NEW YORK STATE | Department of Health | Medicaid Redesign Team

Chronic Pulmonary, Heart, Diabetes, and Primary Care

Clinical Advisory Group (CAG) Meeting

Douglas G. Fish, MD | Office of Health Insurance Programs

Lindsay Cogan , PhD | Office of Quality and Patient Safety

Emily Engel | Bureau of Social Determinants of Health

Pat Lincourt, LCSW | Office of Alcoholism and Substance Abuse Services

Meghann Hardesty, Executive Director | Community Health IPA

May 10, 2018

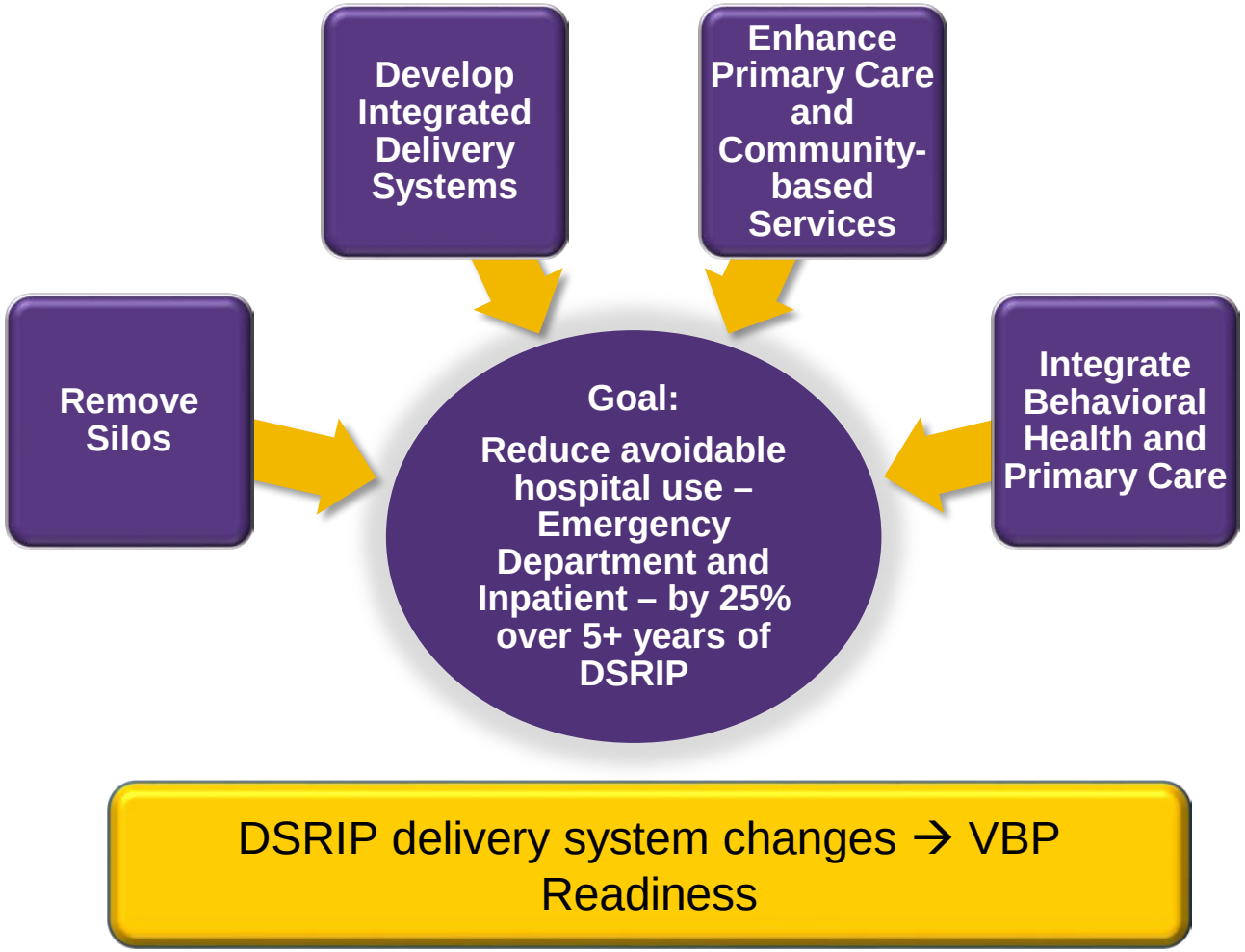
Agenda

1.	Introduction	10 min
2.	Introduction to Bureau of Social Determinants of Health (SDH)	10 min
3.	New York State (NYS) Core Quality Measurement Strategy	40 min
4.	National Quality Measurement Updates	10 min
5.	Overview of New Measurement Year (MY) 2017 BH Measures	20 min
6.	Community Health Independent Practice Association (CHIPA) Pilot Update	20 min
7.	MY 2018 Priority Clinical and Care Delivery Goals	10 min

Section 1: Introduction

Roll Call
DSRIP Program Objectives
Timelines and Expectations

Delivery System Reform Incentive Payment (DSRIP) Program Objectives



- DSRIP was built on the CMS and State goals in the Triple Aim:
  - o Improving quality of care
  - o Improving health
  - o Reducing costs

- DSRIP program goes through March 31, 2020 & NYS DOH 1115 Waiver renewed in December 2016 for 5 years, until 2021.

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/. Accessed May 5, 2016.

VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

2016	2017	2018	2019	2020
DSRIP Goals	*April 2017*	*April 2018*	*April 2019*	*April 2020*
	PPS requested to submit growth plan outlining path to 80-90% VBP	**≥ 10% of total MCO expenditure in Level 1 VBP or above**	**≥ 50% of total MCO expenditure in Level 1 VBP or above. ≥ 15% of total payments contracted in Level 2 or higher**	**80-90% of total MCO expenditure in Level 1 VBP or above ≥ 35% of total payments contracted in Level 2 or higher**

Acronyms: NYS = New York State; PPS = Performing Provider System; MCO = Managed Care Organization

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CAG Timeline & Expectations for 2018

2018 CAG Goals

- Conduct annual review of the quality measure sets
- Identify and analyze clinical and care delivery gaps in current measure sets
- Propose recommendations for 2019

Timeline

- CAGs will convene in **April/ early May & August**
- Based on CAG feedback, the State will present the proposed measure set to the VBP Workgroup for approval in **September**
- The final Measurement Year (MY) 2019 Quality Measure Sets will be released in **October**
- The MY 2018 VBP Reporting Requirements Technical Specifications Manual will be released in **October**

VBP Quality Measure Integration Timeline

Summary of 2017 Measure Readiness by VBP Measure Set

In February of 2017, a total of **76** unique quality measures were approved by the VBP Workgroup for further review and incorporation into the 2017 VBP Program. Of the unique measures approved by the VBP workgroup, the following were approved for reporting as Cat 1 or Cat 2 in 2017 through the following VBP arrangements:

TCGP/IPC Measure Set (40 Total Measures)	HARP Measure Set (41 Total Measures)	HIV/AIDS Measure Set (44 Total Measures)	Maternity Care Measure Set (18 Total Measures)
• **5** measures are unique to the TCGP/IPC Arrangements • **35** measures are shared with at least one of the other measure sets.	• **9** measures unique to the HARP Arrangement • **32** measures that are also included in the TCGP/IPC Arrangement	• **10** measures unique to the HIV/AIDs Arrangement • **34** measures that are also included in the TCGP/IPC Arrangement	• **17** measures unique to the Maternity Care Arrangement • **1** measure that is also included in the TCGP/IPC Arrangement

Acronyms: Cat = Category; TCGP = Total Care for the General Population; IPC = Integrated Primary Care; HARP = Health and Recovery Plan

