NYS Advanced Primary Care Model: Presentation to PPS's

September 18, 2015

Our Goal Today: To Attempt to Answer The Following

1. What is SIM and how does it relate to DSRIP?
2. DSRIP requires providers to be designated at PCMH or APC by 2017; is APC a viable alternative?
3. What is the lift for the provider?
4. Where are we (APC) now – what is the timeline?
5. What is different about APC (versus PCMH)?
6. Which designation is more meaningful?

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New York State Health Innovation Plan

Goal Delivering the Triple Aim – Better care, smarter spending, healthier people

Pillars

1	2	3	4
Improve access to care for all New Yorkers, without disparity	**Integrate care to address patient needs seamlessly**	**Make the cost and quality of care transparent to empower decision making**	**Pay for healthcare value, not volume**
Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	Integration of primary care, behavioral health, acute and postacute care; and supportive care for those that require it	Information to enable consumers and providers to make better decisions at enrollment and at the point of care	Rewards for providers who achieve high standards for quality and consumer experience while controlling costs

Enablers

Workforce strategy	A	Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities
Health information technology	B	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation
Performance measurement & evaluation	C	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation
Population health	D	Improved screening and prevention through closer linkages between primary care, public health, and community based supports

NY's State Innovation Model Testing Grant

$100M over 48 months to develop implement and test a new primary care delivery model inclusive of measurement, workforce and population health

1. Institute a statewide program of regionally-based primary care practice transformation activities to help practices across New York deliver 'advanced primary care';

2. Support performance improvement and capacity expansion in primary care by expanding New York's primary care workforce through innovations in professional education and training;

3. Integrate APC with population health through Public Health Consultants funded to work with regional practice transformation and Population Health Improvement Program (PHIP) contractors

4. Develop a common scorecard, shared quality metrics and enhanced analytics to assure that delivery system and payment models support three- part aim objectives; and

5. Provide state-funded health information technology, including enhanced capacities to exchange clinical data and an all-payer database.

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SIM efforts are centered around 4 multi-stakeholder working groups, coordinated by a Health Innovation Council

Integrated Care

Create an **Advanced Primary Care** delivery model, inclusive of behavioral and population health, a payment methodology that is reasonable, workable, and sustainable and ensure access to high quality care for all New Yorkers

HIT, Transparency and Evaluation

Maximize new technologies that enable enhanced communications between care providers and that utilize data to inform care, assure quality and promote value

Health Innovation Council

Workforce

Support training the next generation of the healthcare workforce to function in a system that is better integrated and includes a strong focus on behavioral and population health

Access to Care

Elimination of financial, geographic, cultural and operational barriers to accessing appropriate care in a timely manner

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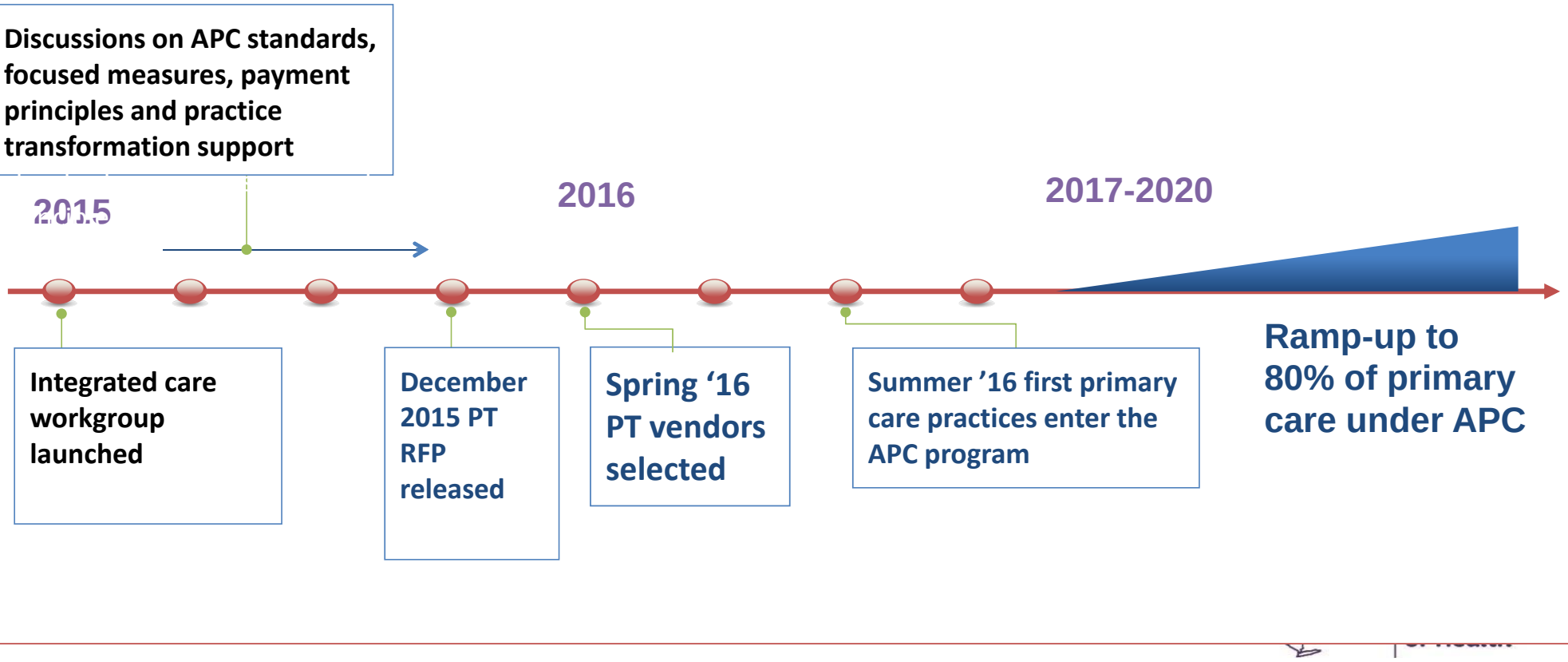
APC Timeline

