NEW YORK STATE OF OPPORTUNITY. Department of Health

Workforce Workgroup Meeting #7

March 6, 2017

Timing	Topic	Lead
10:00 – 10:15	Welcome, Introductions, Agenda and Meeting Goals	Wade Norwood/Dr. Jean Moore
10:15 – 11:10	Subcommittee Reports & Workforce-related Updates ▪ Subcommittee #1 Barriers to Effective Care Coordination ▪ Subcommittee #2 Care Coordination Curriculum ▪ Subcommittee #5 BH Integration and Primary Care ▪ Subcommittee #4 Healthcare Data ▪ Updates	Wade Norwood Thomas Burke Amy (Jones) Renaud Dr. Jean Moore Lisa Ullman
11:10 – 11:40	DSRIP Update ▪ Questions and Answers	Peggy Chan
11:40 – 11:50 11:50 – 12:20 12:20 – 12:30	Sharing Other Good Things that are Happening ▪ Rural Residency Program and Q&A ▪ Inter-professional Education and Q&A ▪ APC Update and Q&A	Thomas Burke Dr. Mark Taubman Ed McNamara
12:30 – 12:55	Next Steps	Wade Norwood/Dr. Jean Moore
12:55 – 1:00	Adjournment	Wade Norwood/Dr. Jean Moore

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Subcommittee #1
Barriers to Effective Care Coordination Report

Wade Norwood

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Charge: Identification of core competencies and functions and regulatory barriers that could impede effective CC

Subcommittee Membership:

Wade Norwood, Finger Lakes Health System Agency, (Chair)
NYS Education Department, Dough Lentivech, (Co-chair)

Cornell University, John August
City University of New York, Bill Ebenstein
Iroquois Healthcare Alliance, Gary Fitzgerald
Hospital Assoc. of NY State, Robin Frank
Hospital Assoc. of NY State Katie Gordon
NYS Off of Mental Health, Melissa Harshbarger
NYS Off of Mental Health, Nicole Haggerty
Greater NY Hospitals Assoc., Tim Johnson
Monroe Community College, Anne Kress
Comm Health Workers Assoc. of NY, Sergio Matos
NYS Department of Health, Judith Mazza
Maimonides Medical Center, Karen Nelson
Local 1199, Helen Schaub
NYS Office of Mental Health, Lloyd Sederer

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Recap from Last Meeting

- Doug presented updated CC Scope Grid
- Recommendations from WW for enhancing the grid
- Sergio presented on CHWs' role
- Discussed subcommittee's plan to use its work path to move to Phase II
- Phase II - Prioritize statutory, regulatory, scope of practice and reimbursement barriers

Activities since last meeting:

CHW:

- Meeting with Sergio for more in-depth discussion of CHW role
- Developed better understanding of the importance, depth and breadth of CHW functions and roles
- Identified the need for further discussions with NYSDOH

Regulatory, Statutory, Scope of Practice & Reimbursement Barriers:

- Formal request sent to the WW membership requesting regulatory, statutory, scope of practice and reimbursement barriers
- None received
- Recommendation from a WW member to compile the list of barriers for the WW's consideration
- Compiled a preliminary list of barriers
- List serves as a starting point for subcommittee's vetting process

Activities since last meeting cont'd:

- 14 barriers were identified
  - -9 categorized as regulatory
  - -5 categorized as reimbursement
- Identified desired outcomes for barriers
- Identified rationale for desired outcomes

Next Steps:

- Expectation that more barriers will be identified and added
- In the process of scheduling our next subcommittee meeting
- Purpose of the meeting is to discuss and enhance the draft list of barriers
- Complete a final list of barriers
- Obtain approval from the subcommittee, WW and HIC

QUESTIONS?

Subcommittee #2
Care Coordination
Curriculum Report

Thomas Burke

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Charge: Identification of curricular content for educating the health workforce on core concepts in CC (embedded in health professions education curricula and to use for continuing education)

Membership is comprised of representatives from academic, practice, and professional association sectors:

- Adelphi University, Dr. Patrick Coonan, (Chair)
- NYS Department of Health, Thomas Burke (Interim Chair)
- Albany College of Pharmacy & Health Sciences, Greg Dewey
- American College of Physicians, Lisa Noel
- City University of New York, Dr. William Ebenstein
- Medical Society of the State of New York, Lisa Harring
- Monroe Community College, Dr. Andrea Wade
- New York State Society of Physician Assistants, Daniel Forsberg
- Northwell Health, Deirdre Duke
- NYS Department of Health, Angella Timothy
- University of Rochester School of Medicine, Dr. Mark Taubman

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Progress to Date:

- Three meetings were held
- Delineated responsibilities
- Completed review of guidelines from DSRIP/SIM CC Guidelines Subcommittee
- Reviewed research of other best practices topics
- Compiled a reference list
- Small group of four subcommittee members was convened
- Goal of this group is to recommend a draft list of cc competencies

Next Steps:

- Present draft cc competencies to subcommittee during week of 4/17
- Draft will be vetted by the full subcommittee
- Present draft to SIM/DSRIP Workforce Workgroup
- Develop goals and identify metrics
- Obtain stakeholder buy-in
- Develop specific method for disseminating the curriculum

Challenges:

- Literature is constantly being revised
- Identifying goals and metrics to evaluate success
- How to mitigate metrics challenge
- Curriculum is recommended not mandated

QUESTIONS?