2017 TCGP/IPC VBP Arrangement Summary

2017 TCGP/IPC VBP Quality Measure Set	2017 Measure Feasibility Review				Anticipated Integration			
	Feasible in 2017		Not Feasible in 2017					
Measure Set Total*	**All Measures**	**Unique to TCGP/IPC**	**All Measures**	**Unique to TCGP/IPC**	**2018**	**2019**	**2020**	**Integration Date Unknown**
40	**23/40**	14/35	**17/40**	21/35	**+3** *(1 unique)*	**+4** *(0 unique)*	**+5** *(1 unique)*	**5** *(1 unique)*
Category 1								
P4P	**16/18**	2/16	**2/18**	14/16	2	0	0	0
P4R	**4/11**	6/10	**7/11**	4/10	1	2	4	0
Category 2								
	3/11	6/9	**8/11**	3/9	0	2	1	5

*35 measures within the set are also included in the HARP, HIV/AIDS, or Maternity Care Measure Sets

Acronyms: P4R = Pay-for-Reporting; P4P = Pay-for-Performance

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TCGP/ IPC VBP Arrangement Anticipated Measure Integration

Total New Measures	2018	2019	2020	Integration Date Unknown
	+ 3 *(1 unique)*	**+ 4** *(0 unique)*	**+ 5** *(1 unique)*	**5** *(1 unique)*
Category 1 Measures				
P4P	Controlling High Blood Pressure	-	-	-
	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	-	-	-
P4R	*Potentially Avoidable Complications in Routine Sick Care or Chronic Care*	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow – Up Plan	Preventive Care and Screening: Influenza Immunization	-
	-	-	Preventive Care and Screening: Screening for Clinical Depression and Follow–Up Plan	-
	-	-	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	-
	-	-	Comprehensive Diabetes Care: Foot Exam	-
Category 2 Measures				
	-	Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence	*Topical Fluoride for Children at Elevated Caries Risk, Dental Services*	Asthma: Assessment of Asthma Control – Ambulatory Care Setting
	-	Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence	-	Continuity of Care from Inpatient Detox or Inpatient Care to Lower Level of Care
	-	Use of Opioid Dependence Pharmacotherapy	-	*Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver*
	-	-	-	Lung Function/Spirometry Evaluation (Asthma)
	-	-	-	Patient Self–Management and Action Plan (Asthma)

Section 2: Introduction to Bureau of Social Determinants of Health

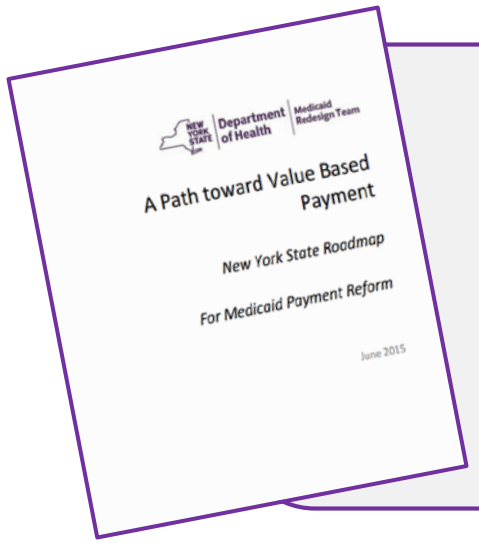
Emily Engel | Bureau of Social Determinants of Health

Bureau of SDH: 2018 Goals

Implement the VBP Roadmap Requirements Related to SDH and CBOs	• Review VBP Level 2 and 3 Contracts and Amendments • Track SDH Interventions and CBO • Provide support and technical assistance
CBO Engagement	• Learning collaboratives with MCOs, VBP contractors, CBOs, & health care providers • Maximize CBO and SDH interventions in the health care system.
Improve SDH Measures in Population Health and Payment Reform	• Increase data collection on SDHs (i.e. electronic health records) • Standardize SDH Quality Measures and incorporating into QARR • Risk Adjustment MMC Plans for SDH
Prevention Agenda	• The State intends to introduce a dedicated value based payment arrangement pilot to focus specifically on achieving potentially trailing Prevention Agenda targets through CBO-led community-wide efforts
Create a New Housing Referral Process	• Integrate MRT SH with PPSs, VBP Contractors, and Health Systems • Create a plan to expand to families to align with the First 1,000 Days

Acronyms: SDH = Social Determinants of Health; CBOs = Community Based Organizations; QARR = Quality Assurance Reporting Requirements; MMC = Medicaid Managed Care; MRT = Medicaid Redesign Team; PPS = Performing Provider System

Standard: Implementation of SDH Intervention

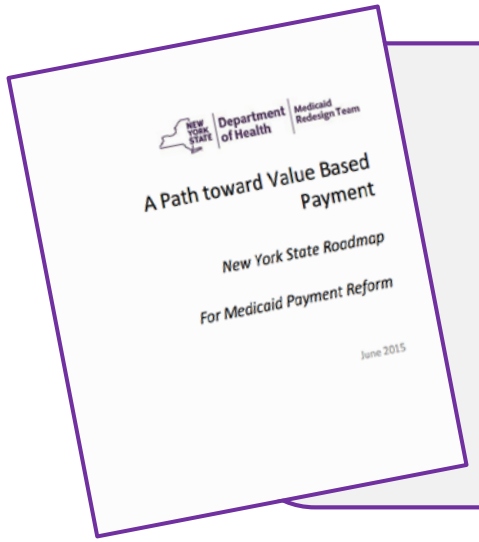


"To stimulate VBP contractors to venture into this crucial domain, VBP ***contractors in Level 2 or Level 3 agreements*** *will be* ***required****, as a statewide standard,* ***to implement*** *at least* ***one social determinant of health intervention****. Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk." (VBP Roadmap, p. 41)*

Description:

VBP contractors in Level 2 or 3 arrangement must implement at least one social determinant of health intervention. Language fulfilling this standard must be included in the MCO contract submission to count as an "on-menu" VBP arrangement.

Guideline: SDH Intervention Selection



*"The **contractors will have the flexibility to decide on the type of intervention** (from size to level of investment) that they implement…The guidelines recommend that selection be based on information including (but not limited to): SDH screening of individual members, member health goals, impact of SDH on their health outcomes, as well as an assessment of community needs and resources." (VBP Roadmap, p. 42)*

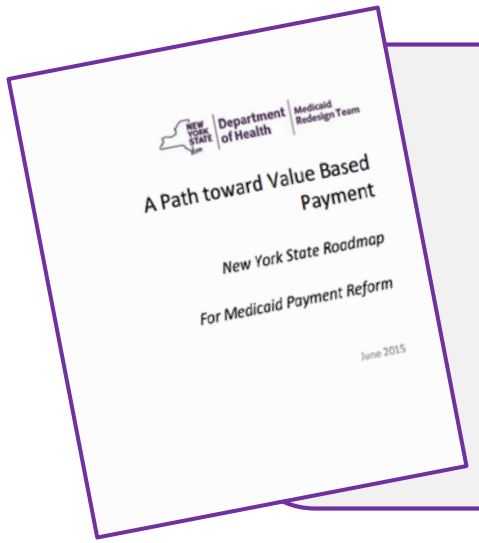
Description:

VBP contractors may decide on their own SDH intervention. Interventions should be measurable and able to be tracked and reported to the State. SDH Interventions must align with the five key areas of SDH outlined in the *SDH Intervention Menu Tool,* which includes:

1) Education, 2) Social, Family and Community Context, 3) Health and Healthcare 4) Neighborhood & Environment and 5) Economic Stability

The SDH Intervention Menu Tool was developed through the NYS VBP SDH Subcommittee and is available here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/

Standard: Inclusion of Tier 1 CBOs



"Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a ***requirement*** *that* ***starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO****."*
(VBP Roadmap, p. 42)

Description:

Starting January 2018, VBP contractors in a Level 2 or 3 arrangement **MUST contract with at least one Tier 1 CBO**. Language describing this standard must be included in the contract submission to count as an "on-menu" VBP arrangement.