New York State Advanced Primary Care Proposed Timeline



Advanced Primary Care

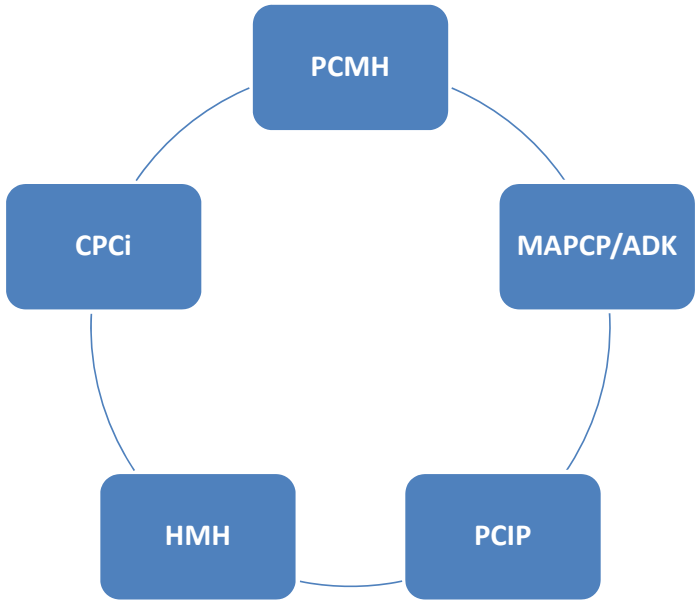
- *Model intended to provide a structure for **multi-payer** initiatives using performance data to inform financial support to primary care practices.*
- *Common measure set including those that are considered most important, with the best evidence base that are practical, sustainable, and common to many initiatives.*
- *PCMH continues to be a useful training tool to help practices develop the capabilities needed to participate in these initiatives.*

Why Advanced Primary Care?

- To build off of lessons learned from multi-payer initiatives in the State (Adirondacks and Hudson Valley) – both of which have proven effective and both of which are time-limited and specific to unique geographies
- To align Medicare and commercial payers – to complement Medicaid (DSRIP) and simplify practice administrative complexities
- To achieve payer alignment and support team-based care
  - To implement outcome-based payments that support team based care and promote quality and efficiency – a win – win for providers (moving off the fee-for-service treadmill) and payers (including Medicaid/DSRIP) to pay for quality on an ongoing basis
- To reduce administrative complexities through a limited, parsimonious set of quality metrics that can be used across plans and payers
  - To provide metrics to payers that support continued investment in practices beyond initial certification

What is Advanced Primary Care (APC)

A model built off of lessons learned from:



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APC will be defined by standards and measures, and supported by practice transformation support and innovative payment strategies

APC program overview

Standards and milestones

- A set of tools and services that will help practices succeed on APC measures
- Reflect changes in structure, process, capabilities at a practice level
- Basis for milestones and ramp-up payments