Subcommittee #5

Behavioral Health & Primary Care Integration Report

Amy (Jones) Renaud

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Charge: Identification of barriers & solutions to implementing integrated behavioral health and primary care services

Subcommittee Membership:

NYS State Department of Health, Margaret Adeigbo
Hospital Association of NY State, Victoria Aufiero
Cornell University, John August
NYS Office of Mental Health, Johney Barnes
United Hospital Fund, Greg Burke
NYS Office of Mental Health, Danielle Chapman
NY Assoc. of Alco & Sub Abuse, John Coppola
City University of New York, William Ebenstein
Fort Drum Regional Health Planning Org, Tracey Leonard
NYS Office of Mental Health, Crystal Scalesci
NYS Department of Health, Angella Timothy
NYS Department of Health, Eric Zasada
NYS Office of People with Develop. Disabilities, Virginia Scott-Adams
NYS Office of Alco & Sub Abuse, Julia Fesko
NYC Dept of Health & Mental Hygiene, Myla Harrison
NYS Off of People with Dev Disab, Dianne W. Henk
NYS Department of Health, Priti Irani
NYS Office of Mental Health, Amy (Jones) Renaud
St. Jo Treat & Recov Center, Katie Kirkpatrick
Local 1199, Sam Krinsky
MVP Health Plan, Inc., Peggy Leonard
NYS Office of Mental Health, Lloyd Sederer
NYS Office of Mental Health, Lloyd Sederer
Assoc. Medical Schools of New York, Jo Widerhorn

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Next Steps:

- Focus on workforce issues related to the integration of BH (Mental Health and Substance Use) and Primary Care
  - Multiple reform initiatives focused on this area

- First Task: Determine what workforce resources we have and identify gaps
  - Complete a grid of BH & PC staff that handle tasks related to the provision of BH services
    - Screening for BH, Diagnosing, Assessing and Treatment Planning, Care Management, and Treatment (Therapy)

  - Align the grid with State Education Scopes of Practice and existing Care Coordination grid

Next Steps cont'd

- Identify barriers to integrating physical and behavioral health services
  - Regulations
  - Scope limitations
  - Reimbursement barriers
- Provide recommendations to training programs to incorporate integrated care into curricula: MD, NP, RN, SW, etc.
- Identify needs for continuing education of existing workforce to enable them to provide integrated care
  - Core competencies and recommended trainings for BH Care Managers

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QUESTIONS?

Subcommittee #4
Healthcare Data

Dr. Jean Moore

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Discussion

Proposed Health Care Regulation Modernization Team (RMT)

Lisa Ullman

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Proposed Health Care Regulation Modernization Team (RMT)

- RMT proposal in the Executive Budget
- RMT charge
- Appointment of up to 25 voting members
- Composition of proposed RMT membership
- RMT process
- Proposed date for RMT to begin work and to submit recommendations to the Governor's Office

NEW YORK STATE | Department of Health | Medicaid Redesign Team

SIM/DSRIP Full Workforce Workgroup Meeting

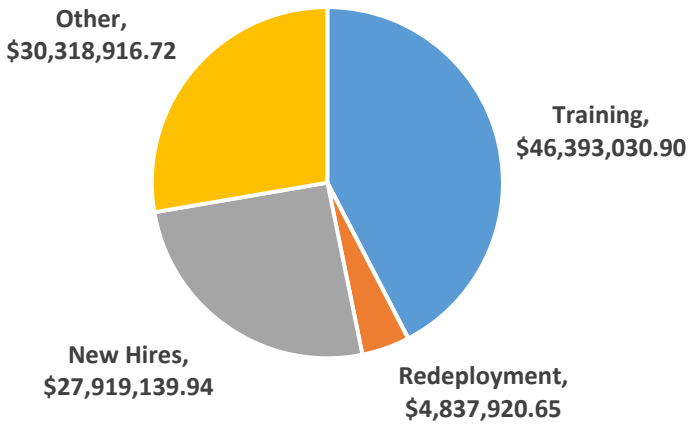
DSRIP Update

March 6, 2017

Workforce Deliverables and Deadlines

Milestone / Deliverable	AV Driving?	Prescribed Reporting Period / 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: DY1 and DY2 Q1 Projections: DY1-DY5 Actuals: DY1, DY2 Q2 and subsequent Q2 and Q4
Workforce New Hire Analysis	Yes	Baselines: DY1 and DY2 Q1 Projections: DY1-DY5 Actuals: DY1, 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

DSRIP Workforce Spending DY1 – DY2Q2



$109.5M

Spent by PPS

$116.2M

Spending commitment

Other includes:

- Workforce Vendor Subcontracting
- Compensation and Benefit Report Development
- Scholarships

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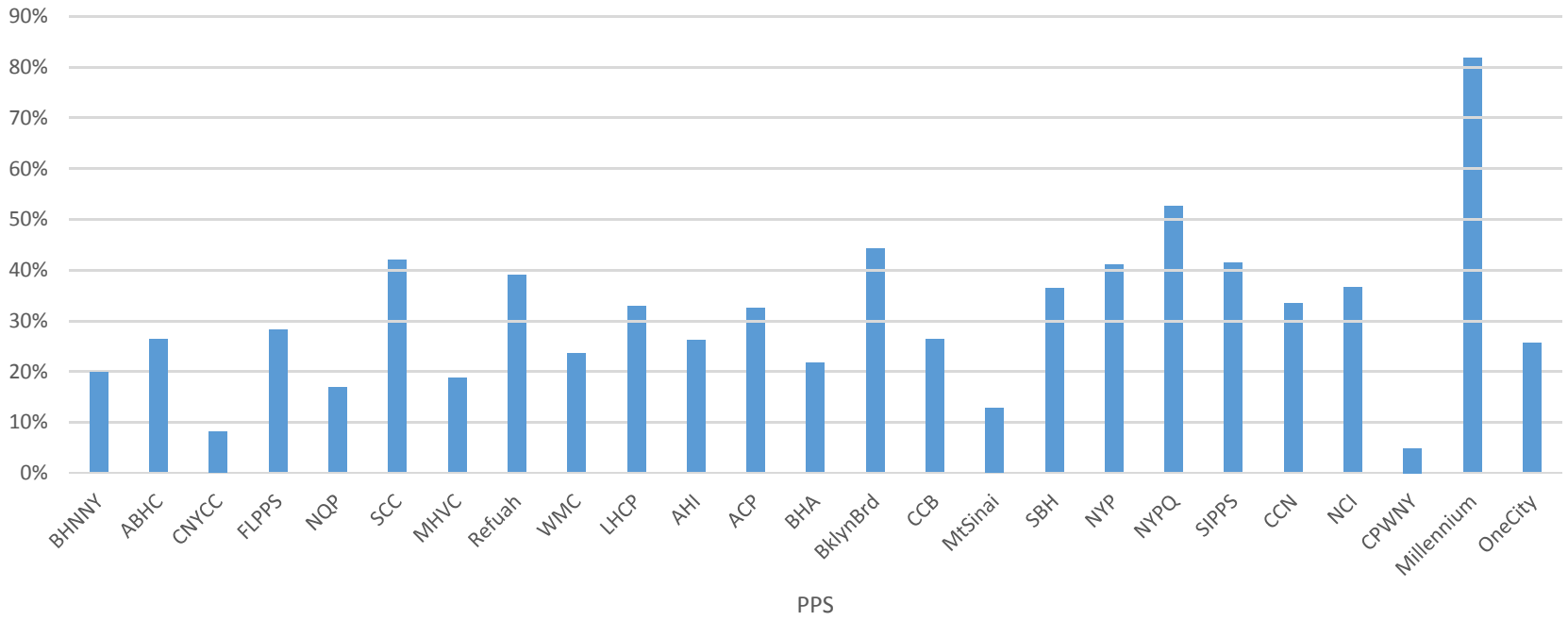
Progress Toward Total Five Year PPS Workforce Spending Commitment as of DY2 Q2



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PPS Progress Toward DY2Q4 Spending Commitment

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Summary of Vacancy Rate Snapshots

Vacancy rates for positions varied among the PPS, even in overlapping regions. This may be explained by the responses and response rate provided by the participating providers in the PPS network as well as other local attributes of the provider network.

PPS Snapshots:

- **There were six PPS who had 12 or more job titles with vacancy rates over 8%**
  - **Four Upstate**
  - **Two New York City**

Top job titles where PPS had vacancies above 8%:

- **Primary Care MDs – 12 PPS**
- **Psychiatrists – 12 PPS**
- **Primary Care NPs – 16 PPS**
- **Psychiatric NPs – 17 PPS**

Top emerging titles where PPS had vacancies above 8%:

- **Peer Support – 16 PPS**
- **CHWs – 9 PPS**
- **RN Care Coordinators – 11 PPS**
- **Care/Patient Navigators – 12 PPS**

UPDATED Summary Snapshot: High Vacancy Rates by Job Title

Number of PPSs with 8%+ Vacancy Rates, by Job Title

Job Title	# of PPSs with 8%+ Vacancy Rate
Primary Care Physician	12
Primary Care Nurse Practitioner	16
Psychiatric Nurse Practitioner	17
Staff Registered Nurse	8
Licensed Practical Nurse	8
RN Care Coordinators/Case Managers/Care Transitions	11
Psychiatrist	13
Psychologist	4
Medical Assistant	8
Social and Human Service Assistants	5
Substance Abuse and Behavioral Disorder Counselors	7