This requirement **does not preclude VBP contractors from including Tier 2 and 3 CBOs in an arrangement** to address one or more social determinants of health. In fact, **VBP Contractors and Payers are encouraged to include Tier 2 and 3 CBOs in their arrangements.**

Tier 1, Tier 2, and Tier 3 CBO Definitions

01

Tier 1 CBO

- Non-profit, non-Medicaid billing, community based social and human service organizations
  - e.g. housing, social services, religious organizations, food banks
- *All or nothing*: All business units of a CBO must be non-Medicaid billing; an organization cannot have one component that bills Medicaid and one component that does not and still meet the Tier 1 definition

02

Tier 2 CBO

- Non-profit, Medicaid billing, non-clinical service providers
  - e.g. transportation provider, care coordination provider

03

Tier 3 CBO

- Non-profit, Medicaid billing, clinical and clinical support service providers
- Licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.

Use the **CBO list** on **DOH's VBP website** to find CBOs in your area

Section 3: NYS Quality Measurement Strategy

Quality Measure Consolidation
Overview of MACRA and VBP Alignment
Discussion of Measure Consolidation

Quality Measure Consolidation: Goals for MY 2018

- Implement a focused list of high value quality measures for VBP in MY 2018.
- Key Principles:
  - Process → Outcome
  - Determine the “right” outcomes
  - Focus on efficient measurement:
    - HIT enablement
    - Lab Clearinghouse
    - Integration of Registry Information
- Align quality measurement efforts across stakeholder communities and State-led quality programs
  - DOH and other Health-related Agencies
  - Managed Care Organizations (to include commercial payers)
  - Qualified Entities
  - Electronic Health Record Vendors/ Data Aggregators
  - Healthcare Providers

CMS Meaningful Measures Framework

Focus everyone's effort on the same quality areas:

- Address high-impact measure areas
- Patient-centered and meaningful to patients
- Outcome-based where possible
- Relevant and meaningful to providers
- Minimize level of burden for providers
  - Remove measures where performance is already very high
- Significant opportunity for improvement
- Address measure needs for population-based payment through alternative payment models
- Align across programs and/or other payers

NYS Focus on Meaningful Measures Objectives

Focus Areas:

1. Align across programs and/or other payers
2. Outcome-based where possible
3. Relevant and meaningful to providers
4. Minimize level of burden for providers
   - Remove measures where performance is already very high
5. Address measure needs for population-based payment through alternative payment models

State Efforts:

- Medicaid Involvement in Advanced Primary Care (APC) Initiative
- Reevaluate Quality Measure Sets (Clinical Advisory Groups, Measure Support Task Force, VBP Workgroup)
- VBP Pilot Measure Testing (Controlling High Blood Pressure)

MACRA Includes Several Important Provisions that Affect Federal Health Care Policy

- The *Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA)* requires Centers for Medicare & Medicaid Services (CMS) to implement an incentive program, the Medicare Quality Payment Program (QPP). This policy will reform Medicare Part B payments for more than 600,000 clinicians across the country.
- Under the Medicare QPP, eligible clinicians* (those subject to participation in the program) can participate via one of two tracks:

Merit-based Incentive Payment System (MIPS)

MIPS participants will earn a performance based payment adjustment through MIPS

OR

Advanced Alternative Payment Models (Advanced APMs)

Advanced APM Participants will earn a Medicare incentive payment for sufficiently participating in an innovative payment model

Source: CMS, *Quality Payment Program Year 2*, HIMMS Conference, 2018; CMS, *The Merit-Based Incentive Payment System (MIPS).* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf. *Accessed: April 2 2018.*

QPP Requires Clinicians to Select and Report on Quality Measures

Merit-based Incentive Payment System (MIPS)

Eligible clinicians participating in MIPS are required to select and report on **6 quality performance measures** from the MIPS quality measure list, including **at least 1 outcome measure** or another high-priority measure (if there is no applicable outcome measure)

- 2018 MIPS Quality Measure list consists of **271 measures**, including a substantial number of specialty specific measures.

Advanced Alternative Payment Models (Advanced APMs)

Advanced APM Criteria also requires that the arrangement includes **MIPS-comparable quality measures** tied to payment

- Must have an evidence-based focus, be reliable and valid, and at least one of the following:
  1. Included on the annual MIPS list of measures
  2. Endorsed by a "consensus-based entity" (i.e. the National Quality Forum)
  3. Developed under section 1848(s) - Priorities and Funding for Measure Development - of the Social Security Act (the Act)
  4. Submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act
  5. Other support for measure validation
- **At least one measure must be an outcome** (or intermediate outcome) **measure** on the MIPS measure list (if available)

How does the TCGP/IPC Measure set align with the Advanced APM quality measure criteria?

Included on the 2018 MIPS List of Measures

- 21 measures in both the 2018 MIPS and TCGP/IPC measure sets
- 19 process measures (18 Cat 1, 1 Cat 2)
- 2 outcome /intermediate outcome measures (both Cat 1)

Endorsed by a "consensus-based entity" (i.e. NQF)

- 20 NQF endorsed measures in both the 2018 MIPS and TCGP/IPC measure sets (all Cat 1)
- 11 NQF endorsed measures in TCGP/IPC but not on the MIPS list (8 Cat 1, 3 Cat 2)

Other TCGP/IPC Measures

- 21 measures in the TCGP/IPC measure set that are not on the MIPS list and are not NQF endorsed (9 Cat 1, 12 Cat 2)

Acronyms: Cat = Category; NQF = National Quality Forum

2018 VBP TCGP/IPC Measures Included in MIPS Measure Set

TCGP/IPC Measure	Category	Classification	Measure Steward	NQF Endorsed?	MIPS Measure?
Outcome / Intermediate Outcome Measures					
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Cat 1	P4P	NCQA	Y	Y
Controlling High Blood Pressure	Cat 1	P4P	NCQA	Y	Y
Process Measures					
Anti-Depressant Medication Management	Cat 1	P4P	NCQA	Y	Y
Breast Cancer Screening	Cat 1	P4P	NCQA	Y	Y
Cervical Cancer Screening	Cat 1	P4P	NCQA	Y	Y
Childhood Immunization Status	Cat 1	P4P	NCQA	Y	Y
Chlamydia Screening for Women	Cat 1	P4P	NCQA	Y	Y
Colorectal Cancer Screening	Cat 1	P4P	NCQA	Y	Y
Diabetes Foot Care	Cat 1	P4R	NCQA	Y	Y
Diabetes: Eye Exam	Cat 1	P4P	NCQA	Y	Y
Diabetes: Medical Attention for Nephropathy	Cat 1	P4P	NCQA	Y	Y
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Cat 1	P4R	NCQA	Y	Y
Immunizations for Adolescents	Cat 1	P4P	NCQA	Y	Y
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Cat 1	P4P	NCQA	Y	Y
Medication Management for People with Asthma	Cat 1	P4P	NCQA	Y	Y
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Cat 1	P4R	NCQA	N	Y
Preventive Care and Screening: Influenza Immunization	Cat 1	P4R	AMA-PCPI	Y	Y
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Cat 1	P4R	CMS	Y	Y
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Cat 1	P4R	AMA-PCPI	Y	Y
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Cat 1	P4P	NCQA	Y	Y
Maternal Depression Screening	Cat 2	N/A	NCQA	N	Y