Measures

- A set of standardized process and outcome measures at a patient level with intrinsic value to patients and payers
- Facilitated by structural changes mandated by standards, but not duplicative
- Basis for outcome-based payments

Payment and practice transformation support

- Support for practices to invest in resources to succeed on measures, contingent on meeting milestones
- Multi-payer agreement on payment for a standardized set of measures to reward success on desired outcomes

SHIP Advanced Primary Care (APC) Model

Pre-APC

- Transitional, **time-limited** status with obligation to reach APC status
- Demonstrate capacity/willingness to 'transform'

APC

- **Potential final destination** for some practices without infrastructure to reach Premium APC
- Key infrastructure in place for management of complex populations
- Demonstrated higher level PCMH with results

Premium APC

- Practices manage population health, integrating behavioral health
- Medical neighborhood and community-facing care coordination
- 'ACO-ish'
- Performance driven payments

Department of Health

The APC Tiers

Domains/

Levels to APC

- Pre-APC
- APC
- Premium APC

7 Standards

- Patient Centered Care
- Population Health
- Care Management
- Access to Care
- Quality Improvement
- Care Coordination
- Health Information Technology

Converging on

- The Triple Aim
- Better Health, Better Care
- At Lower Cost

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APC Tiers – Revised Aug 20, 2015 (1/4)

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
1. Patient-centered care	At least **annual** patient survey, or patient advisory council or patient focus group and incorporation of results/recommendations as part of QI plan.	All previous plus: a. At least **semi-annual** patient survey, or patient advisory council or patient focus group and show evidence of incorporation of results as part of QI plan. b. Conduct comprehensive health assessment for each patient inclusive of discussion of advanced directives. c. Develop care plans in concert with patient preferences and goals d. Provide culturally and linguistically appropriate care and services to promote access and quality.	All previous plus: a. At least **quarterly** patient surveys or patient advisory council or focus group and show evidence of incorporation as part of QI plan. b. Report survey results to patients, payers or both. c. Include patient or family member as part of practice advisory council or governance structure. d. Report results of at least one standardized measure to patients.
2. Population health		a. Identify **at least annually** patients due for preventive or chronic care management services and communicate reminders. b. Evaluate health disparities in access/outcome as part of QI plan. c. Offer or refer patients to structured health education programs such as group classes, peer support, and self-management programs. d. Measure and report one prevention agenda (PA) goal consistent with local PA goals.	All previous plus: a. Evaluate health disparities as part of QI plan **and develop plan to address** b. Identify, **more than annually**, patients due for preventive or chronic care management services, communicate reminders and **ensure provision of appropriate follow-up care** c. Maintain a list of community-based services that are relevant to the practice's high-risk population and establish referral and feedback mechanisms for linking patients with these services.

APC Tiers – Revised Aug 20, 2015 (2/4)

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
3. Care manage-ment	a. Identify high risk patients who would benefit from care management (CM) b. Screening, treatment and referral where indicated for behavioral health issues.	All previous plus: a. Provide/offer (CM) to **at least 75% of** high risk patients. b. Electronic medication reconciliation for patients transitioning from institutional care. c. Provide core elements of Collaborative Care model for depression screening and management, including assessment, data collection and tracking metrics over time.	All previous plus: a. CM services offered to **all** high-risk patients. b. Integrate practice care management with Medicaid health home and health plan care managers as appropriate. c. Evidence-based screening, intervention, and referral to treatment, to prevent, identify, and address substance use disorders
4. Access to care	a. 24/7 same day patient access to nurse or other clinician via telephone and/or secure electronic messaging	All previous plus: a. Access to EHR by the on-call clinician after hours. b. Patient access to care during non-traditional hours including at least one session/week of evening/weekend office hours. c. Synchronous and asynchronous communication such as secure electronic messaging between patient and provider with commitment to an explicit response time goal.	All previous
5. Quality improve-ment	a. Evaluate practice performance using a set of at least 3 standardized quality (HEDIS, QARR, MU CQMs, etc.).	All previous plus: a. Measure and report at least six standardized measures (including behavioral health and patient experience) b. Incorporate results as part of a formal QI process. c. At least half of measures should be from EHR.	All previous plus: a. At least half of measures make use of CQM data.

