

Redesigning
THE MEDICAID PROGRAM



NEW YORK MEDICAID REDESIGN

Workforce Flexibility and Change of Scope of Practice Work Group

October 3, 2011

Work Group Goals

Goals for October 3, 2011 Meeting:

- ☑ To familiarize members with the MRT process, timeframes and final MRT product formats.
- ☑ To provide members with background on topics related to the work group's charge.
- ☑ To identify priority workforce flexibility/scope of practice proposals that the work group wishes to pursue.

Work Group Goals (continued)

- ☑ To review, amend and adopt the MRT charge after brainstorming and prioritizing ideas.
- ☑ To begin to develop sub-groups to work on priority proposals and assign members to each group.

Overall Work Group Goal

- ☑ To develop consensus recommendations related to the Workforce Flexibility work group's charge and identify areas in statute, regulation and policy that will require change in order to implement the recommendations.
- ☑ Forward Workgroup recommendations to full Medicaid Redesign Team for consideration by November 15.

Work Group Charge

- ☑ This work group will develop a multi-year strategy to redefine and develop the workforce, to ensure that the comprehensive health care needs of New York's population are met in the future.
- ☑ The proposed strategy will include redefining the roles of certain types of providers and aligning training and certification requirements with workforce development goals. The objective will be to formulate consensus recommendations and identify areas in statute, regulation and policy that would require changes in order to implement them.

Work Group Charge (continued)

- ☑ The work group will consider proposals for implementation in FY 2012-2013 that would increase workforce flexibility, including those outlined in MRT 200.
- ☑ The goal should be to create a consensus product that both builds and redefines the workforce to allow New York to ensure that the comprehensive health care needs of our population are met in the future.
- ☑ The work group will discuss implementation of changes in health care settings outside the long term care sector, as well as changes to the scope of practice of advanced practice clinicians in all settings.

Work Group Charge (continued)

- ☑ This work is related to MRT recommendation #200, Change in Scope of Practice for Mid-level Providers to Promote Efficiency and Lower Medicaid Costs.
- ☑ Work group membership will include representatives of the State Education Department, New York State Nurses Association and other interested stakeholders.

Work Group Charge (continued)

- ☑ Smaller groups within this work group will focus on several issues:
 - *Permit nurses (under their scope of practice exemption) to orient/direct home health aides (HHAs) and personal care workers to provide nursing care as is currently allowed in the consumer-directed personal assistance program;*
 - *Allow licensed practical nurses (LPs) to complete assessments in long-term care settings;*
 - *Extend the use of medication aides into nursing homes;*
 - *Extend the scope of practice of HHAs to include the administration of pre-poured medications to both self-directed and non-self-directing individuals; and*
 - *Expand the scope of practice to allow dental hygienists to address the need for services in underserved areas.*

Miscellaneous Information

Items of Interest

- ☑ All meetings are open to the public.
- ☑ Meetings are recorded by conference call and posted to the Department's website .
- ☑ All meeting materials will also be posted on the website the day of the meeting www.health.ny.gov/
- ☑ Questions/comments can be sent to mrtworkforce@health.state.ny.us
- ☑ Everyone should introduce themselves and speak directly into the microphones.
- ☑ There is a dial-in number for the public (up to 300 people).
- ☑ A summary of the meetings will be posted after each meeting.

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MRT Process Overview

Presented by:

Karen Westervelt

Special Policy Advisor for Primary Care Development

October 3, 2011

Governor's Vision for Reform

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure." - **Governor Andrew M. Cuomo, January 5, 2011**

Governor's Vision for Reform

Governor Cuomo believes New York can do better:

- ☑ New York spends more than twice the national average on Medicaid on a per capita basis, and spending per enrollee is the second highest in the nation.
- ☑ New York ranks 21st out of all states for overall health system quality and ranks last among all states for avoidable hospital use and costs.
- ☑ Real reform must be pursued in collaboration with key stakeholders.

Governor's Solution = MRT

- ☑ On January 5, 2011, Governor Cuomo issued an Executive Order aimed at redesigning New York's outsized Medicaid program.
- ☑ The order called for the creation of a Medicaid Redesign Team (MRT) to uncover ways to save money and improve quality within the Medicaid program for the 2011-12 state budget.
- ☑ The MRT was also tasked with engaging stakeholders, Medicaid beneficiaries and citizens.
- ☑ Under MRT Phase 1, 73 proposals either have been implemented or are in process of being implemented.
- ☑ The Department of Health has been very actively engaged in implementation of these proposals.

MRT Phase 1: Bottom Line

- ☑ Reduces Medicaid spending by \$2.3 billion in FY 2011-12.
- ☑ Enacts a series of measures to both control costs in short term and enact longer-term reforms.
- ☑ Caps Medicaid spending growth in state law.
- ☑ Begins three-year phase-in to care management for all.

MRT Phase 2: Overview

- ☑ In Phase 2, the MRT was directed to create a coordinated plan to ensure that the program can function within a multi-year spending limit and improve program quality.
- ☑ The MRT has been subdivided into ten work groups.
- ☑ So far, all work groups have been formed and deliberations are in process.
- ☑ Each work group has a specific charge.
- ☑ All work groups involve stakeholders in their member composition.

(continued)

MRT Phase 2: Overview

The Work Groups:

- ☑ Managed Long Term Care Implementation and Waiver Redesign - *IN PROCESS*
- ☑ Behavioral Health Reform - *IN PROCESS*
- ☑ Program Streamlining and State/Local Responsibilities – *IN PROCESS*
- ☑ Payment Reform and Quality Measurement – *IN PROCESS*
- ☑ Basic Benefit Review – *IN PROCESS*
- ☑ Health Disparities – *IN PROCESS*
- ☑ Affordable Housing – *NEWLY LAUNCHED*
- ☑ Medical Malpractice – *TO BE FORMED*
- ☑ Health Systems Redesign: Brooklyn – *IN PROCESS*
- ☑ Workforce Flexibility/Change of Scope of Practice – *NEWLY LAUNCHED*

MRT Phase 2: Work Group Timeline

Work groups have met, or will meet, three to four times throughout the summer and into the fall.



The first “wave” of work groups will report to the MRT in late October or early November.



The second “wave” of work groups will report to the MRT in mid-November.



The third “wave” of work groups (launched in early August) will report to the MRT in early December.



Final MRT recommendations to be presented to Governor Cuomo for his consideration in his proposed FY 12-13 budget.

MRT Phase 2:

How the Public Can Get Involved

Each work group has a web page. All meeting materials will be published.

Each work group has an email address so that ideas can be shared.

Work group meetings will have dial-in phone options for members of the public who can't travel.

Work group meetings will be public.

MRT Final Product

- ☑ A summary of Phase 2 reforms and the approved recommendations of the ten work groups will go to the full MRT for consideration by early December.
- ☑ The full MRT will make recommendations to the Governor.
- ☑ This combined product will establish a comprehensive action plan for true Medicaid reform in New York State.
- ☑ The action plan may be turned into a comprehensive 1115 waiver to ensure that the state has sufficient flexibility to enact all of the reforms.

Redesigning
THE MEDICAID PROGRAM



Workforce Flexibility/Scope of Practice Workgroup MRT Proposal #200

Presented by:

Mary Ann Anglin

Office of Health Insurance Programs

October 3, 2011



MRT Proposal 200

This original proposal endorsed by the Medicaid Redesign Team is a reflection of several proposals from various stakeholders representing homecare, nursing and other associations, mostly impacting long term care settings:

- *Change in scope of practice for mid-level providers to promote efficiency and lower Medicaid costs.*



Current MRT Workforce Proposals (MRT #200) Part A

- Permit nurses (under scope of practice exemption) to orient/direct home health aides and personal care workers to provide nursing care as is currently allowed in the Consumer Directed Personal Assistance Program.
- Requires amendment of the following:
 - *NYS Nurse Practice Act, Education Law, Article 139, § 6908*
 - *Nurse Practice Exemption; and*
 - *Title 18 NYCRR § 505.28(b)(2) & (10) & (g).*

Recommended by: **Home Care Association (HCA)**



Current MRT Workforce Proposals (MRT #200) Part B

- Allow Nurse Practitioners to sign medical evaluations for adult care facilities and assisted living residences.
- Statutory authority provided by Chapter 168 of the Laws of 2011.
- Dear Administrator letter was issued August 31, 2011.