Job Title	# of PPSs with 8%+ Vacancy Rate
Nursing Aide/Assistant	9
Certified Home Health Aide	5
Personal Care Aide	6
Licensed Clinical Social Worker	14
Bachelor's Social Worker	3
Licensed Master's Social Worker	9
Social Worker Care Coordinator/Case Manager/Care Transition	6
Care Manager / Coordinator	8
Care or Patient Navigator	12
Community Health Worker	9
Peer Support Worker	16

Note: 23 PPS submitted vacancy rate data

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Summary Snapshot: PPSs with High Vacancy Rates

Number of Job Titles with 8%+ Vacancy Rates, by PPS

PPS	# of Job Titles with 8%+ Vacancy Rate
Suffolk Care Collaborative	0
Nassau Queens PPS	5
Advocate Community Partners	8
NYU Lutheran PPS	10
Maimonides Medical Center	14
SBH Health System	15
New York-Presbyterian/Queens	8
OneCity Health PPS	7
Alliance for Better Health Care	10
Albany Medical Center Hospital	9
Bronx Health Access	1

PPS	# of Job Titles with 8%+ Vacancy Rate
Central NY Care Collaborative	9
Finger Lakes PPS	12
Montefiore Medical Center	5
WMCHealth PPS	9
Bassett PPS	12
Adirondack Health Institute	14
Care Compass Network	8
North Country Initiative	16
Community Partners Western NY	11
Millennium Care Collaborative	9
Mount Sinai	7
New York-Presbyterian	8

Note: Only 23 PPSs submitted vacancy rate data
Note: Only 22 key job titles were considered for this analysis

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March 6, 2017

PAOP Mid-Point Assessment Presentations
Workforce Highlights

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Collaboration with Arthur Ashe Institute for Urban Health (CCHL)

Step 1
- Arthur Ashe aligned the training strategy with our PPS's approach to CCHL and the Brooklyn Community Needs Assessment (developed with Maimonides, HHC and NYAM).

Step 2
- Arthur Ashe interviewed key community-based partners to assess their training capacities and capabilities relative to the needs of the populations they serve.

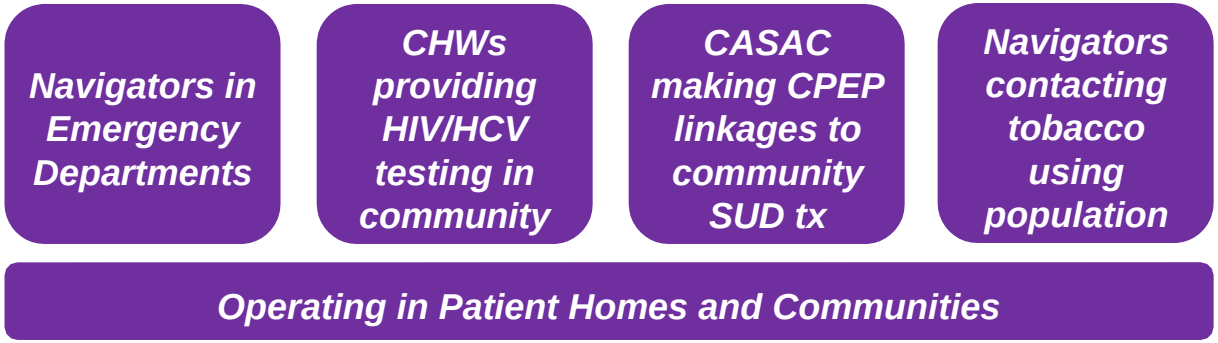
Step 3
- Arthur Ashe created the NYU Lutheran PPS's Cultural Competency and Health Literacy Training Strategy, which was approved by the PPS's Executive Committee.

Step 4
- Next steps: *Implementation of Cultural Competency and Health Literacy Training Strategy*

NYU Lutheran
NYU LANGONE HEALTH SYSTEM

PPS Innovations: What is New for Patients?