Acronyms: NCQA = National Center for Quality Assurance; AMAM-PCPI = American Medical Association Physician Consortium for Performance Improvement

2018 VBP TCGP/IPC Measures *Not* Included in MIPS Quality Measure Set

TCGP/IPC Measure	Category	Classification	Measure Steward	NQF Endorsed?	MIPS Measure?
Outcome / Intermediate Outcome Measures					
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Cat 1	P4R	NCQA	Y	N
Potentially Avoidable Complications in Routine Sick Care or Chronic Care	Cat 1	P4R	Altarum	N	N
Process Measures					
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Cat 1	P4P	CMS	Y	N
Comprehensive Diabetes Care: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	Cat 1	P4P	NCQA	Y	N
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]	Cat 1	P4P	NCQA	Y	N
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Cat 1	P4P	NCQA	Y	N
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	Cat 1	P4R	NYS	N	N
Statin Therapy for Patients with Cardiovascular Disease	Cat 1	P4R	NCQA	N	N
Statin Therapy for Patients with Diabetes	Cat 1	P4R	NCQA	N	N
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Cat 1	P4R	NCQA	Y	N

Measure Consolidation Efforts by CMS

Measure Consolidation

CMS FY 2019 IPPS/LTCH PPS Proposed Rule

- Recognizing the burden currently on providers, CMS is proposing to ***remove unnecessary, redundant, and process-driven quality measures*** from a number of quality reporting and pay-for-performance programs
- This will eliminate a significant number of measures acute care hospitals are required to report and will remove duplicative measures across the five hospital quality and value-based purchasing programs
    - 19 measures removed from the programs
    - De-duplicate another 21 measures
    - Maintain *meaningful* measures of hospital quality and patient safety

Acronyms: FY = Fiscal Year; IPPS = Inpatient Prospective Payment System; LTCH = Long-Term Care Hospital; PPS = Prospective Payment System

Discussion: Consolidation of VBP Quality Measures

Reducing provider burden and achieving alignment across programs

- The current number of quality measures and the reporting challenges across programs place a significant reporting burden on providers.
- Given this context, please consider the following questions:

1. Should the VBP TCGP/IPC Arrangement Quality Measure Set be condensed to achieve greater alignment with other payers? How should measures be prioritized?
2. Should the Measure Set be condensed to a core set of outcome-based measures where possible? How should measures be prioritized (outcome and process measures)?
3. What are the most appropriate outcome measures for the TCGP/IPC arrangement population? Where none exist, what are the most appropriate process measures, e.g., related to children's care?

Section 4: National Quality Measurement Updates

Chronic Pulmonary, Heart, Diabetes and Primary Care
Mental Health and Substance Use

National Quality Measurement Updates

Chronic Pulmonary, Heart, Diabetes and Primary Care

HEDIS 2019 Public Comment

- Measure Change – Controlling High Blood Pressure
  - o Update the blood pressure target to <140/90 mm Hg for all hypertensive patients 18–85 years of age.
  - o Remove the medical record confirmation requirement and use two outpatient encounters to identify the denominator.
  - o Add administrative numerator specifications.
  - o Allow use of telephone, videoconferencing, and asynchronous telehealth encounters to satisfy one of two required outpatient visits in the denominator.
  - o Allow remote monitoring device readings directly transmitted to and interpreted by the provider to satisfy the numerator.

National Quality Measurement Updates

Mental Health

HEDIS 2019 Public Comment

- Follow-up after ED Visit for Mental Illness
  - Include members with a principal diagnosis indicating *intentional self-harm:*
    - Suicide attempt
    - Poisoning by drugs, medicaments and biological substances due to intentional self-harm
    - Toxic effects of nonmedicinal substances due to intentional self-harm
    - Asphyxiation due to intentional self-harm

Substance Use

HEDIS 2019 Public Comment

- New Measure – Risk of Chronic Opioid Use

NQF Endorsement

- 3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) from Alcohol and/or Drugs (CMS)
- *Spring 2018* Use of Pharmacotherapy for Opioid Use Disorder
- *Fall 2018* Follow-up after Inpatient Hospitalization or Residential Treatment for SUD (alcohol or other drugs)

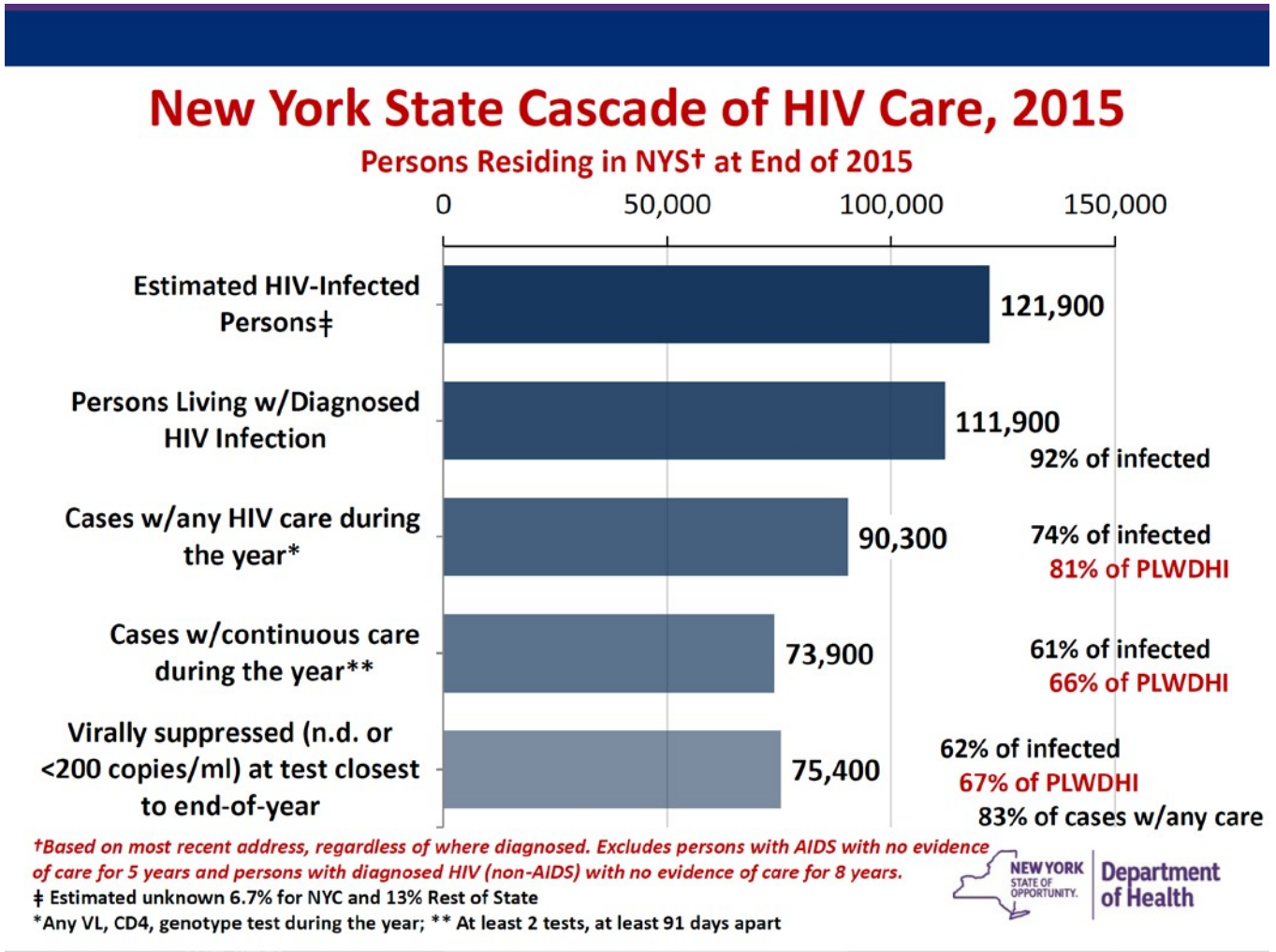
Section 5: Overview of New MY 2017 Behavioral Health Measures