Recommended by: **Home Care Association (HCA)**



Current MRT Workforce Proposals (MRT #200) Part C

- Eliminate restrictions on nursing practice in adult homes.
- Requires amendment of the following:
 - *NYS Nurse Practice Act, Education Law, Article 139.*
 - *Title 18 NYCRR § 485.6.1 and § 486.1.*

Recommended by: **Home Care Association (HCA)**



Current MRT Workforce Proposals (MRT #200) Part D

- Allow LPNs to complete assessments in long term care settings.
- Requires amendment of the following:
 - *NYS Nurse Practice Act, Education Law, Article 139.*
 - *Title 10 NYCRR § 415.11; and*
 - *Title 10 NYCRR § 700.3.*

Recommended by:

Blossom South Nursing and Rehabilitation Center



Current MRT Workforce Proposals (MRT #200) Part E

- Extend the use of Medication Aides to nursing homes.
- Requires amendment of the following:
 - *NYS Nurse Practice Act, Education Law, Article 139, § 6908 – Nurse Practice Exemption; and*
 - *Title 10 NYCRR, §415.13.*

Recommended by: **SNYA and NYSHFA**



Current MRT Workforce Proposals (MRT #200) Part F

- Expand scope of practice for home health aides to include administration of pre-poured medications for both self-directing and non-self-directing individuals.
- Requires amendment of the following:
 - *NYS Nurse Practice Act, Education Law, Article 139, § 6908*
 - *Nurse Practice Exemption; and*
 - *Title 18 NYCRR, § 505.28.*

Recommended by: **Home Care Association (HCA)**

Adopted and Proposed Legislation – Health Care Workforce Scope of Practice

Workforce Flexibility Scope of Practice
Workgroup

Monday, October 3, 2011

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**NEW YORK STATE DEPARTMENT
OF HEALTH**

The Legislative Landscape

- 4 Enacted Legislative items in SFY 11-12 pertaining to scope of practice;
- 1 item vetoed;
- 13 Pending 2-house bills in 11-12 as of 9/13/11.
- 9 Pending 1-house bills

Enacted

- A4296A/S291 - Defines occupational therapy assistant and provides requirements for a license as an occupational therapy assistant
- A4579/S2985 - Demonstration program permitting pharmacists to collaborate with physicians on drug therapy in teaching hospitals & DTCs (not nursing homes);

Enacted, Cont'd

- S325/A1747 - Authorizes nurse practitioners to sign death certificates in like manner as physicians and imposes upon nurse practitioners the same duties as physicians related to such certificates;
- S2470/A1370 - Enacts the “safe patient handling act” and Task Force.

Vetoed

- A6539B/S4563A - amends Article 28 of the public health law by adding certain requirements for surgical technologists working in health care facilities.

Pending Two-House Bills

- A1537/S2766 (also A4867/S4731) - provides for the certification to practice as a certified registered nurse anesthetist anyone with a registered professional nursing license and the appropriate educational requirements.
- A2157/S3881 – Allows nurse practitioners to perform any function as a physician in making a diagnosis of illness or physical condition;
- A8569/S1803B - Regulates the practice of naturopathic medicine

Pending Two-House Bills (Continued)

- A4519/S2935 - Establishes requirements for occupational therapists and occupational therapy assistants
- A5308/S3289 - Allows the practice of registered professional nursing by a certified nurse practitioner to include diagnosis and performance without collaboration of a licensed physician;
- A6179A/S3880 - Provides for the licensing of orientation and mobility specialists and vision rehabilitation therapists

Pending Two-House Bills (Continued -3)

- A7124/S2753 - Requires health care professional undergraduate, graduate and continuing education in chronic pain management and treatment;
- A85/S892 - Provides for the dispensing of emergency contraception under certain circumstances and conditions;
- A2820/S3059 - Provides for the certification of and qualifications for dentists practicing oral and maxillofacial surgery; includes such dentist within provisions of law regulating office-based surgery

Pending Two-House Bills (Continued - 4)

- A7355/S4376B - Provides for the licensing of physician assistants and the continued registration of specialist assistants;
- A921/S4553 - Enacts the “safe staffing for quality care act;”
- A4153/S4640 - Provides for the licensure of perfusionists; establishes a state board of perfusion and provides for continuing professional education

Pending – One House Bills (Assembly)

- A32 - Includes the alternative and complementary integration and application of scientific principles in the scope of the practice of dietetics and nutrition;
- A1603 - Authorizes nurse practitioners to admit mentally ill patients to an inpatient mental health unit on a voluntary or involuntary basis;
- A3404 - authorizes certified or registered dietitians and certified nutritionists as providers under the insurance law to be eligible for direct reimbursement when a policy provides coverage for nutrition and dietetic services.
- A3954 - Requires reporting of cases of pesticide poisoning by licensed or certified health care practitioners acting within the lawful scope of their practice

Pending – One House Bills (Senate)

- S324 - Allows certified nurse practitioners to practice without collaboration of a licensed physician;
- S766 - Authorizes physician assistants under the supervision of a physician to perform most medical services that a physician can perform
- S3058 – Amends the scope of practice of dentistry to authorize dentists who are adequately trained to perform any procedure in the oral and maxillofacial area;

Pending – One House Bills (Senate) continued

- S4525B - Authorizes nurse practitioners to admit a patient to an inpatient mental health unit on a voluntary or involuntary basis.
- S5066 - Creates a course of instruction to train mental health providers in veteran specific mental health issues.

Redesigning
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Scope of Practice

*Registered Nurse, Licensed Practical Nurse,
Home Health Aide, Personal Care Aide,
Certified Nursing Assistant*

Presented by:

**Rebecca Fuller-Gray, Office of Health Systems
Management**



New York State Education Department Office of the Professions

- Licenses and regulates 48 professions including registered nurses (RN) and licensed practical nurses (LPN)
 - As of April 2009 – licensed nearly 320,000 RNs and LPNs in NYS
- Responsible for practice issues and the rules governing the profession including standards of practice; scope of practice and related areas
 - Requires licensed professionals to confine practice to personal scope of competence
- The Office of the Professions/ Office of Professional Discipline
 - Investigates and prosecutes complaints against licensed professionals; and
 - Works with other enforcement agencies in cases involving illegal (unlicensed) practice



State Board for Nursing

- Assists the Board of Regents and the Department of Education on matters of professional licensing, practice and conduct in the nursing profession



What is Scope of Practice

- Based in state licensing laws and rules
- Sets legal framework for service delivery by a specific health profession in a state
 - Defines parameters of practice for a profession
 - Limits practice to people who successfully complete specified education and/or training
 - Restricts use of title and/or credential to license holders in the profession
 - Designed to provide consumer protection
 - Jean Moore, Center for Health Workforce Studies, University at Albany, School of Public Health



Variation of Scope of Practice

- Depends on a number of factors
 - Setting
 - Type of patient
 - Required professional oversight
 - Prior authorization
- Moore, School of Public Health



Unprofessional Conduct Regents Rules

Part 29

- Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform, or performing without adequate supervision professional services which the licensee is authorized to perform only under the supervision of a licensed professional (except in an emergency situation where a person's life is in danger).



Unprofessional Conduct Regents Rules

Part 29

- Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, by experience or by licensure to perform them.
- Failure to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensed professional.
- Penalties are imposed by the Board of Regents for professional misconduct; all disciplinary proceedings are considered matters of public information; and, can result in fines and revocation of license.



Nursing

Nursing professions in New York State:

- *Registered Professional Nurse*
- *Licensed Practical Nurse*
- *Nurse Practitioner*



The Nurse Practice Act Section 6902 of Article 139

- The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's (Education) regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.