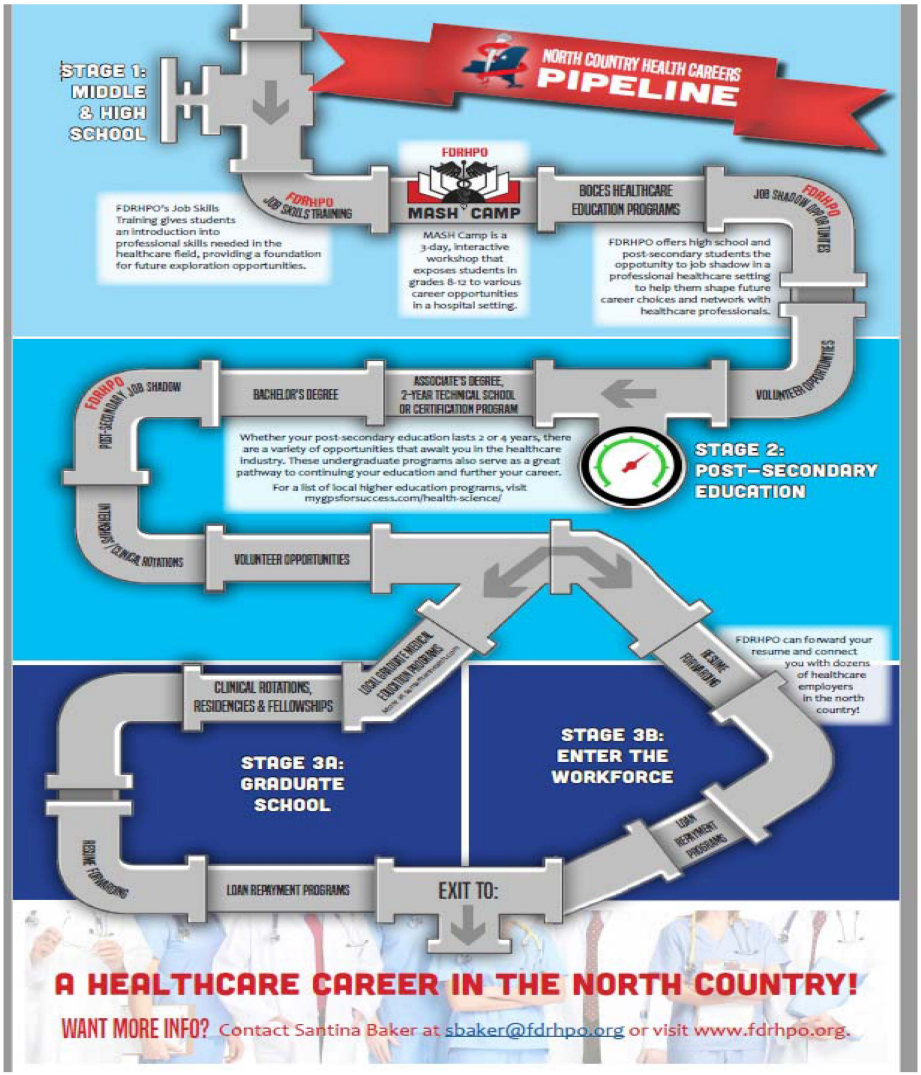
43 Patient Navigators, Community Health Workers, Peers, and other Field-Based Staff working across a variety of settings



NewYork-Presbyterian
Performing Provider System

Workforce

- **Leveraging Long-term Pipeline**
  - *Career exploration programs*
- **Collaborating with Institutions of Higher Education**
  - *Bachelors & Masters Programs at community college (i.e. Nurse Practitioner & Social Worker)*
  - *Development of North Country Care Coordination Certificate Program with SUNY Jefferson & SUNY Canton*
- **Customized Training Videos** *(DSRIP 101, Blood Pressure Measurement, Health Literacy & MEB, Medicaid Health Home, Care Transitions)*
- **Provider Incentive Programs**
  - *Approximately $3 million for recruitment of 8 Primary Care Physicians, 6 Family Nurse Practitioners, 2 Psychiatric Nurse Practitioners, 5 Physician Assistants, 2 Psychologists, 2 Psychiatrists, 2 Dentists, 4 Certified Diabetes Educators (growth), 1 Licensed Clinical Social Worker (growth) & 6 Licensed Clinical Social Worker-R (5 growth, 1 recruit)*
- **Regional Expansion of Graduate Medical Education**
  - *Partner hospital – recipient of Rural Residency GME Grant. PPS providing support of residency spots at local GME Program with rotations at regional sites. Minimum 3 year service commitment to region*


NORTH COUNTRY HEALTH CAREERS
PIPELINE
STAGE 1:
MIDDLE
& HIGH
SCHOOL
FDRHPO
JOB SKILLS TRAINING
FDRHPO's Job Skills Training gives students an introduction into professional skills needed in the healthcare field, providing a foundation for future exploration opportunities.
FDRHPO
MASH CAMP
MASH Camp is a 3-day, interactive workshop that exposes students in grades 8-12 to various career opportunities in a hospital setting.
BOCES HEALTHCARE EDUCATION PROGRAMS
FDRHPO
JOB SHADOW OPPORTUNITIES
FDRHPO offers high school and post-secondary students the oppotunity to job shadow in a professional healthcare setting to help them shape future career choices and network with healthcare professionals.
VOLUNTEER OPPORTUNITIES
ASSOCIATE'S DEGREE, 2-YEAR TECHNICAL SCHOOL OR CERTIFICATION PROGRAM
BACHELOR'S DEGREE
FDRHPO
POST-SECONDARY JOB SHADOW
Whether your post-secondary education lasts 2 or 4 years, there are a variety of opportunities that await you in the healthcare industry. These undergraduate programs also serve as a great pathway to continuing your education and further your career.
For a list of local higher education programs, visit mygpsforsuccess.com/health-science/
STAGE 2:
POST-SECONDARY
EDUCATION
INTERNSHIPS / CLINICAL ROTATIONS
VOLUNTEER OPPORTUNITIES
FDRHPO can forward your resume and connect you with dozens of healthcare employers in the north country!
RESUME FORWARDING
LOAN REPAYMENT PROGRAMS
CLINICAL ROTATIONS, RESIDENCIES & FELLOWSHIPS
STAGE 3A:
GRADUATE
SCHOOL
STAGE 3B:
ENTER THE
WORKFORCE
RESUME FORWARDING
LOAN REPAYMENT PROGRAMS
EXIT TO:
A HEALTHCARE CAREER IN THE NORTH COUNTRY!
WANT MORE INFO? Contact Santina Baker at sbaker@fdrhpo.org or visit www.fdrhpo.org.

