Partners Improving the Health of New York State
Health Transformation in New York State
Progress on Health Transformation in NYS

• Improving Access
• Containing Costs
• Capital Investments for Health System Transformation
• Advancing the Prevention Agenda
• Delivery System Reform Incentive Payment (DSRIP)
• State Health Innovation Plan (SHIP)
Improving Access

New York State of Health (NYSoH)

Over 3.6M New Yorkers Enrolled

QHP and Essential Plans increased by 39% from 2016 to 2017.

- Medicaid: 67% (2,427,375)
- Child Health Plus: 7% (242,880)
- Essential Plan: 18% (665,324)
- QHP: 8% (299,214)

Note: All figures current as of January 31, 2017
Source: NYSoH
Improving Access

Medicaid Enrollment Has Expanded Dramatically Under Governor Cuomo

<table>
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<tr>
<th>Year</th>
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Millions
Medicaid Spending per Recipient (CY2003-2015)

Source: NYS DOH OHIP DataMart (based on claims paid through June 2016)
Healthcare Capital Investments from SFY 14-18

– Capital Restructuring Financing Program (CRFP): $1.2B
– Healthcare Facility Transformation Program: $1.7B
  • Kings County: $700M
  • Oneida: $300M
  • Statewide: $200M
  • Statewide II: $500M
– Essential Healthcare Program: $355M
The Prevention Agenda has become a catalyst for action and a blueprint for improving health outcomes

- The Prevention Agenda is NYS’s public health improvement plan with the goal to improve health and reduce health disparities across the state through an increased emphasis on prevention.

- Since 2014, the Prevention Agenda has made substantial progress across 96 measures of public health and prevention – meeting and exceeding our goals ahead of schedule in several areas.

- Our plan for the next phase of the Prevention Agenda includes adoption of a health across all policies approach.
Prevention Agenda Dashboard measures progress on 96 statewide outcome indicators, including reductions in health disparities.

As of December 2016:

- **34 indicators show progress** (28 with significant improvement)
  - Preventable Hospitalizations Rate
  - Obesity Rates
  - Asthma Related Hospitalizations
  - Tobacco Use
- **51 not met and staying the same**
- **11 not met and going in wrong direction**

Progress on 96 Prevention Agenda Indicators

- **2013-2018**

https://health.ny.gov/preventionagendadashboard
NYS Supports a Robust Public Health Program

- Communicable Disease Prevention, including HIV
- Chronic Disease Prevention
- Environmental Health Protection
- Public Health Preparedness
- Public Health Laboratory
- Family Health Services, including Family Planning, School Based Health Centers, Home Visiting...
Since 2014 Health System Performance Has Significantly Improved Under Governor Cuomo

New York’s Transformation Vision and Investments

Statewide DSRIP Goals for 2020

- 25% reduction in avoidable hospital use
- At least 80% managed care payments to providers via value-based payment methods
- Transform the New York State health care system into a “financially viable, high performing system”

DSRIP program funding
DSRIP funding via waiver and additional federal/state funding

Capital Restructuring Financing Program funding
State funding for capital and infrastructure improvements

Medicaid Redesign funding
Health home development, long-term care services, home- and community-based services funding via waiver

Interim Access Assurance Fund
Time-limited funding for safety-net providers via waiver

DSRIP Investments: $9.2 Billion
- $6.42 billion
- $1.2 billion
- $1.08 billion
- $500 million
DSRIP Implementation Timeline and Key Benchmarks

We are here & midpoint assessment is complete

Focus on Infrastructure Development/System Design

Q1|Q2|Q3|Q4

DY0

Submission/Approval of Project Plan

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

Focus on Continued System/Clinical Improvement

Q1|Q2|Q3|Q4

DY1

Q1|Q2|Q3|Q4

DY2

Domain 3: Clinical Improvement P4P Performance Measures begin

Domain 2: System Transformation P4P Performance Measures begin

Focus on Project Outcomes/Sustainability

Q1|Q2|Q3|Q4

DY3

Q1|Q2|Q3|Q4

DY4

Q1|Q2|Q3|Q4

DY5

Domains 2 & 3 are completely P4P

Domain 4: PPS working in collaboration with community and diverse set of service providers to address statewide public health priorities; system improvements and increased quality of care will positively impact health outcomes of total population.
State Health Innovation Plan (SHIP)