Cascade on Gaps in Care in Opioid Treatment
Update on New Measure Development

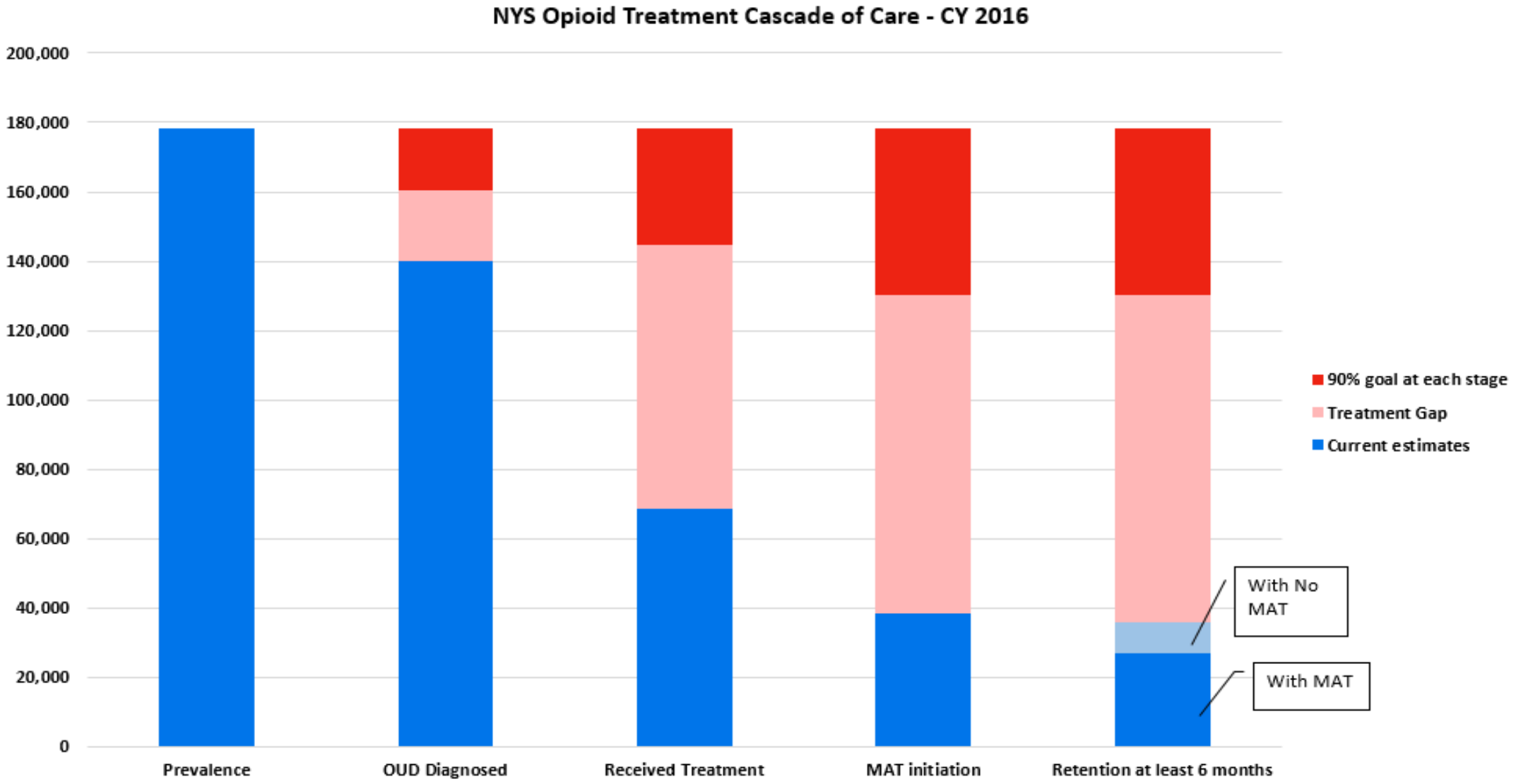
Cascade on Gaps in Care in Opioid Treatment

Pat Lincourt | Office of Alcoholism and Substance Abuse Services

HIV Care Cascade



Source: http://etedashboardny.org/data/prevalence-and-care/hiv-care-cascades/



Source for Prevalence: 2016 U.S Census Bureau. SAMSHA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013, 2014 and 2015.
Source for remaining bars: Medicaid Claims Data CY 2016

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2016 Category 1 & 2 Measure Results – Alcohol and Substance Abuse or Dependence

Initiation of Pharmacotherapy upon New Episode of Opioid Dependence – Category 1

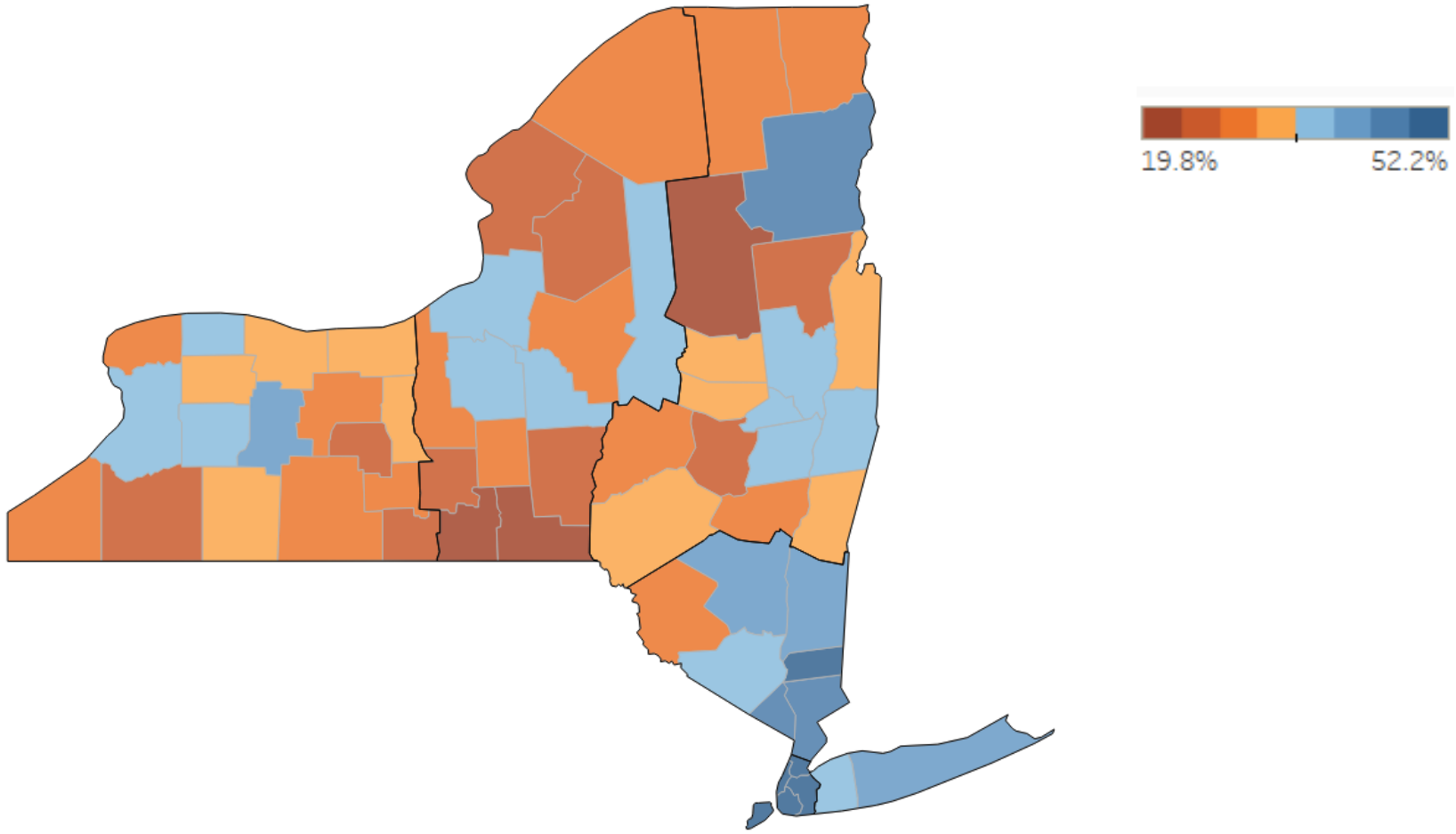
Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