Suffolk Care Collaborative

ACHIEVEMENTS: WORKFORCE DEVELOPMENT & TRAINING

- Partnered with Nassau Queens PPS, the Long Island Health Collaborative and the Center for Suburban Studies at Hofstra University to deliver a **Cultural Competency and Health Literacy (CC&HL) Training** program. **60** Master Trainers and **122** workforce staff have been trained as of January 2017.
- SCC Facilitated **17** OASAS Certified SBIRT Training Sessions across **9** Suffolk County Hospitals, resulting in **238** staff across hospitals and PCP sites, completed training and received OASAS SBIRT Certifications.
- Community Health Worker Training for staff engaged in our Asthma Home Environmental Trigger Assessment Program curricula provided by the Association for Asthma Educators, developed by **Certified Asthma Educators**.
- Partnership with North Carolina Center for Excellence in **Integrated Care** in design of Primary Care & Behavioral Health Integrated Care Education Series and Implementation for participating provider practices.
- Care Coordination & Transition Management (**CCTM**) from the American Academy of Ambulatory Care Nursing certification effort initiated September 2016 for roughly **25** Nurses across all **11** Hospitals participating in TOC Project.
- Over **80** Directors of Nursing across **44** Skilled Nursing Facility partners received an INTERACT Champion Certification in November of 2015 which kicked-off our program implementation efforts.
- **30** Care Management Organization staff training immersion at **Geisinger Health System**.
- **MAX** Series Participation in the Train-the-Trainer Program.

Workforce Transformation

Partnering with Hofstra University to develop an online CCHL PPS wide training and a Population Health Certification Program	Trained Nassau County Police Force on mental health first aid and training of all new Probation Officers	Trained 26 RN's, care managers & coordinators on care coordination and population health	175 primary care physicians & their staff received training on behavioral health integration or cardiovascular disease (e.g. Million Hearts Campaign)	Over 50 SNF Leaders attended a day long INTERACT training, & have subsequently launched web based INTERACT modules for the whole facility

Training & Developing the Community Workforce

Through DY2Q3…
- BPHC has developed 29 courses delivered to 781 trainees across the PPS
- 27 CBOs have registered staff to participate in these courses

Training Programs in Cultural Responsiveness: DY2Q4 – DY3

Programs for segments of BPHC workforce:

1. Leaders as change agents for cultural responsiveness
2. Cultural affirming care for frontline staff
3. Cultural competency & the social determinants of health for practitioners: promotes behaviors & attitudes that enhance patient-provider communication & trust

Programs based on PPS community needs

4. Train-the-trainer for CBOs to educate community members on community health literacy topics (obtaining health insurance & navigating health care system)
5. Patient-centered care for immigrant seniors addresses behavioral & psychosocial issues

Raising cultural competency for the frontline:

6. Knowledge & skills for recovery-oriented care for people with behavioral health conditions
7. Understanding cultural values for home health workers
8. Poverty simulation to experience how living in poverty effects health behaviors and to influence policy changes

Celebrating Graduates

New York City Council Member Ritchie Torres and Ousman Laast, Office of U.S. Senator Kirsten Gillibrand, celebrating Peer Leaders & CHWs trained by Health People (Diabetes Self Management) and a.i.r. bronx (Asthma Home Based Self Management)

Providing Cultural Responsiveness Training

- The Jewish Board
- NYC Human Resource Administration's Office
- Immigrant Health and Cancer Disparities Service
- Healthlink NY
- People Care
- New York Association of Psychiatric Rehabilitation Services
- Regional Aid for Interim Needs (R.A.I.N)
- Selfhelp Community Services

BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

A Trained Workforce is a Transformed Workforce

Higher Education Partnerships

- Created CHW & Care Management Credit Certificate Programs at College of Staten Island (CSI)
- $300,000 in Scholarships for PPS Partners
- Held CSI PPS Partner Day to discuss:
  - Future Curriculum Needs
  - Internships
  - Development of Hiring Pipeline

Training Scope

xG Health Care Management Training

- Engaging home care and hospital staff including nurses and physicians on transitions of care and chronic disease management:
  - COPD, Diabetes, Heart Failure

INTERACT

- All 10 Skilled Nursing Facilities trained on INTERACT
- 22 Certified INTERACT Facility Site Champions