Nursing Diagnosis

- The identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis.
 - Includes patient assessment through the collection and interpretation of patient clinical data
 - The development of nursing care goals and
 - The subsequent establishment of a nursing care plan



Nurse Practitioner

- A nurse practitioner is a RN who has earned a separate license as a NP through additional education and experience in a distinct specialty area of practice. Nurse Practitioners:
 - May diagnose, treat and prescribe for a patient's condition that falls within their specialty area of practice in collaboration with a licensed physician qualified in the specialty involved.
 - Are autonomous and do not practice under the supervision of the collaborating physician



Registered Professional Nurse

- A Registered Professional Nurse may:
 - *Diagnose and treat a patient's unique responses to diagnosed health problems*
 - *Perform health assessments to identify new symptoms of possibly undiagnosed conditions or complications*
 - *Teach and counsel patients about maintenance of health and prevention of illness or complications*
 - *Execute medical regimes as prescribed by licensed physicians, dentists, nurse practitioners, physician assistants and podiatrists*
 - *Contribute as members of an interdisciplinary health care team and as consultants on health related committees to plan and implement the health care needs of consumers.*



Registered Nurse Scope of Practice

- May function independently in providing nursing care in such areas as:
- Case finding, including but not limited to:
 - *Identification of epidemiological trends*
 - *Client abuse assessment*
 - *Early identification of emergent complications*



Registered Nurse Scope of Practice

- Health teaching, including but not limited to:
 - *Patient teaching regarding signs and symptoms of medication side effects.*
 - *Patient teaching regarding disease process (heart disease, cancer) and management in relation to life factors such as culture and ethnicity.*
 - *Health care promotion, such as disease prevention, accident prevention, and teaching normal child growth and development.*



Registered Nurse Scope of Practice

- Health counseling, including but not limited to:
 - *Mental health counseling;*
 - *Addiction counseling;*
 - *Health counseling related to management of chronic disease such as Alzheimer's, Parkinson's, Bi-Polar and Diabetes.*



Registered Nurse Scope of Practice

- Care Restorative of Life and Well Being, including but not limited to:
 - *Rehabilitation services such as bowel/bladder training, ostomy/wound care.*
 - *Triage and continuous assessment for early identification of signs and symptoms of post operative complications with timely intervention.*
 - *Ongoing surveillance and nursing intervention to rescue chronically ill persons from development of negative effects and secondary results of treatment.*



Registered Nurse Scope of Practice

- Care Supportive of Life and Well Being, including but not limited to:
 - *Hospice and palliative care.*
 - *Chronic pain management through non-pharmacological nursing measures such as relaxation, imagery, therapeutic touch.*
 - *Public health care including elder care, well-baby care, school and industrial nursing.*



The Nurse Practice Act Section 6902 of Article 139

- The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding health teaching, health counseling and provision of supportive and restorative care under the direction of a registered professional nurse or licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's (Education) regulations.



Licensed Practical Nurse

- A Licensed Practical Nurse:
 - *Provides skilled nursing care tasks and procedures under the direction of a Registered Nurse, physician, or other authorized health care provider.*



Scope of Practice Licensed Practical Nurse

Section 6902 of Article 139 of the Education Law and Section 64.6 of the Regulations of the Commission of Education:

- *A LPN performs tasks and responsibilities under the direction of a registered professional nurse, nurse practitioner, physician, physician assistant, specialist assistant, dentist and podiatrist.*
- *Under the direction means that a RN must be present on the premises or immediately available by telephone when professional services are given by a licensed practical nurse.*
- *Degree of supervision should be appropriate to the circumstances.*



Scope of Practice Licensed Practical Nurse

- LPNs may NOT conduct a nursing diagnosis or the assessment phase of the nursing process.
- An LPN may NOT assess or interpret clinical data or develop nursing care plans.
 - Some tasks that LPNs may not conduct include:
 - *Perform triage services*
 - *Administer IV-push medications*
- The role of the LPN is determined by a number of factors including the complexity of the procedure, the degree of direction, the setting, as well as the skill and competence of the licensee. E.g. IV therapy: acute care, long term care and home care.



Scope of Practice Licensed Practical Nurse

- Function by law in a dependent role at the direction of the RN or other authorized health care providers.
Under such direction they may:
 - *Administer medications;*
 - *Provide nursing treatment;*
 - *Gather patient measurements, signs and symptoms;*
 - *They may NOT function independent of direction.*



Home Health Aides

- In order to provide home health aide services in NYS, a person must successfully complete a training and competency evaluation program or a competency program conducted by an approved home health aide training program.
- Training and evaluation requirements are in accordance with Part 484 of Title 42 of the Code of Federal Regulations and Section 700.2 of Title 10 NYCRR.
- Home health aide training program must include classroom and supervised practical training
 - *Trainee must receive a minimum of 75 hours of training including 16 hours of supervised practical training*



Home Health Aides

- Title 10 of the NYCRR Section 700.2(c)(15) defines the provision of home health aide services as:
 - *Health care tasks;*
 - *Personal hygiene services;*
 - *Housekeeping tasks;*
 - *Other related support services essential to the patient's health.*



Home Health Aides

- The Matrix of Permissible and Non-Permissible Activities: Home Health Aide Services lists the health related activities which a home health aide is allowed to perform without violating Article 129 of the State Education Law.
- Designations of activities are very specific and detailed to reflect the collaborative work and agreement by the SED to assure that:
 - *There is a common understanding of all activities associated with each task.*
 - *The home care industry understands which parts of the activity may be performed by the home health aide without violating the Nurse Practice Act.*



Home Health Aides

- Health related tasks are grouped to include the following:
 - *Preparation of meals in accordance with modified diets or complex modified diets*
 - *Administration of medications*
 - *Provision of special skin care*
 - *Use of medical equipment, supplies and devices*
 - *Change of dressing to stable surface wounds*
 - *Performance of simple measurements and tests to routinely monitor the patient's medical condition*
 - *Performance of a maintenance exercise program*
 - *Care of an ostomy after the ostomy has achieved its normal function.*



Home Health Aides

- A RN must assess the functions, tasks, activities and degree of assistance needed by each patient
- Factors that determine whether health related tasks can be assigned include:
 - *Potential for harm;*
 - *Complexity of tasks;*
 - *Requires problem solving or innovation;*
 - *Whether the patient response is unpredictable or unknown.*



Home Health Aides

- Tasks arrayed on matrix are divided into three categories:
 - *Permissible activities;*
 - *Activities permissible under special circumstances;*
 - *Non-permissible activities.*
- Permissible Activities
 - *Expected to be taught either in the basic home health aide training program or on-the-job in a home care agency.*
 - *Once trained and evaluated as competent, the aide may perform the task without being retrained in the task.*



Home Health Aides

- Tasks permissible under special circumstances:
 - *Not routinely taught in home health aide training program.*
 - *Tasks are considered complex and each aide must receive training in the exact skill and/or procedure to be performed with each patient.*
 - *Training and competency evaluation in the performance of these tasks are not transferable from patient to patient.*



Home Health Aides

- Tasks permissible under special circumstances can only be performed for a patient whose characteristics and case situation meet all the following criteria:
 - **The patient is self directing**
 - *The self directing patient has the capability to make choices about activities of daily living, understands the impact of these choices and assumes responsibility for the results of the choices.*



Home Health Aides

- The patient has a need for assistance with the task or activity for routine maintenance of his/her health.
- The patient can not physically perform the task or activity because of his/her disability.
- The patient has no informal caregiver available at the time the task or activity must be performed or the care giver is available but is unwilling or unable to perform the task or the caregiver's involvement is unacceptable to the patient.



Home Health Aides

- Non-permissible activities :
 - May not be performed by a home health aide under any circumstances. The performance of such activities by the aide would be in violation of Article 139 of the Education Law.
 - *Example: Insert NG tubes, irrigate NG tube, instill feeding through NG tube*



Home Health Aides

- Service Agency Responsibility:
 - *The home care agency utilizing the services of the aide is responsible to ascertain each aide's ability to perform the health related tasks listed on the Matrix.*
 - *Agency must provide and document appropriate in-service education or on-the-job training and provide adequate supervision and evaluation to assure that each aide is competent to perform the tasks that are required for each patient.*



Personal Care Aide

- In order to provide personal care aide services in NYS, a person must successfully complete a training and competency evaluation program or a competency program conducted by an approved personal care aide training program.
- The Home Care Core Curriculum is 40 hours in length and addresses the preparation of an individual to perform the tasks outlined in the Level I and Level II Personal Care Aide Scope of Functions and Tasks.