APC Tiers – Revised Aug 20, 2015 (3/4)

	PRE APC (Commits to meeting APC Standards within 1-2 years)	APC	PREMIUM APC
6. Care coordination	a. System in place to track high risk referrals	a. Track referrals and reports of referral visit to PCP and have processes to address uncompleted referrals or reports. b. Have care compacts or collaborative agreements with specialists (including behavioral health) to improve transitions in care. c. Have systems in place to identify and contact patients seen in an ED or hospital discharges.	All previous plus: a. Measure the effectiveness of care transitions processes in contacting and following up with patients and implement QI efforts as needed.
7. Health Inform-ation Tech-nology	Practice able to meet one of the following: a. Attest to Meaningful Use Stage 1 within one year b. Signed contract with an EHR vendor c. IT and data utilization capabilities including: • Tool to enable population health tracking and quality reporting over time • Access to and use of reports (clinical or claim-based) that identify high risk patients • Ability to electronically document and share a care plan, with all members of the practice.	All previous plus: a. Meaningful Use Stage 1 b. Connected to local RHIO or has plans to connect with six months.	All previous a. Meets all MU Stage 2 and Stage 3 requirements. b. Connected to local RHIOs and uses data for patient care activities.

Measurement Goals

Measures should strive toward alignment and parsimony:

- Alignment
  - Same measures across payers
  - Measures that serve multiple purposes – APC and other
- Avoid completely new measures
- Include both process and outcome
  - Process measures should be closely associated with improved outcomes

Revised APC Core Measures draft with expected data sources

Claims Claims + EMR Survey

Prevention

1. Colorectal Cancer Screening*
2. Chlamydia Screening*
3. Influenza Immunization - all ages*
4. Childhood Immunization (status)*
5. Fluoride Varnish Application

Chronic Disease (Prevention and Management)

6. Tobacco Use Screening and Intervention*
7. Controlling High Blood Pressure*
8. Diabetes A1C Poor Control*
9. Appropriate Medication Management for People with Asthma*
10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents **and adults***

***DSRIP Measures**

Behavioral Health/Substance Abuse

11. Depression screening and management*
12. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

Patient Reported

13. Record Advance Directives for 65 and older
14. CAHPS Access to Care, Getting Care Quickly*

Appropriate Use

15. Use of Imaging Studies for Low Back Pain
16. **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**
17. Avoidable Hospitalization*
18. Avoidable readmission*
19. Emergency Dept. Utilization*

Cost of Care

20. Total Cost of Care

Practice Transformation RFP

FUNDING:

$67M available for practice transformation through SIM grant

AWARDS:

Number TBD

TIMELINE:

RFP Released Fall/Winter 2015

Contracts executed for Summer 2016 start date

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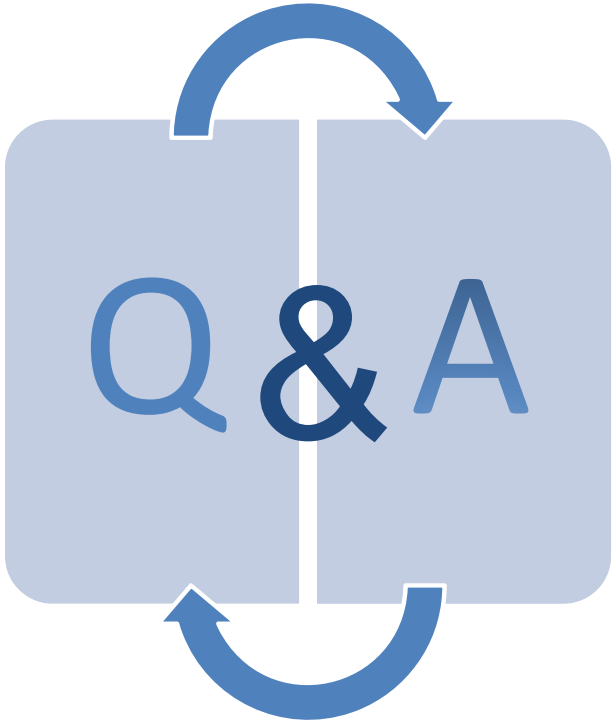
NCQA's PCMH and APC

- Is APC a viable alternative to NCQA PCMH: For those who feel PCMH too heavy a lift? For those nearing retirement?
- How is APC different from PCMH?
- Which is more meaningful (to patients, providers, payers)?

APC…



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For more information on the New York SIM project, visit
https://www.health.ny.gov/technology/innovation_plan_initiative/

For any SIM questions, or to join our SIM Newsletter, email sim@health.ny.gov

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