**Goal**

*Delivering the Triple Aim – Healthier people, better care and individual experience, smarter spending*

**Pillars**

1. **Improve access to care for all New Yorkers, without disparity**
   - Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way

2. **Integrate care to address patient needs seamlessly**
   - Integration of primary care, behavioral health, acute and post-acute care, and supportive care for those that require it

3. **Make the cost and quality of care transparent to empower decision making**
   - Information to enable individuals and providers to make better decisions at enrollment and at the point of care

4. **Pay for health care value, not volume**
   - Rewards for providers who achieve high standards for quality and individual experience while controlling costs

5. **Promote population health**
   - Improved screening and prevention through closer linkages between primary care, public health, and community-based supports

**Enablers**

1. **Workforce strategy**
   - Matching the capacity and skills of our health care workforce to the evolving needs of our communities

2. **Health information technology**
   - Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation

3. **Performance measurement & evaluation**
   - Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation
**NYS Advanced Primary Care (APC)**

**Vision**

- Create a vision for Advanced Primary Care (APC) that coordinates care across specialties and care settings, improves experience/quality, and reduces costs

- Catalyze multi-payer (including Commercial, Medicaid, and Medicare) investments in primary care practices

- Align on an innovative but consistent measurement and payment system with payers and providers that drives improvements in population health

- Provide and finance practice transformation technical assistance

**Goals**

- 80% of the state’s population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral healthcare

- 80% of care paid for under a value-based financial arrangement

- Alignment with other State & Federal Practice Transformation Initiatives (DSRIP/CPC+)
Health Information Exchange

Hospitalization Event Notifications and Reductions in Readmissions of Medicare Fee-for-Service Beneficiaries in the Bronx, New York

Journal of the American Medical Informatics Association
October 7, 2016

An Empirical Analysis of the Financial Benefits of Health Information Exchange in Emergency Departments

Journal of the American Medical Informatics Association
June 27, 2015

Value Based Care

Improve patient outcomes – both treatment & prevention

Supports care coordination & shared savings opportunities

Less time testing and more on patient care

Improve accuracy and speed of diagnosis
The goal of the APD is to serve as a comprehensive data and analytical resource for supporting decision making and research.

- The APD will link health care data with other data sources for use in robust analytic solutions by integrating claims and encounters with additional clinical data, health assessments, functional assessments, and social information.

- Ultimately, the APD will provide information for use in quality measurement, consumer transparency, health care policy, and health care research.
The All Payer Database Supports Health Transformation Initiatives

Systematic Integration of Data Technology

- All Payer Database
- SHIN-NY
- Health Assessment Data
- Public Health Data (Registries, Survey Data)
- Non-Health / Non-Claim Based Data

Analysis and Analytics

- Quality and Performance Standards Driving Quality Improvement
- Quality, Outcome and Cost Measurement: Advanced Primary Care Scorecard
- Manage and Coordinate Care through Tracking of High Acuity Patients
- Efficiency and Patient Safety Metrics
- Clinical Decision Support

Health Care Reform System Transformation

- Delivery System Reform Incentive Payment Program (DSRIP)
- State Innovation Model (SIM) Advanced Primary Care (APC) Model
- Transforming Practice Efforts: Clinical Practice Initiative (TCPI), CPC, PCMH
- Value Based Health Care Competition / Outcomes-Based Payment Models
- CMS Medicare Reform: MACRA Quality Payment Program
Health Across All Policies

An approach recognizing that:

• Health is an outcome of a wide range of factors, many of which fall outside the purview of the health sector
• All government policies can have an impact (positive or negative) on the determinants of health
• The impacts of health determinants are not equally distributed among population groups: health disparities must be addressed
• Efforts to improve the health of the population require collaborative government agency and private sector partnerships to develop integrated solutions
What Determines Health?