Palliative Care Training

- Comprehensive Palliative Care training implemented All
- Participation from 10 Skilled Nursing Facilities

1199 TEF

- 22 different training courses offered

LEAN Training

- SI PPS sponsored LEAN education series for all partners
- PPS partners using LEAN for process redesign

Training Outcomes

- Over 15,000 hours of PPS partner training
- Partners and CBOs fully engaged in training
- 1,000 participants surveyed

Outcomes

- Improved patient access to clinical and social services
- Process improvement
- Improved communication and understanding

BRONX HEALTH ACCESS

Sustainable Projects and Initiatives

1. **Care Coordination, High Utilizers.**
2. **Diabetes and Asthma Programs.**
3. **Creating New Initiatives to Meet Pay for Performance Measures.**
4. **Workforce Transformation.**

1. Building Knowledge

i. Cultural Competency & Health Literacy Trainings
ii. DSRIP 101
iii. Diabetes Self-Management Program Training

2. Building Skills

i. CASAC program
ii. Language of Care – Spanish for Healthcare workers
iii. Medical Assistant Training

3. Creating Opportunities

i. Community Health Worker Apprenticeship
ii. Bilingual RN Program
iii. HIV Peer Certification

Supporting a More Integrated Workforce

- ***Trainings Utilize a Train-The-Trainer (TTT) Model***

  Once trained, participants commit to providing a minimum of 2 trainings/year
  - 24 trainers have completed Brief Action Planning
  - By March, 12 trainers will complete Motivational Interviewing
  - Through 2017, an additional 50 trainers for Care Management and 3 trainers enrolled in the MAX TTT program

- ***Increasing Primary Care Capacity for the Region***
  - Launching a Nurse Practitioner residency program in Sept 2017
  - 18 – 24 Nurse Practitioners over 4 years
  - Placements in FQHC's, Behavioral Health and Primary Care sites
  - MHVC covers tuition costs and preceptor costs

- ***Partnering w/ Regional Colleges to Design Future Workforce***
  - 6 Meetings w/ local colleges to define future curriculum needs

- ***Promoting Health Equity***
  - All trainings include a module that relates to cultural competency
  - Supporter of the Blueprint for Health Equity, 3 events held in 2016, 7 planned for 2017
  - Cultural Competency TTT program in 2017 for up to 60 trainers

Montefiore HUDSON VALLEY COLLABORATIVE

QUESTIONS?

SIM Rural Residency Program

Thomas F. Burke

NEW YORK STATE OF OPPORTUNITY. Department of Health

Rural Residency Program

- Goal/Objectives – increase number of primary care physicians practicing in rural communities to support the SHIP through creation of **new** primary care residency programs in rural communities

- SIM – provides seed-funding to assist health care organizations to invest in the creation of residency programs that will be accredited by the end of the grant period

- Funding through a Request for Application (RFA) process – matched by organizational/community support:

  - program staff
  - costs to become accredited
  - curriculum development
  - recruitment costs
  - the development of affiliation agreements with providers

Rural Residency Program

- Organizations will develop new programs or expand existing programs in new rural communities
- Identify a potential sponsor and hospital(s) for inpatient rotations
- Include community-based ambulatory care training sites
  - D&TC
  - Physician Practices
  - Local Health Departments
- Focus recruitment efforts on students/residents from rural communities

Rural Residency Program - Grantees

- Seven hospitals applied and ALL were funded
- Five Family Medicine, one Internal Medicine and one both Family and Internal Medicine programs
- Four Osteopathic and three Allopathic Medicine
- Three expand to new site(s), two create rural track and two create brand new program
- When fully implemented, programs will train between 84 to 93 residents annually
- SIM funding begins February 2017 for two years

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Discussion

Inter-professional Education

Dr. Mark Taubman

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Place holder

APC Update

Ed McNamara

What is APC?

- Statewide multi-payer approach to align care AND payment reform focused on primary care that:
  - Works to achieve triple aim goals
  - Engages practices, patients, and payers
  - Builds on evidence, experience, existing demonstrations, PCMH
  - Supports comprehensive, patient-centric primary care with coordinated care for complex patients
  - Fosters collaboration between primary care, other clinical care, and community-based services
  - Effectively utilizes HIT, including EHR, data analytics, and population health tools
  - Offers alternative payment models that support the services and infrastructure needed for advanced primary care

How is APC different from PCMH?

- Model is consistent with the principles of NCQA PCMH, but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes

Who Can Become APC?