Region	Rate	Numerator	Denominator
Statewide*	43.2%	21,634	50,040
Central	31.2%	1,659	5,314
Hudson Valley	41.8%	2,124	5,085
Long Island	39.5%	2,065	5,226
New York	52.2%	11,576	22,165
Northeast	34.6%	1,288	3,718
Western	34.3%	2,920	8,521

* Missing region data for <1% of members, included in statewide denominator

Initiation of Pharmacotherapy upon New Episode of Opioid Dependence – Category 1

Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016



Utilization of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence – Category 1

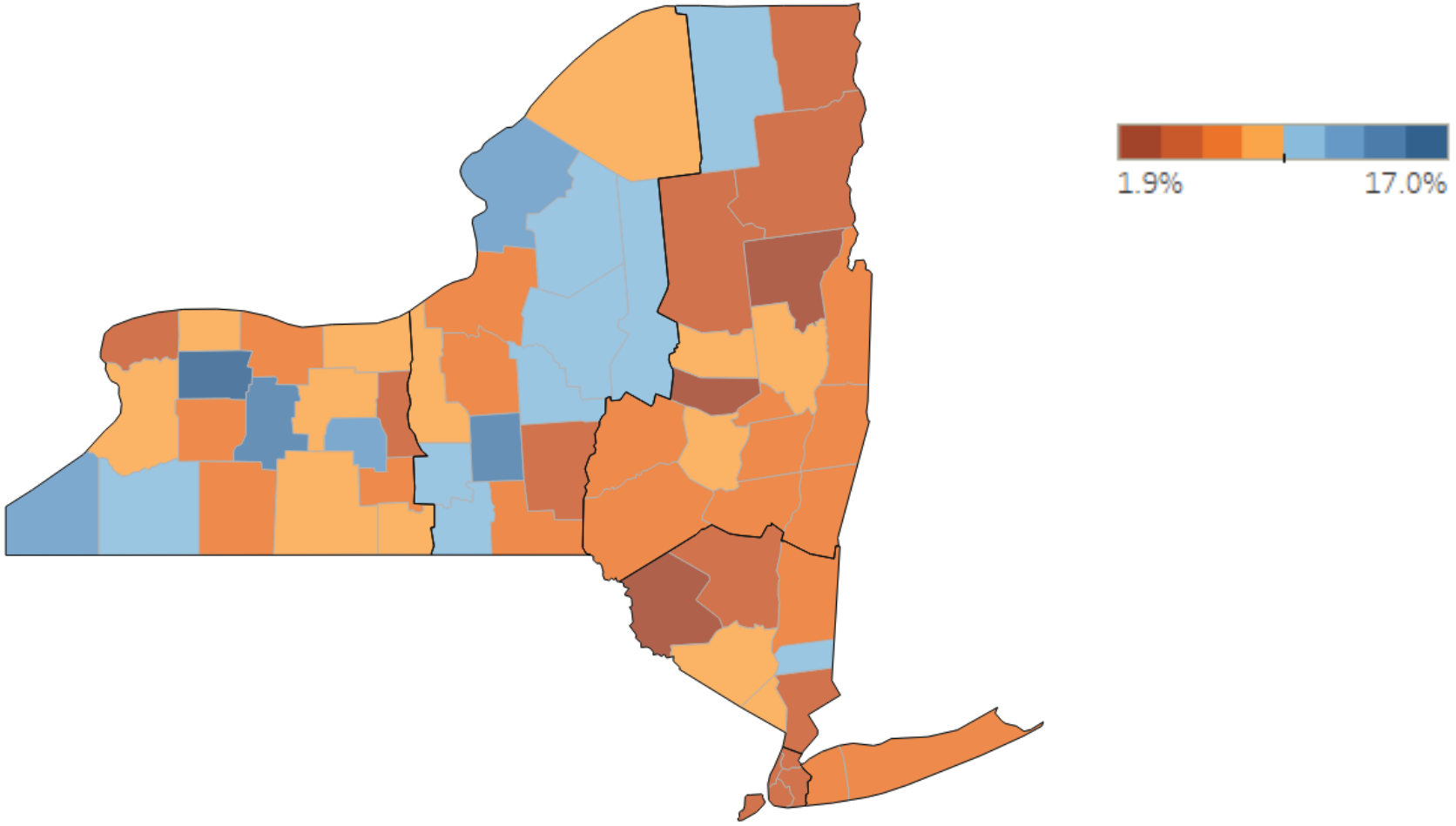
Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

Region	Rate	Numerator	Denominator
Statewide*	6.0%	6158	102423
Central	8.5%	815	9573
Hudson Valley	5.3%	432	8091
Long Island	6.2%	593	9632
New York	4.5%	2088	46611
Northeast	6.7%	511	7620
Western	8.2%	1714	20861

* Missing region data for <1% of members, included in statewide denominator

Utilization of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence – Category 1

Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016



Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence – Category 2

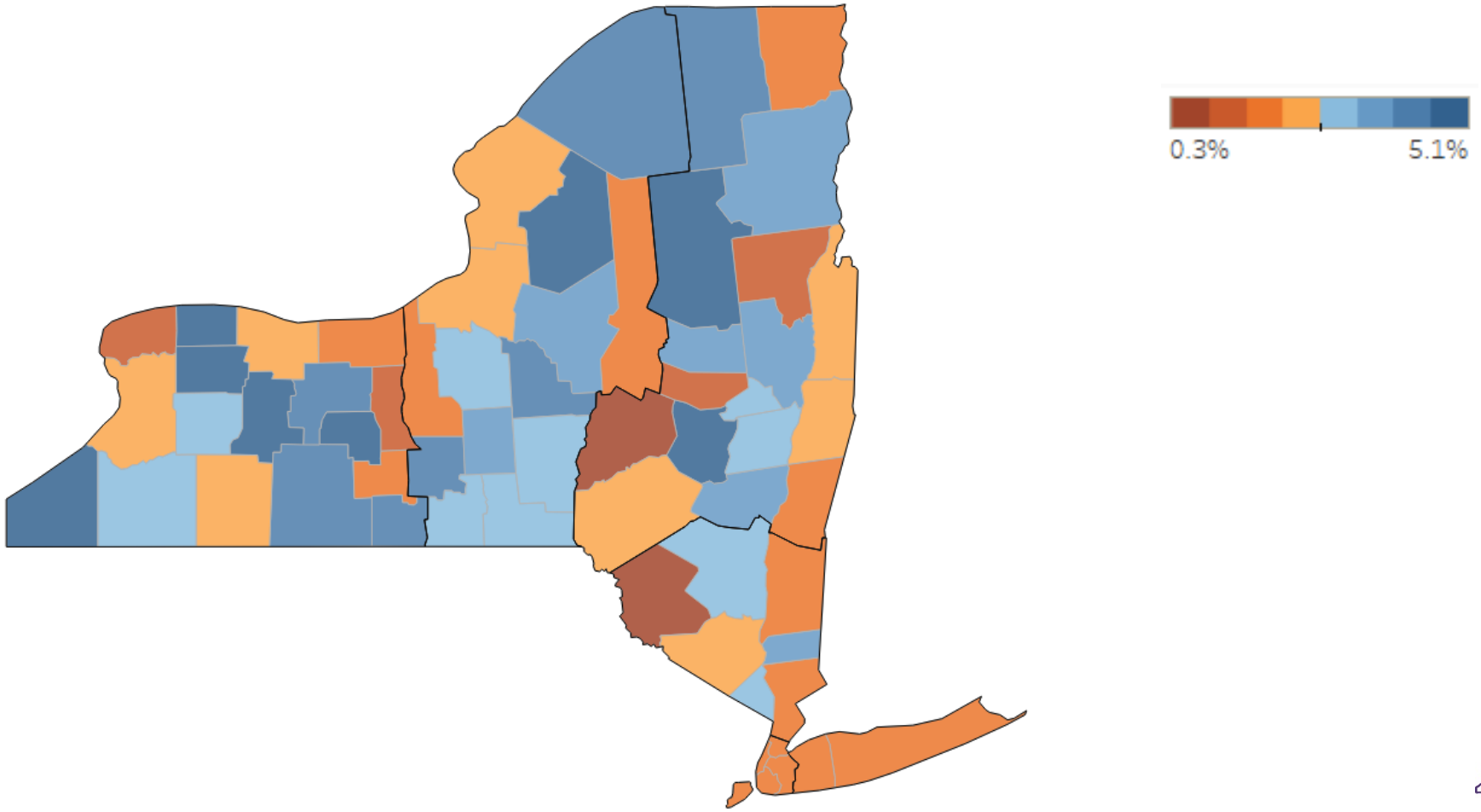
Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

Region	Rate	Numerator	Denominator
Statewide*	2.2%	1,745	80,510
Central	2.9%	228	7,772
Hudson Valley	2.0%	126	6,258
Long Island	1.9%	135	7,092
New York	1.8%	683	37,457
Northeast	2.6%	155	5,917
Western	2.6%	417	15,987

* Missing region data for <1% of members, included in statewide denominator

Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence – Category 2

Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016



Utilization of Pharmacotherapy upon New Episode of Opioid Dependence – Category 2

Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016

Region	Rate	Numerator	Denominator
Statewide*	58.2%	51,328	88,139
Central	56.0%	4,554	8138
Hudson Valley	54.2%	4,342	8,014
Long Island	50.9%	4,709	9,245
New York	61.6%	25,933	42,078
Northeast	54.5%	3,327	6,109
Western	58.2%	8,459	14,539

* Missing region data for <1% of members, included in statewide denominator

Utilization of Pharmacotherapy upon New Episode of Opioid Dependence – Category 2

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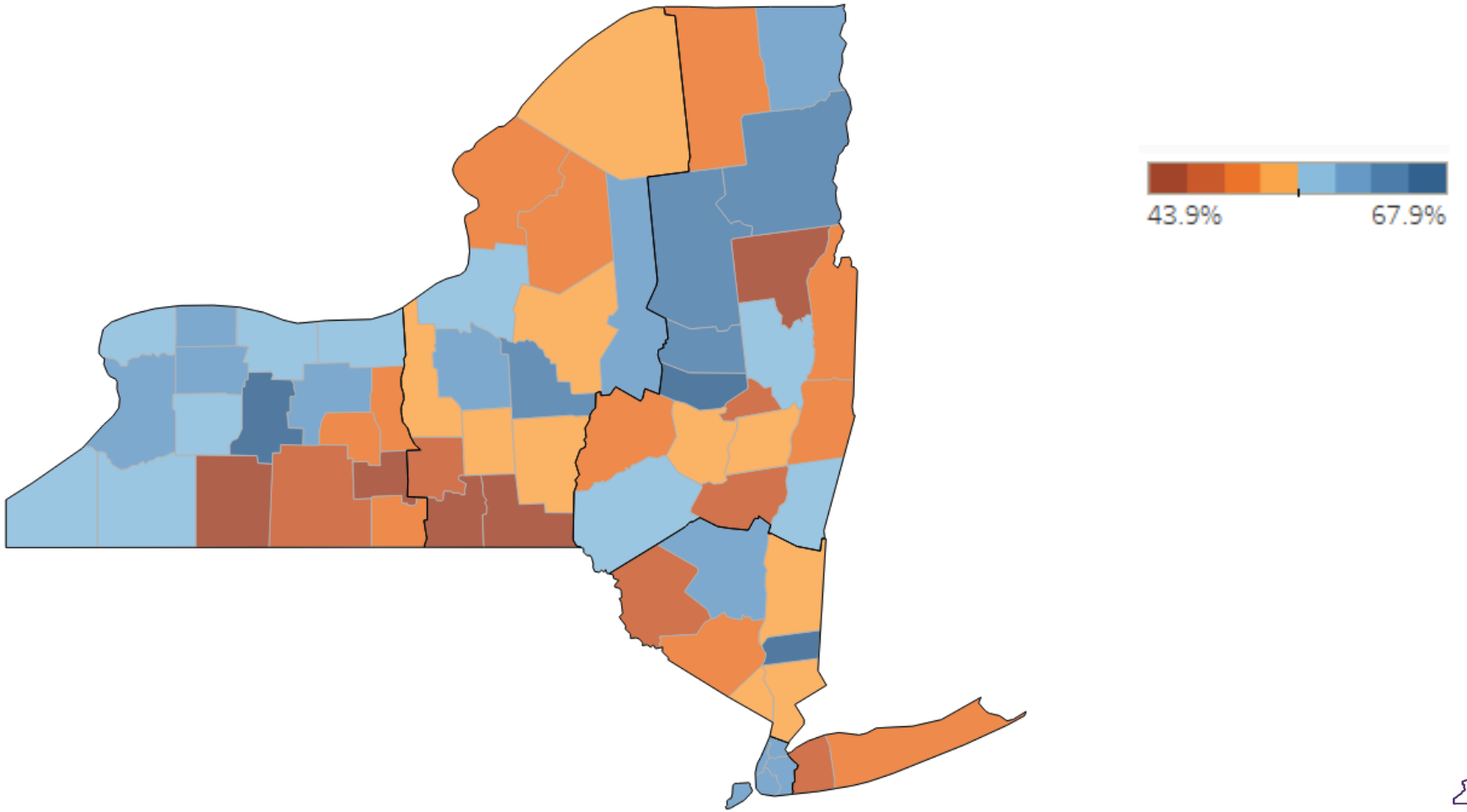
Utilization of Pharmacotherapy upon New Episode of Opioid Dependence – Category 2

Among Members Ages 13+ in HMO/PHSP, HARP, or HIV SNP plans, By Region, 2016



Continuity of Care from Inpatient Detox to Lower Level of Care (COD) – Category 2 for TCGP/IPC

Among Members Ages 21-64 years in HMO/PHSP, HARP, or HIV SNP, By Region, 2016

Region	Rate	Numerator	Denominator
Statewide	46.8%	12,749	27,233
Central	58.5%	744	1,271
Hudson Valley	48.2%	1,188	2,464
Long Island	42.5%	1,456	3,430
New York	44.8%	7,679	17,131
Northeast	52.0%	663	1,275
Western	61.3%	1,019	1,662