Impact of Different Factors on Risk of Premature Death

- Genetics: 30%
- Health Care: 10%
- Social and Environmental Factors: 20%
- Individual Behaviors: 40%

Health In All Policies is a multi-sectoral approach to improving health
# Health Across All Policies

<table>
<thead>
<tr>
<th>Economic Development</th>
<th>Healthy Eating</th>
<th>Active Living</th>
<th>Built Environment</th>
<th>Injuries, Violence and Occupational Health</th>
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<tr>
<td>• Job creation and economic stability</td>
<td>• Healthy food procurement policies in hospitals and other institutions</td>
<td>• Complete Streets policies</td>
<td>• “Green” building practices</td>
<td>• Reduce violence by targeting prevention programs particularly to highest-risk populations</td>
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<td>• Shared space agreements and joint use agreements to increase areas designated for public recreation, particularly in low-income communities</td>
<td>• Incentives for compliance with and enforcement of existing housing and building code in high-risk housing.</td>
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<td>• Optimize indoor air quality building codes</td>
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<td>• Reducing slip and fall hazards in common areas of residences and public buildings</td>
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**Focus on Healthy Aging and Creating Age Friendly Communities**
Three Buckets of Prevention

Traditional Clinical Prevention
1. Increase the use of evidence-based services

Innovative Clinical Prevention
2. Provide services outside the clinical setting

Total Population or Community-Wide Prevention
3. Implement interventions that reach whole populations

Alignment of NYSDOH Prevention Activities* Across Initiatives and By Bucket of Prevention

**NYSDOH Initiatives**
- Medicaid Reform: Delivery System Reform Incentive Payment Program
- State Innovation Plan
- CDC-funded Initiatives
- State-funded initiatives
- Prevention Agenda 2013-18

**Bucket 1:** Traditional clinical preventive interventions
- PPS Domains 1-3 Projects (cardiovascular disease, diabetes, asthma)
- APC: Care Coordination milestone
- LIFT Population Health
- Cancer Services Program
- Health Systems Learning Collaborative
- Breastfeeding Quality Improvement in Hospitals
- Health Systems for a Tobacco-Free NY

1.4 Expand the role of providers in obesity prevention
2.2 Promote tobacco cessation
3.2 Promote evidence-based care

**Bucket 2:** Innovative preventive interventions that extend care outside the clinical setting
- PPS Domains 1-3 Projects (cardiovascular disease, diabetes, asthma)
- APC: Care Coordination / Population Health milestones
- LIFT Population Health
- Pharmacist’s role in chronic disease management
- Promotion of National Diabetes Prevention Programs
- Creating Breastfeeding Friendly Communities
- NYS Smokers’ Quitline
- Breast Cancer Patient Navigators

3.1 Increase screening rates
3.3 Promote chronic disease self-management education

**Bucket 3:** Total population or community-wide interventions
- PPS Domain 4 Projects (based on Prevention Agenda) (tobacco)
- APC: Population Health milestones
- LIFT Population Health
- Sodium Reduction in Communities
- Food procurement policies
- Creating Healthy Schools and Communities
- Advancing Tobacco-Free Communities
- State Aid for Chronic Disease Prevention

1.1 Create healthy communities for nutrition and physical activity
2.1 Prevent initiation of tobacco
2.3 Eliminate exposure to second hand smoke

*The list of activities is not comprehensive, but illustrative, with a focus on chronic disease prevention. October 2016.
On-Going Challenges

- Pressure on Safety-Net and Rural Providers
- Resistance to payment reform and other healthcare reforms
- Trade-Offs from Consolidation of Health Systems
- Regulatory Obstacles to Change
- Continuing Opioid and Mental Health Crisis
New Opportunities

- Regulatory Modernization
- Embracing Technology
- Increased Focus on Health Across All Policies
- Scaling the successful DSRIP and SHIP initiatives
Thank you