Personal Care Aides

- Personal Care Tasks and Functions:
 - Environmental support
 - *General housekeeping tasks*
 - Nutritional support
 - *Simple modified diets, i.e. low fiber or low fat*
 - *Diabetic, Renal or Complex Diets, may assist with feeding but can not develop menu, prepare meals or assist with tube feeding*
 - Personal Care Functions
 - *Bathing client and providing skin care with some exceptions*
 - *Toileting*
 - *Walking*
 - *Transferring, positioning and range of motion*
 - *Using medical supplies and equipment*
 - *Well baby*
 - *Assisting with changing a clean dressing of a stable wound*



Personal Care Aides

- Assisting with the self administration of medication:
 - *Assisting includes reminding the client when to take medications, reading the label for the client, bringing the medication and any necessary supplies or equipment to the client, opening the container, positioning the client for medication administration, providing appropriate liquids for swallowing medication, storing, cleaning and disposal of used supplies and equipment and storing medication properly.*
 - *Self administration means that the client directly swallows, applies, inhales, inserts or injects a medication into his or her own body.*



Certified Nurse Aide

- Nurse aide shall mean any person who provides direct personal resident care and services including, but not limited to, safety, comfort, personal hygiene or resident protection services, for compensation, under the supervision of a registered professional nurse or licensed practical nurse in the facility.



Certified Nurse Aide

- All individuals performing nurse aide duties in a nursing home on a full-time, part-time or contractual basis must meet minimum training and competency requirements in accordance with state and federal regulations and be listed in good standing on the Nurse Aide Registry.
- The majority of nurse aides on the registry become certified by successfully completing a NYS-approved nursing home nurse aide training program and passing the Competency Examination which consists of two parts:
 - 1) *Clinical Skills exam (practical portion); and*
 - 2) *Written (or Oral) exam.*



Certified Nurse Aide

The aide must demonstrate competency in the following areas:

- *Interpersonal relations and communication skills.*
- *Providing personal care.*
- *Care of the dying resident.*
- *Infection control.*
- *Fire safety and emergency procedures, including the Heimlich maneuver.*
- *Promoting residents' independence.*
- *Respecting residents' rights; and*
- *Resident abuse, mistreatment and neglect reporting requirements as set forth in Section 2803-d of the Public Health Law.*



Nurse Practice Act Exemptions

- Consumer Directed Personal Care Assistance Program
- Aides in OPWDD settings



Consumer Directed Personal Assistance Program

- This Medicaid program provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services.
- Services can include any of the services provided by a personal care aide (home attendant), home health aide, or skilled services.



Consumer Directed Personal Assistance Program

- Consumers have flexibility and freedom in choosing their caregivers.
- Before a person can receive services, his or her doctor must send a completed Physician's Order for Services to the local social services district, which then completes a social and nursing assessment.
- A nurse assessor (RN) determines whether the consumer can appropriately participate in CDPAP, and recommends the amount, frequency and duration of services.



Consumer Directed Personal Assistance Program

- Consumers must be able and willing to make informed choices regarding the management of the services they receive, or have a legal guardian or designated relative or other adult able and willing to help make informed choices.
- The consumer or designee is responsible for recruiting, hiring, training, supervising and terminating caregivers, and must arrange for back-up coverage when necessary, arrange and coordinate other services; and keep payroll records.



Consumer Directed Personal Assistant

- Regulations Title 18 of the NYCRR 505.28.
- Nurse in conjunction with the physician of record ensures that the consumer or consumer representative has competency in performing or knowing how to perform tasks and functions necessary.
- RN develops plan of care (POC) based on assessment. The POC, is updated every 6-12 months depending on the local district requirement.
- Consumer is responsible for implementation of the care plan and takes full responsibility for oversight of care.



SED/OMRDD Memorandum for RN Nursing Supervision #203-01

- Developed to define the appropriate level of supervision of a registered professional nurse that is to be provided to unlicensed direct care staff who perform tasks or activities commonly identified as nursing procedures.
 - *Applies to all certified community-based residences with the exception of family care home.*
 - *RN is responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities.*
 - *Employing agency is responsible to ensure that all staff are adequately trained regarding the elements of clinical nursing supervision and the difference between clinical nursing supervision and administrative supervision.*



SED/OMRDD Memorandum for RN Nursing Supervision #203-01

- Adequate nursing supervision is the provision of guidance by an RN for the accomplishment of a nursing procedure, including:
 - *Initial training of the task or activity and*
 - *Periodic inspection of the actual act of accomplishing the task or activity*
- The amount and type of nursing supervision is determined by the RN responsible for supervising the task or activity and depends on:
 - *The complexity of the task*
 - *The skill, experience and training of the staff*
 - *The health conditions and health status of the consumer*



SED/OMRDD Memorandum for RN Nursing Supervision #203-01

- Frequency of visits
 - *At the discretion of the RN responsible for supervision but no LESS than once per week*
- Professional Nursing Availability
 - *RN must be available to unlicensed direct care staff 24 hours per day, 7 days per week*
 - *RN must be either on site or immediately available by telephone*



SED/OMRDD Memorandum for RN Nursing Supervision #203-01

- Plan of Nursing Services
 - *RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care including medication administration for diagnosed medical conditions.*
 - *Must be updated annually or whenever there is a significant change in the consumer's condition.*



SED/OMRDD Memorandum for RN Nursing Supervision #203-01

- Nursing Procedures
 - *RN is responsible to determine which nursing procedures unlicensed direct care staff will be allowed to perform and which unlicensed staff will be allowed to perform*
 - *RN must exercise professional judgment as to when delegation is unsafe and/or not in the consumer's best interest based on the:*
 - Complexity of the task
 - Condition of the consumer
 - Training, skill and experience of the staff involved, including relevant factors related to the individuals' ability to safely provide nursing services



SED/OMRDD Memorandum for RN Nursing Supervision #203-01

- In no case will an RN allow direct care staff to perform a nursing procedure that is outside the scope of practice of an LPN.
- Additional requirements apply see memorandum.



CONTACT INFORMATION

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Redesigning
THE MEDICAID PROGRAM



Dental Hygienists

Presented by:

Jayanth Kumar, DDS, Bureau of Dental Health

Scope of Practice: Dental Hygienists

- Background
- Current regulations and its impact
 - ▣ *School-based programs*
 - ▣ *Nursing homes*
 - ▣ *Public health clinics*
- Proposed Workforce Models
- Progress

A Guidance Document for the Practice of Dentistry and Dental Hygiene in Private Offices and Institutions

An advisory document for dentists, dental hygienists and institutions such as nursing homes and schools

- In New York State, the practice of dental hygiene must be performed under the supervision of a licensed dentist. There are two levels of supervision - personal and general.
- Personal supervision means that the dentist is in the dental office or facility, personally diagnoses the condition to be treated, personally authorizes the procedure and, before dismissal of the patient, personally examines the condition after treatment is completed.
- General supervision means that a supervising dentist is available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances. General supervision does not mandate that the employing dentist be physically present in the office at all times.

The definition described includes three parameters:

A supervising dentist must always be available – this could be another dentist down the hall or across the street who could be quickly summoned. In some situations, a conversation with the supervising dentist may suffice, as long as the supervising dentist could be quickly summoned should the need arise.

The treatment rendered by the dental hygienist is authorized in advance (proof of authorization, in the absence of the employer-dentist, should be written somewhere).

“... exercises that degree of supervision appropriate ...,” which means, for example, a patient new to the practice or a patient presenting a difficult management or medical problem should not appear on a day the dentist is not physically present in the office.

The relationship between the dentist and the dental hygienist requires that professional judgment be exercised in the above-cited examples. A dental hygienist treating pre-school and school age children in a school setting, for example, may be authorized by the supervising dentist to see these patients for the first time without the supervising dentist being present.