- Internal Medicine, Family, and Pediatrics practice

APC Capabilities: Nothing Completely New or Unfamiliar

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 health of 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 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

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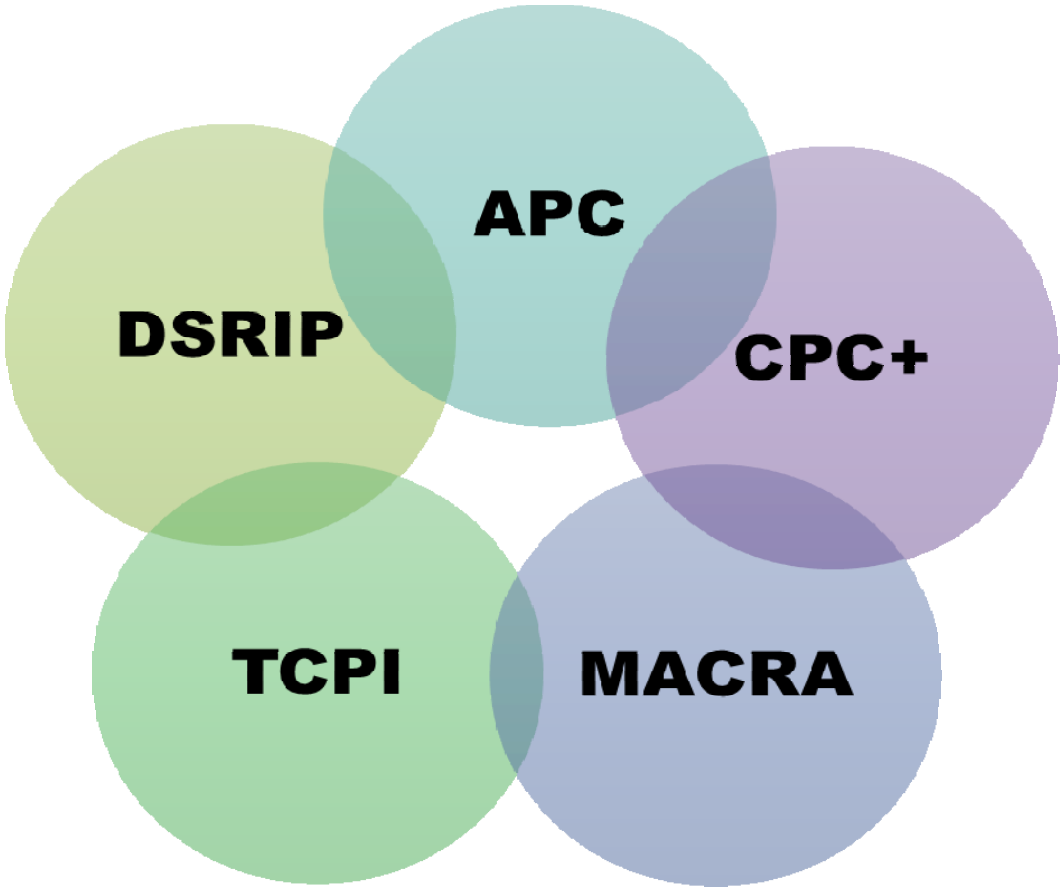
APC Structural Milestones

	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* **Prior milestones, plus …**	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 …**
Participation	i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year	i. Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	i. Process for Advanced Directive discussions with all patients	i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year	i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)
Population health			i. Participate in local and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs
Care Management/ Coord.	i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	i. Identify and empanel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral	i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health
Access to care	i. 24/7 access to a provider	i. Same-day appointments ii. Culturally and linguistically appropriate services	i. At least 1 session weekly during non-traditional hours
HIT	i. Plan for achieving Gate 2 milestones within one year	i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year	i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support
Payment model	i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	i. Minimum FFS with P4P contracts with APC-participating payers representing 60% of panel	i. Minimum FFS + gainsharing contracts with APC-participating payers representing 60% of panel

APC VBP Payment Goals

- Support primary care practices as they transition from FFS to VBP
- Support primary care practices as they put new services in place (advanced primary care) that are not reimbursed by FFS and which may, during the transition period, reduce revenue from FFS
- Create a viable payment replacement which rewards value using aligned metrics

Many programs: Working on Alignment



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APC Updates

- Technical Assistance (TA) vendor contracts awarded
- Independent Validation Agent (IVA)* to be procured
- Statewide practice transformation databased--finalized
- RFI for payers—released and analyzed, 1:1 meetings conducted
- Practice enrollment starts now

*Independent Validation Agent (IVA) is an entity to verify the transformation work from TA vendors and practices.

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TA Vendor Update

Goal is to:

- Support primary care practices to help them achieve the milestones in APC
  - TA vendor contracts awarded
  - Contracting in last stages of being finalized
  - TA vendor kickoff meeting conducted
  - Multiple TA on-boarding meetings planned
  - Future: Exchange of best practices with other transformation programs being discussed

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APC TA Vendors

Name of Awardee	Region
Adirondack Health Institute	Capital District and Adirondacks
CDPHP	Capital District
HANYS	Capital District and Long Island
Chautauqua County Health	Western (Buffalo)
Solutions 4 Community Health	Mid-Hudson Valley and Long Island
Institute for Family Health	**NYC**
IPRO	**NYC, Central NY (Syracuse) and Long Island**
Fund for Public Health in New York	**NYC**
Finger Lakes	Finger Lakes (Rochester) and Central NY (Syracuse)

Next Steps

Wade Norwood
Jean Moore

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Adjournment