed Clinical Social Workers
Substance Abuse and Behavioral Disorder Counselors
Other Mental Health/Substance Abuse Titles Requiring Certification
Social and Human Service Assistants
Psychiatric Aides/Techs
Other
Nursing Care Managers/ Coordinators/Navigators/Coaches
RN Care Coordinators/Case Managers/Care Transitions
LPN Care Coordinators/Case Managers
Social Worker Case Management/ Care Management
Bachelor's Social Work
Licensed Masters Social Workers
Social Worker Care Coordinators/Case Managers/Care Transition
Other
Patient Education
Certified Asthma Educators
Certified Diabetes Educators
Health Coach
Health Educators
Other

Non-licensed Care Coordination/Case Management/Care Management/Patient Navigators/Community Health Workers (Except RNs, LPNs, and Social Workers)
Care Manager/Coordinator
Patient or Care Navigator
Community Health Worker
Peer Support Worker
Administrative Staff -- All Titles
Executive Staff
Financial
Human Resources
Other
Administrative Support -- All Titles
Office Clerks
Secretaries and Administrative Assistants
Coders/Billers
Dietary/Food Service
Financial Service Representatives
Housekeeping
Medical Interpreters
Patient Service Representatives
Transportation
Other
Janitors and cleaners

Health Information Technology
Health Information Technology Managers
Hardware Maintenance
Software Programmers
Technical Support
Other
Home Health Care
Certified Home Health Aides
Personal Care Aides
Other
Other Allied Health
Nutritionists/Dieticians
Occupational Therapists
Occupational Therapy Assistants/Aides
Pharmacists
Pharmacy Technicians
Physical Therapists
Physical Therapy Assistants/Aides
Respiratory Therapists
Speech Language Pathologists
Other

Appendix: Required Data Collection Elements for Compensation & Benefits Analysis

- **The following are required data elements for measuring and reporting Compensation & Benefits:**
  - Number employees
  - Number vacancies / intend to fill
  - Compensation rate (mean, median, 25th & 75th percentile)
    - *Note: The PPS should collect average compensation rate for each job title at a given facility, and then the PPS's aggregate reporting over all facilities should provide the mean, median, 25th & 75th percentile of these average compensation rates*
  - Benefits as a percentage of compensation
  - Collective Bargaining Agreement (CBA) status
  - For only the "Non-licensed Care Coordination" category:
    - Is there a degree requirement?
    - If yes, what is/are the minimum degree requirement(s)?
  - For each Job Title, PPSs will report in aggregate across all organizations as well as for each Facility Type