Workforce Models

- Working models
 - *Dental Health Aide Therapist (DHAT)*
 - *Advanced Dental Therapist (MN)*
- Proposed
 - *Community Dental Health Coordinator (ADA)*
 - *Advanced Dental Hygiene Practitioner (ADHA)*
 - *Collaborative Practice (NY). Dental hygienists working without supervision (but within a collaborative practice agreement with a licensed dentist)*

Summary of Dental Procedures Included in the Calculator²¹

Category of Services	Procedures Provided by Dentists and Allied Providers*	Dental Hygienist	Dental Therapist	Hygienist-Therapist	Dentist (Owner or Associate)
Diagnostic	Oral evaluations			●	●
Radiographs/imaging	Panoramic X-ray	●	●	●	●
Preventive	Cleanings	●	●	●	●
	Sealants	●	●	●	●
Restorative	Silver fillings		●	●	●
	Tooth-Colored fillings		●	●	●
	Prefabricated stainless crown		●	●	●
	Temporary filling		●	●	●
	Temporary crown			●	●
	Permanent crown				●
Endodontics	Pulpotomy**		●	●	●
Periodontics	Non-surgical services	●		●	●
Prosthodontics	Complete dentures				●
Extractions	Simple extractions of primary or permanent teeth		●	●	●

Help Wanted:

A Policy Maker's Guide to New Dental Providers



Conclusion

New thinking and action is needed to respond to the serious dental access problems facing states.

Demographic shifts are reducing the number and availability of dentists even as demand increases. As the most highly trained and educated dental providers, dentists will remain the leaders and experts in the field and the only providers who can perform the most complex and clinically difficult procedures. However, new dental providers offer a way for states to help ensure that vital primary dental care is accessible to constituents regardless of age, race, ethnicity, income, geographic location and/or insurance status. State examples and studies from around the world confirm that providers with a smaller scope of practice than dentists can efficiently and safely perform many components of dental care. States are working hard to gather data, build consensus, develop systems of care, and train and educate new types of providers who can join the dental team, supply basic primary dental care to underserved populations and expand the safety net.

ADA Statement on the Kellogg Study of Alaska Dental Health Aide Therapist Program

The ADA believes that workforce innovations such as our own community dental health coordinator (CDHC) show greater potential in helping underserved people overcome the profound barriers that limit or completely block their access to dentists. The CDHC is based on a proven model-the community health worker-which has been extraordinarily successful in educating patients in their various communities to seek medical care. We feel that a similar model could be equally effective in promoting dental care.

Health Care Workforce Scope of Practice – Other Efforts

Workforce Flexibility Scope of Practice
Workgroup

Monday, October 3, 2011

|

**NEW YORK STATE DEPARTMENT
OF HEALTH**

- President's Job Council
- HWDS Workforce Planning Grant (DOL)

President's Job Council Mission

- Provide non-partisan advice to the President on:
 - continuing to strengthen the Nation's economy and ensure the competitiveness of the United States; and
 - ways to create jobs, opportunity, and prosperity for the American people.

President's Job Council Tasks

- Solicit ideas for the President on how to bolster the economy and the prosperity of the American people;
- Report on policies to:
 - Promote the growth of the economy,
 - Enhance the skills and education of Americans,
 - Maintain a stable and sound financial/banking system,
 - Create stable jobs for American workers, and improve the long term prosperity and competitiveness of the American people; and
- Provide analysis and information on the operation, regulation, and healthy functioning of the economy and other factors contributing to the sustainable growth and competitiveness of industry and the labor force.

Status

- Met February (at the White House) and June (Durham NC);
- Held 7 other “outreach” sessions throughout the U.S. through Sept. 1;
- Presented “ideas report” to the President in June;
- Will meet with the President on or about October 11 in Pittsburgh and in December to address further high-potential job-growth opportunities.

NYS Healthcare Job Readiness and Placement Initiative

- Overseen by New York City-based steering committee;
- Initiative “catalyzed” by the Council on Jobs;
- Outcome/product/funding of the initiative not clear at this time;
- To be formally launched in October

Initiative Ideas

- Expand the Workforce1 Healthcare Career Center;
- Build on the work of the New York Alliance for Careers in Healthcare to address critical workforce supply problems identified by industry leaders;
- Engage employers in development of standard curriculum and credentials for the changing healthcare sector;
- Create a healthcare-specific database of jobseekers for NYC; expand to rest of NYS if successful

Initiative Ideas (cont'd)

- Implement targeted interventions;
- Link Initiative efforts with Regional Economic Development Councils;
- Align reimbursement with changing healthcare paradigms such as PCMH;
- Establish a coordinating entity to sustain and expand pilot efforts.

HWDS Workforce Planning Grant (DOL)

- \$150,000 grant awarded by HRSA to the NYS Workforce Investment Board (SWIB);
- Formed the Healthcare Workforce Development Subcommittee (HWDS);
- Goal to plan for expansion of primary care workforce;
- Follow-up \$1.5 million implementation funding initially offered by HRSA.

HWDS Membership

- North Shore Long Island Jewish Health Systems
- Service Employees International Union 1199
- Schenectady County Community College
- State University of New York
- The Center for Health Workforce Studies, SUNY Albany
- New York State Department of Education
- The Workforce Development Institute
- The New York Health Foundation
- Department of Health
- Office of Temporary and Disability Assistance
- Department of Labor

HWDS Workgroups

- Asset Mapping
- Data Collection
- Career Pathways
- Healthcare Credentials
- Healthcare Rules and Regulations

HWDS Action Items

- Develop Health Workforce Resource Clearinghouse and Healthcare Workforce Data Repository;
- Maximize financial incentives and awareness for the education and placement of primary care physicians in underserved areas;
- Explore funding to study and get consensus around emerging job duties and education required for new and emerging jobs as a result of healthcare reform;
- Use this group (MRT) as initial forum for addressing emerging scope of practice issues; and
- Empanel a multi-agency taskforce to avoid duplication of effort.

HWDS Next Steps

- Interim report to HRSA submitted this month;
- Final report by February 2012;
- Will also seek additional funding opportunities to carry out the recommendations.

Redesigning
THE MEDICAID PROGRAM



Episodic Payment

Presented by:

Robert Loftus, Office of Health Insurance Programs

Certified Home Health Agency (CHHA) Episodic Payments

- ▶ Effective April 1, 2012
 - Does not apply to pediatric patients (< 18 yrs.)
- ▶ 60-day episodic payment structure
- ▶ Statewide Base Price adjusted by:
 - Wage Index
 - OASIS score – Grouper determines case mix weight – 108 case mix groups/rate codes
- ▶ Interim payment – 50% of case mix, wage adjusted Price
- ▶ Final payment – 100% of case mix, wage adjusted Price
 - Underlying cost (services reported on revenue codes) determines LUPA, Outlier amount

New York State Health Home



CMS Medicaid Director Letter

“The health home service delivery model is an important option for providing a cost-effective, longitudinal “home” to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions.”

CMS Medicaid Director Letter

“The goal in building “health homes” will be to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses.”

General Information

Section 2703 of the Patient Protection and Affordable Care Act (ACA)

- provides states, under the state plan option or through a waiver, the authority to implement health homes effective January 1, 2011.
- provides the opportunity to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness.
- provides 90 percent FMAP rate for **health home services** for the first eight fiscal quarters that a health home state plan amendment is in effect.
- provides planning grant funds at regular FMAP for health home design and SPA preparation activities.

Health Homes Overview

Intent - Treat the individual's physical and behavioral health condition and provide linkages to long-term community care services and supports, social services, and family services.

Purpose - Improve patient quality outcomes, reduce inpatient, emergency room, and long term care costs.

Services - Comprehensive care management, coordination and health promotion; transitional care from inpatient to other settings, referral to community and social support services, and use of health information technology to link services.

Health Homes Overview

Beneficiary criteria - At least two chronic conditions, one chronic condition and at risk for another, or one serious and persistent mental health condition. Chronic conditions include mental health condition, substance abuse disorder, asthma, diabetes, heart disease, being overweight (BMI over 25).

Designated Providers -Physicians, clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies; interdisciplinary health teams.

Payment - flexibility in designing the payment methodology including structuring a tiered payment methodology that adjusts for severity of illness and the “capabilities” of the designated provider.

Health Home Rules

Targeting - States may provide health home services to all eligible individuals or may target services to individuals with particular chronic conditions.

States may elect to target the population to individuals with higher numbers, or severity, of chronic or mental health conditions.

Comparability - States may offer health home services in a different amount, duration, and scope than services provided to non eligible individuals

States must include all categorically needy individuals who meet the State's criteria and this may include individuals in any medically needy group or section 1115 population.

Health Home Rules

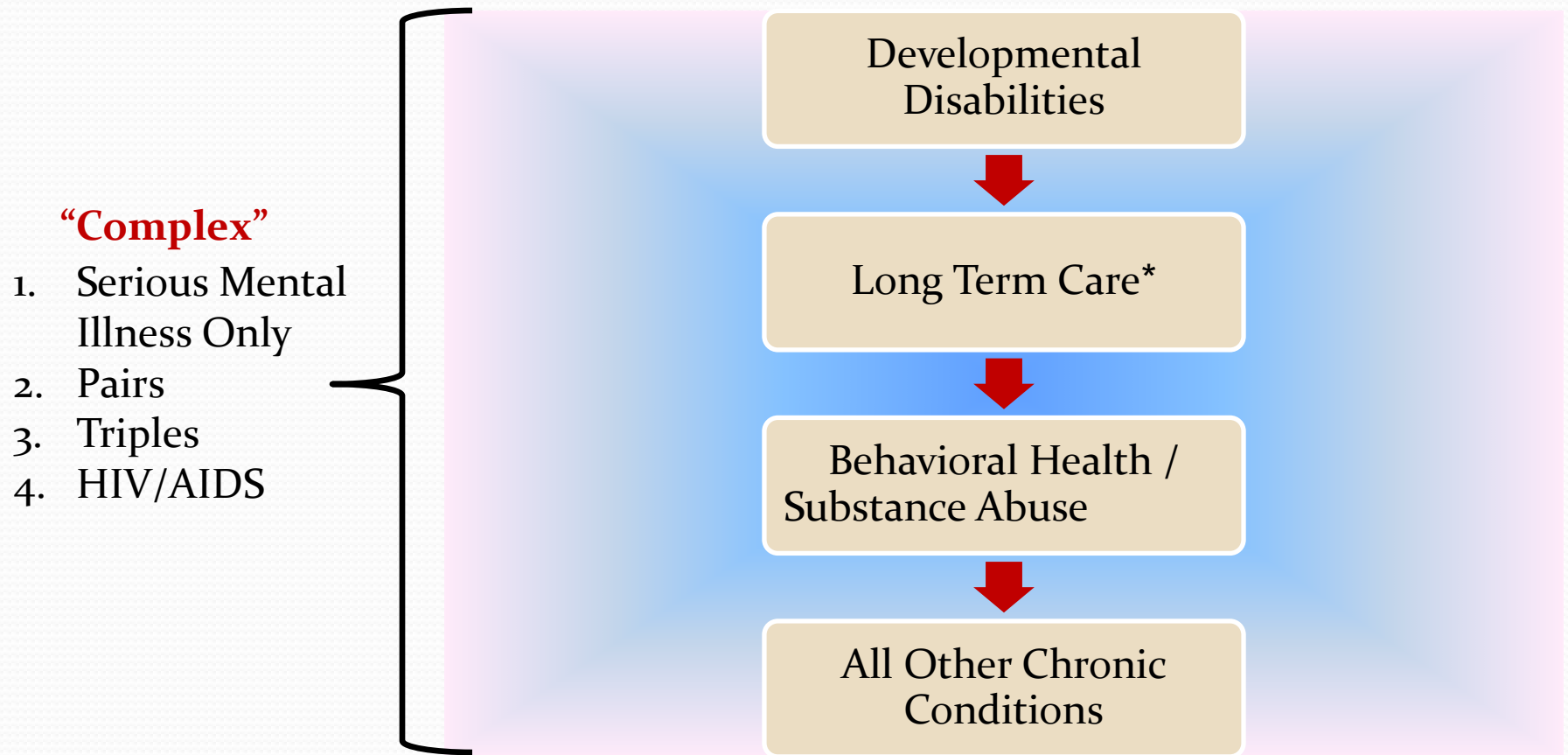
Duals - States are advised that there is no statutory flexibility to exclude dual eligible Medicare/Medicaid beneficiaries from receiving health home services.

Behavioral Health - States must consult with SAMSHA (Substance Abuse and Mental Health Services Administration) prior to the SPA submission, in addressing issues of prevention and treatment of mental illness and substance use disorders

Health Home Providers

- NY will use “designated providers” for the Health Home Program
- Designated providers can be:
 - Managed Care Plans
 - Hospitals
 - Medical, mental and chemical dependency treatment clinics
 - Federally Qualified Health Centers (FQHCs)
 - Targeted Case Management (TCM) programs
 - Primary care practitioner practices
 - Patient Centered Medical Homes (PCMHs)
 - Any other Medicaid enrolled entity that meets NY’s health home requirements
 - Considering adding other long term care providers

Mutually Exclusive Hierarchical Selection Based on Service Utilization



* Long Term Care includes: more than 120 days of consecutive LTC needs and/or enrollment in Managed Long Term Care (PACE, Partial MLTC and MAP).

HH Populations - 2010

• Developmental Disabilities

- 52,118 Recipients
 - \$10,429 PMPM

• Long Term Care

- 209,622 Recipients
 - \$4509 PMPM

Total Complex
N=976,356
\$2,338 PMPM
32% Dual
51% MMC

\$6.5 Billion

50% Dual

10% MMC

\$10.7 Billion

77% Dual

18% MMC

\$25.9 Billion

\$6.3 Billion

16% Dual

61% MMC

\$2.4 Billion

20% Dual

69% MMC

• Mental Health and/or Substance Abuse

- 408,529 Recipients
 - \$1,370 PMPM

• All Other Chronic Conditions

- 306,087 Recipients
 - \$698 PMPM

CRG Grouping	Category	Developmental Disabilities	Long Term Care	Behavioral Health and/or Substance Abuse	Other Chronic	Total
Serious Mental Illness Only	Expenditures	\$ 61,154,098	\$ 193,305,913	\$ 1,358,906,853		\$ 1,613,366,865
	Member Months	20,406	58,715	1,126,636		1,205,757
	Recipients	1,740	5,328	104,366		111,434
	PMPM	\$ 2,996.87	\$ 3,292.27	\$ 1,206.16		\$ 1,338.05
	Percent Dual-Eligible (%)	21.7	68.0	20.8		23.1
	Percent MMC (%)	22.4	15.1	52.5		50.2
Chronic Condition Pairs	Expenditures	\$ 5,804,521,610	\$ 6,940,553,624	\$ 3,605,804,276	\$ 1,839,489,731	\$ 18,190,369,241
	Member Months	553,939	1,667,351	2,944,128	3,083,170	8,248,588
	Recipients	46,522	147,509	256,555	271,069	721,655
	PMPM	\$ 10,478.63	\$ 4,162.62	\$ 1,224.74	\$ 596.62	\$ 2,205.27
	Percent Dual-Eligible (%)	51.5	81.3	14.0	20.1	32.4
	Percent MMC (%)	9.6	18.6	65.4	71.4	54.4
Chronic Condition Triples	Expenditures	\$ 564,121,257	\$ 2,643,508,630	\$ 644,631,036	\$ 144,331,580	\$ 3,996,592,502
	Member Months	42,356	520,248	310,945	138,223	1,011,772
	Recipients	3,567	45,789	26,734	12,271	88,361
	PMPM	\$ 13,318.57	\$ 5,081.25	\$ 2,073.14	\$ 1,044.19	\$ 3,950.09
	Percent Dual-Eligible (%)	44.6	76.3	14.5	31.9	49.9
	Percent MMC (%)	5.1	18.2	66.9	59.1	38.2
HIV / AIDS	Expenditures	\$ 37,689,875	\$ 910,920,370	\$ 718,818,625	\$ 435,060,883	\$ 2,102,489,753
	Member Months	3,420	124,340	237,256	246,382	611,398
	Recipients	289	10,996	20,874	22,747	54,906
	PMPM	\$ 11,020.43	\$ 7,326.04	\$ 3,029.72	\$ 1,765.80	\$ 3,438.82
	Percent Dual-Eligible (%)	20.4	27.3	13.2	16.4	17.4
	Percent MMC (%)	12.7	11.1	29.0	42.3	30.6
Total Complex	Expenditures	\$ 6,467,486,840	\$ 10,688,288,537	\$ 6,328,160,789	\$ 2,418,882,194	\$ 25,902,818,362
	Member Months	620,121	2,370,654	4,618,965	3,467,775	11,077,515
	Recipients	52,118	209,622	408,529	306,087	976,356
	PMPM	\$ 10,429.39	\$ 4,508.58	\$ 1,370.04	\$ 697.53	\$ 2,338.32
	Percent Dual-Eligible (%)	49.9	77.1	15.7	20.3	32.2
	Percent MMC (%)	9.7	18.0	60.5	68.8	51.2

2010 Health Home CRG Group – MH/SA Top DXs

Diagnosis Grouping	Sum of MH/SA Spend	Sum of MH/SA Recips
TOTAL	\$ 7,270,312,543	411,980
Schizophrenia	\$ 1,064,324,943	71,796
Schizophrenia and Other Moderate Chronic Disease	\$ 987,483,578	51,021
HIV Disease	\$ 896,305,908	22,252
Dementing Disease and Other Dominant Chronic Disease	\$ 323,686,677	11,961
Diabetes - Hypertension - Other Dominant Chronic Disease	\$ 237,735,446	11,303
Diabetes and Other Dominant Chronic Disease	\$ 160,873,540	7,826
Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease	\$ 156,625,537	15,842
Schizophrenia and Other Dominant Chronic Disease	\$ 140,336,943	5,809
Diabetes and Other Moderate Chronic Disease	\$ 139,516,879	11,583
Asthma and Other Moderate Chronic Disease	\$ 138,597,650	11,757
Diabetes - 2 or More Other Dominant Chronic Diseases	\$ 137,828,720	4,185
Depressive and Other Psychoses	\$ 136,096,859	13,809

Diagnosis Grouping	Sum of MH/SA Spend	Sum of MH/SA Recips
Two Other Moderate Chronic Diseases	\$133,721,190	16,691
Moderate Chronic Substance Abuse and Other Moderate Chronic Disease	\$130,702,804	10,031
One Other Moderate Chronic Disease and Other Chronic Disease	\$128,258,771	16,832
Bi-Polar Disorder	\$104,845,381	7,233
One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	\$97,316,553	6,436
Diabetes - Advanced Coronary Artery Disease - Other Dominant Chronic Disease	\$90,245,930	3,303
Schizophrenia and Other Chronic Disease	\$89,393,330	5,494
Chronic Obstructive Pulmonary Disease and Other Dominant Chronic Disease	\$85,555,831	4,328
Diabetes and Hypertension	\$83,038,235	9,638
Diabetes and Asthma	\$79,170,754	5,484
Diabetes and Advanced Coronary Artery Disease	\$57,899,075	3,577
Dialysis without Diabetes	\$55,750,739	904

Chronic Illness Demo

Patient Population

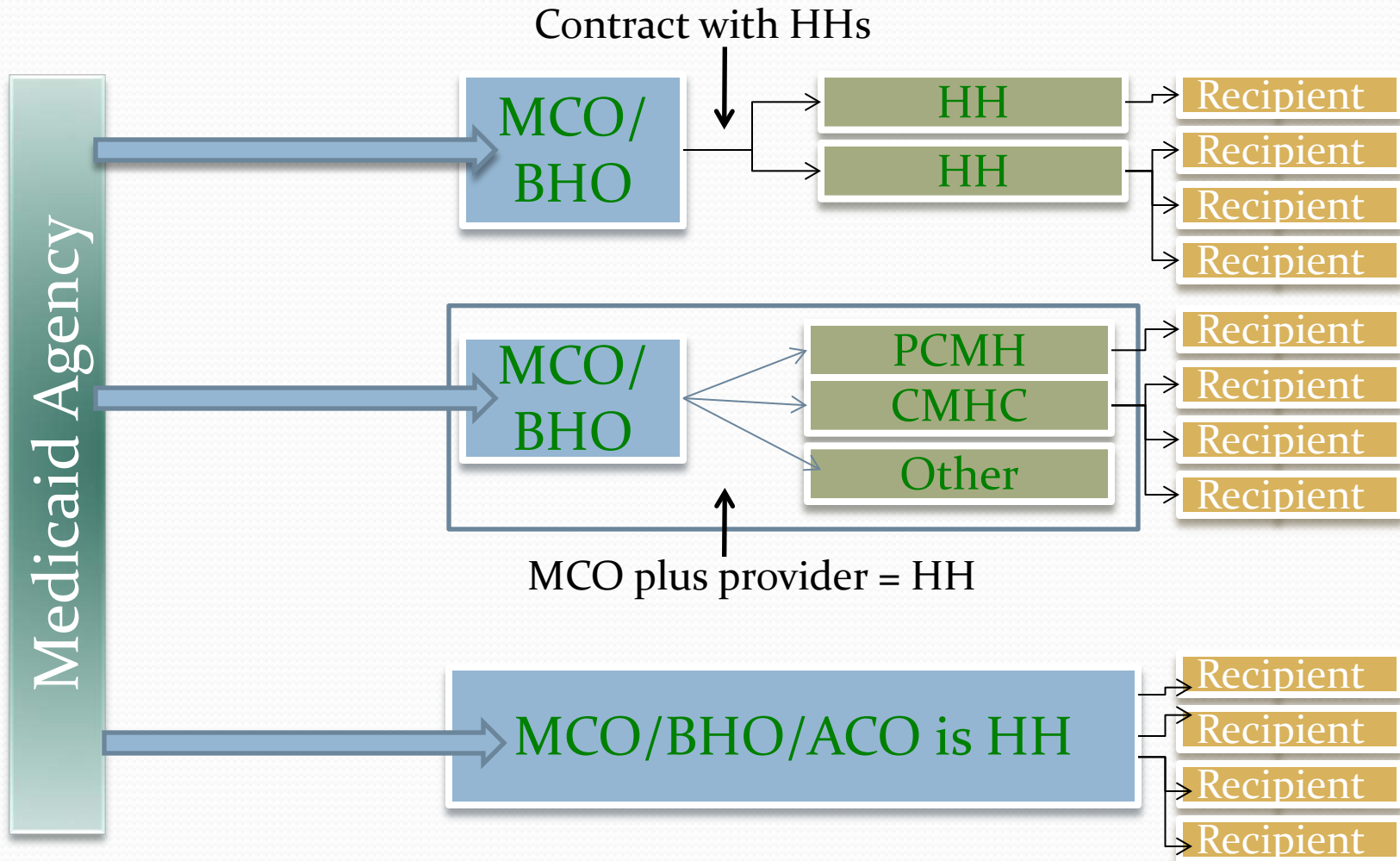
Prior Diagnostic History
Patients with Risk Scores 50+*
NYC Residents

Percent of Patients with Co-Occurring Condition

		CVD	AMI	Ischemic Heart Dis	CHF	Hyper-tension	Diabetes	Asthma	COPD	Renal Disease	Sickle Cell	Alc/Subst Abuse	Mental Illness	HIV/AIDS
Cereb Vasc Dis	5.0%	100.0%	15.0%	49.5%	36.2%	81.6%	51.7%	35.3%	24.8%	13.7%	2.9%	56.4%	62.7%	13.7%
AMI	6.0%	12.5%	100.0%	80.9%	53.3%	90.1%	56.6%	40.4%	31.5%	17.4%	2.1%	55.2%	56.2%	13.5%
Ischemic Heart Dis	22.4%	11.1%	21.7%	100.0%	45.3%	86.9%	54.0%	42.0%	30.2%	13.2%	2.1%	53.5%	58.4%	14.0%
CHF	16.2%	11.2%	19.8%	62.8%	100.0%	89.5%	56.9%	42.7%	34.9%	20.7%	2.7%	48.4%	48.0%	13.4%
Hypertension	50.9%	8.0%	10.6%	38.3%	28.4%	100.0%	46.2%	41.0%	25.4%	11.6%	1.8%	63.1%	62.9%	20.0%
Diabetes	29.0%	8.9%	11.7%	41.8%	31.7%	81.3%	100.0%	41.2%	23.9%	13.0%	1.4%	55.4%	62.7%	15.6%
Asthma	36.3%	4.9%	6.7%	25.9%	19.0%	57.5%	32.9%	100.0%	32.5%	4.3%	2.3%	72.9%	70.0%	29.6%
COPD	20.8%	6.0%	9.1%	32.5%	27.2%	62.2%	33.3%	56.7%	100.0%	6.0%	1.7%	74.2%	65.6%	29.9%
Renal Disease	6.3%	10.8%	16.5%	46.7%	52.8%	93.3%	59.6%	24.3%	19.8%	100.0%	2.2%	36.6%	37.4%	18.0%
Sickle Cell	2.9%	5.0%	4.2%	15.7%	14.9%	31.3%	14.0%	28.2%	12.3%	4.7%	100.0%	48.9%	50.7%	15.0%
Alc/Subst Abuse	72.8%	3.9%	4.5%	16.5%	10.7%	44.1%	22.0%	36.4%	21.2%	3.2%	2.0%	100.0%	70.9%	33.4%
Mental Illness	66.2%	4.7%	5.1%	19.7%	11.7%	48.3%	27.4%	38.4%	20.6%	3.6%				

* High Risk of Future Inpatient Admission
Source: NYU Wagner School, NYS OHIP, 2009.

Examples of Structuring Health Homes (HH) In Managed Care Delivery System



Implementation Status

- Enrollment target – January 2012 For Phase One
- Phase One Counties – Bronx, Brooklyn, Nassau, Monroe, Warren, Washington, Essex, Hamilton, Saratoga, Clinton, Franklin, St. Lawrence, Schenectady
- Phase two – April 2012, Phase Three – June 2012
- CMS and SAMSHA Consults occurred with State HH Team - DOH, OMH, OASAS and Aids Institute
- Draft quality measures have been developed with expert stakeholder group
- Draft rates and finance model has been developed with State agencies – revising now based on feedback from expert panel.
- Final State Plan submitted – much work up front with CMS on draft SPA.
- NYS Health Home Website (links to many relevant materials):

http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm

Questions?

- Join the Health Home Listserv and get updated health home information. Go to:
http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm.
- Questions or comments regarding NYS implementation of Health Homes can be directed to hh2011@health.state.ny.us.

Medical Homes


MRT Workgroup on Workforce Flexibility
October 3, 2011

Foster Gesten, MD, FACP
Medical Director
Office of Health Insurance Programs

Brief History

- ▶ Primary care underinvestment (Medicaid)
- ▶ Existing and future challenges in primary care capacity
- ▶ Institutional settings create challenges in continuity, coordination, access
- ▶ National and state interest in ‘patient centered medical homes’
 - Accelerated by multi-payer pilots, NCQA recognition program, analysis of avoidable costs (inpatient, ER, specialty, high cost radiology, etc.)

Goals of Medical Home

- ▶ Better coordination of care between physicians (primary care and specialists)
 - ▶ Improved access to physician/practice
 - *Including e-communication*
 - ▶ Patient education and engagement in prevention and care for chronic conditions
 - ▶ Safety associated with electronic prescribing
 - ▶ Patient reminder systems, registries, tracking (results, referrals)
 - ▶ Capacity to measure and improve quality
- 

Programs in New York

- ▶ Statewide Medicaid PCMH Incentive Program (2010)
 - FFS and MMC
 - All primary care providers
 - National Committee for Quality Assurance (NCQA) recognition at any level
- ▶ Multipayer PCMH Programs
 - Adirondack Demonstration (2010)
 - Incorporates MAPCP (CMS/Medicare), Medicaid, Empire Plan (state employees), and 6 other payers
 - Hudson Valley (THINC)
 - Rochester
 - Western New York

What Happened?

- ▶ Payments for Medicaid and ADK began in 2010
- ▶ Went from ~ 400 NCQA recognized providers in 2009 to ~ 3800 recognized providers as of last quarter
 - Significantly higher than any other state
 - ~60% are level 3 recognized
- ▶ Almost 900,000 Medicaid members receive primary care in medical home
 - ~1 / 3 of all enrollees

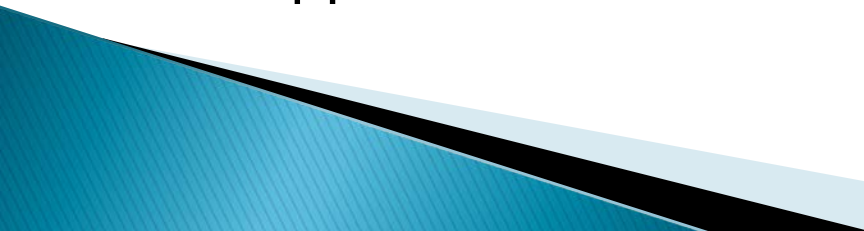
New Developments

- ▶ Meaningful Use and PCMH alignment
- ▶ New standards from NCQA (2011)
 - Harder
- ▶ Joint Commission Standards
- ▶ Health Homes
 - Medical (and non-medical) 'neighborhood' of care for complex, co-morbid populations
- ▶ MRT 70....one million and CHPlus
- ▶ ACOs and New Payment Models
- ▶ Federal investments
 - FQHCs and PCMH
 - Medicaid Partnership Plan Waiver
 - Hospital-Medical Home Demonstration

Workforce Implications

- ▶ Existing providers working at ‘top of their license’
- ▶ New roles for nurses and others
 - Care management, coordination, transitions, education, self-management support, practice management support, practice enhancement assistance, quality improvement
- ▶ Psychosocial and behavioral components of health care
 - Social workers, counselors, peers
- ▶ Team Care
 - Inclusion of pharmacists, health educators, community health workers, community organizations, public health, home care

Some Realities...

- ▶ Limited new investment in care transformation
 - It may take a village but there is no funding for a village
 - Local prioritization based on need and local resources, capacity, etc.
 - One size, one job function, does not fit all
 - ▶ Primary care physician shortages
 - Need to increase salaries
 - ▶ Infrastructure to support 'team care' across settings and provider types
 - Data and information
 - Role clarity
 - ▶ Scope of Practice
 - Limitations for direct billing
 - Opportunities in more global payment arrangements
- 

Questions?



Brainstorming Session

Goal

- ☑ To identify a manageable number of priority areas related to the Workforce Flexibility Work Group's charge. These areas should have a reasonable likelihood of being implemented within SFY 2011-2012. Ideas not selected as priorities will still be recorded for possible consideration at a later date.

Step 1: Brainstorming

- ☑ Participants should use the morning session and lunch-break to generate their ideas for priority areas.
- ☑ Meeting leader goes around the table accepting one idea from each participant and continues the process until ideas are exhausted (or until the one hour session expires). Members can pass on any go-around. In this step, all ideas are accepted without filters, judgment, challenges, questions, or analysis. Members may build on the ideas proposed by others, but may not modify ideas already presented. All ideas are captured on flipcharts and posted visibly.

Step 2: Group Analysis

- ☑ Participants are offered an opportunity to ask for clarification on ideas proposed by others.
- ☑ Reduce the list by identifying duplicate ideas
- ☑ Cluster ideas that are clearly similar or strongly related
- ☑ Group the reduced list by sector, occupation, or other characteristics as agreed to by the work group (may start grouping by sector).

Step 3: Voting for Priority Areas

- ☑ Each member may vote for as many priority areas as they want.
- ☑ Ideas will be rank-ordered by number of votes

Step 4: Identify Volunteers

- ☑ Identification of volunteers to work on priority areas as time allows.