Continuity of Care from Inpatient Rehabilitation to Lower Level of Care (COR) - Category 2 for TCGP/IPC

Among Members Ages 21-64 years in HMO/PHSP, HARP, or HIV SNP, By Region, 2016

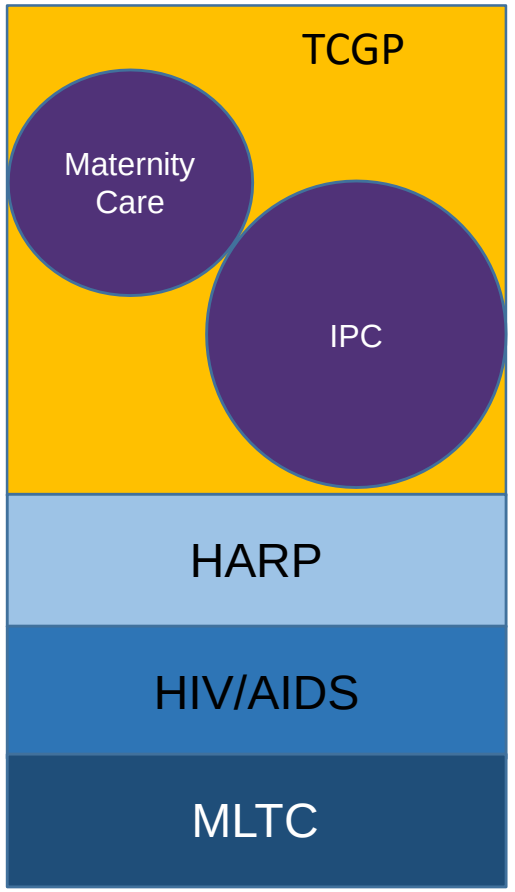
Region	Rate	Numerator	Denominator
Statewide*	45.4%	9,540	21,014
Central	54.7%	1,410	2,577
Hudson Valley	44.9%	936	2,087
Long Island	44.6%	983	2,206
New York	38.2%	3,222	8,444
Northeast	52.1%	820	1,574
Western	52.6%	2,165	4,117

* Missing region data for <1% of members, included in statewide denominator

Overview of TCGP/ IPC Logic

VBP Arrangements

- Arrangement **Types***
  - o Population:
    - o Total Care for the General Population (TCGP)
  - o Episode-based
    - o Integrated Primary Care (IPC)
    - o Maternity Care
  - o Subpopulations
    - o Health and Recovery Plans (HARP)
    - o HIV/AIDS Care
    - o Managed Long Term Care (MLTC)
- Department of Health (DOH) VBP Resource Library website (Link)



Arrangements do not yet include Dually Eligible members

Total Care for the General Population

Goal: Improve population health through enhancing the quality of the total spectrum of care.

- Maximum impact for health systems focusing on both population health and streamlining specialty and inpatient care
  - This means providers will need to have the capability to invest in and focus on population health efforts.
  - Providers should focus efforts on addressing inefficiencies and potentially avoidable complications throughout the entire spectrum of care.

- All patients attributed to the arrangement, not just the patients a provider services, are included in TCGP.
  - Providers will likely need to invest in care coordination, referral patterns and discharge management.

In this arrangement, the VBP Contractor assumes responsibility for the care of the entire attributed population. Members attributed to this arrangement cannot be covered by a different arrangement.

Total Population

— Subpopulations*

Total Care for General Population

*Note: VBP Contractors and MCOs are free to add one or more subpopulations to their TCGP contracts.

Integrated Primary Care (IPC)

Components of Care

Preventive Care → Includes care activities such as wellness visits, checkups, immunizations, screening and routine tests.

Similar to Affordable Care Act (ACA) list of preventive care activities.

+

Sick Care → Includes care for symptoms such as headache or abdominal pain and minor acute conditions such as rhinitis, etc.

+

Chronic Care* → Consists of care related to 14 physical and behavioral chronic conditions that have been prioritized on the basis of prevalence and total costs.

14 episodes included in Chronic care:

1) Hypertension
2) Coronary Artery Disease (CAD)
3) Arrhythmia, Heart Block and Conductive Disorders
4) Congestive Heart Failure (CHF)
5) Asthma
6) Chronic Obstructive Pulmonary Disease (COPD)
7) Bipolar Disorder
8) Depression & Anxiety
9) Trauma & Stressor
10) Substance Use Disorder (SUD)
11) Diabetes
12) Gastro-esophageal reflux disease
13) Osteoarthritis
14) Lower Back Pain

Note: Patients who are attributed to subpopulations are excluded.

*Given the prevalence of chronic co-morbidities, VBP Contractors, by default, include the 14 chronic conditions as a whole within IPC, rather than selecting one or more of the individual chronic conditions.

Source: NYS Department of Health website: VBP Bootcamp – Session 1

Community Health IPA

Quality Measures in VBP Pilot with Affinity Health Plan

To be covered

1. Overview of CHIPA
2. VBP Pilot with Affinity and Selected Quality Measures
3. Baseline Performance
4. Approach to Managing Performance
    a) Implementation of Population Health Management Platform
    b) Establishment of Workgroup to Oversee Performance
5. Discussion

CHIPA

- Community Health IPA LLC (CHIPA) is an IPA owned by FQHCs and Look-Alikes from across New York
- 24 members with more applications in process
- Contracting efforts/negotiations underway with multiple plans
- Infrastructure development underway

Current CHIPA Members

1. Anthony L. Jordan Health Corporation
2. Apicha Community Health Center
3. Boriken Neighborhood Health Center
4. Brightpoint
5. Community Health Center of Buffalo
6. Community Health Center of Richmond
7. Community Healthcare Network
8. Cornerstone Family Healthcare, Inc.
9. Finger Lakes Community Health, Inc.
10. Hudson River HealthCare, Inc.
11. Institute for Family Health, Inc.
12. Jericho Road Community Health Center
13. Long Island FQHC, Inc.
14. Neighborhood Health Center
15. North Country Family Health Center
16. Oak Orchard Health
17. Regional Primary Care Network, Inc.
18. Ryan/Chelsea-Clinton Community Health Center, Inc.
19. Settlement Health
20. Southern Tier Community Health Center Network, Inc. (dba: Universal Primary Care)
21. The Chautauqua Center
22. Tri-County Family Medicine
23. Urban Health Plan, Inc.
24. William F. Ryan Community Health Center, Inc.

VBP Pilot with Affinity Health Plan

- Selected as a VBP pilot in 2016 and entered into an arrangement with Affinity starting January 1, 2017
- Agreement only covers 6 CHIPA members
  - Urban, HRHC, Institute, WFR, RCC, Cornerstone
  - These were the only centers participating with Affinity at the time contract was signed
- Level 1 in first year and Level 2 in second year

Quality Measures - Maintenance

Maintenance Quality Measures (5)	Percentile			2015 Performance (as example)		
	90th	75th	50th	Denominator	Numerator	Rate of Completion
Well Child Visit: 3-6 Years Old	87.5%	83.9%	81.8%	1,443	1,216	84.0%
Cervical Cancer Screening	77.6%	73.9%	72.5%	2,883	3,940	73.2%
Chlamydia Screening (16-24 Years Old)	78.3%	74.7%	70.2%	745	966	77.0%
Medication Management for People with Asthma 50% Days Covered (Ages 5-18)	52.2%	51.6%	50.7%	280	167	59.6%
Medication Management for People with Asthma 50% Days Covered (Ages 19-64)	67.7%	67.5%	64.9%	258	199	77.1%

Quality Measures - Improvement

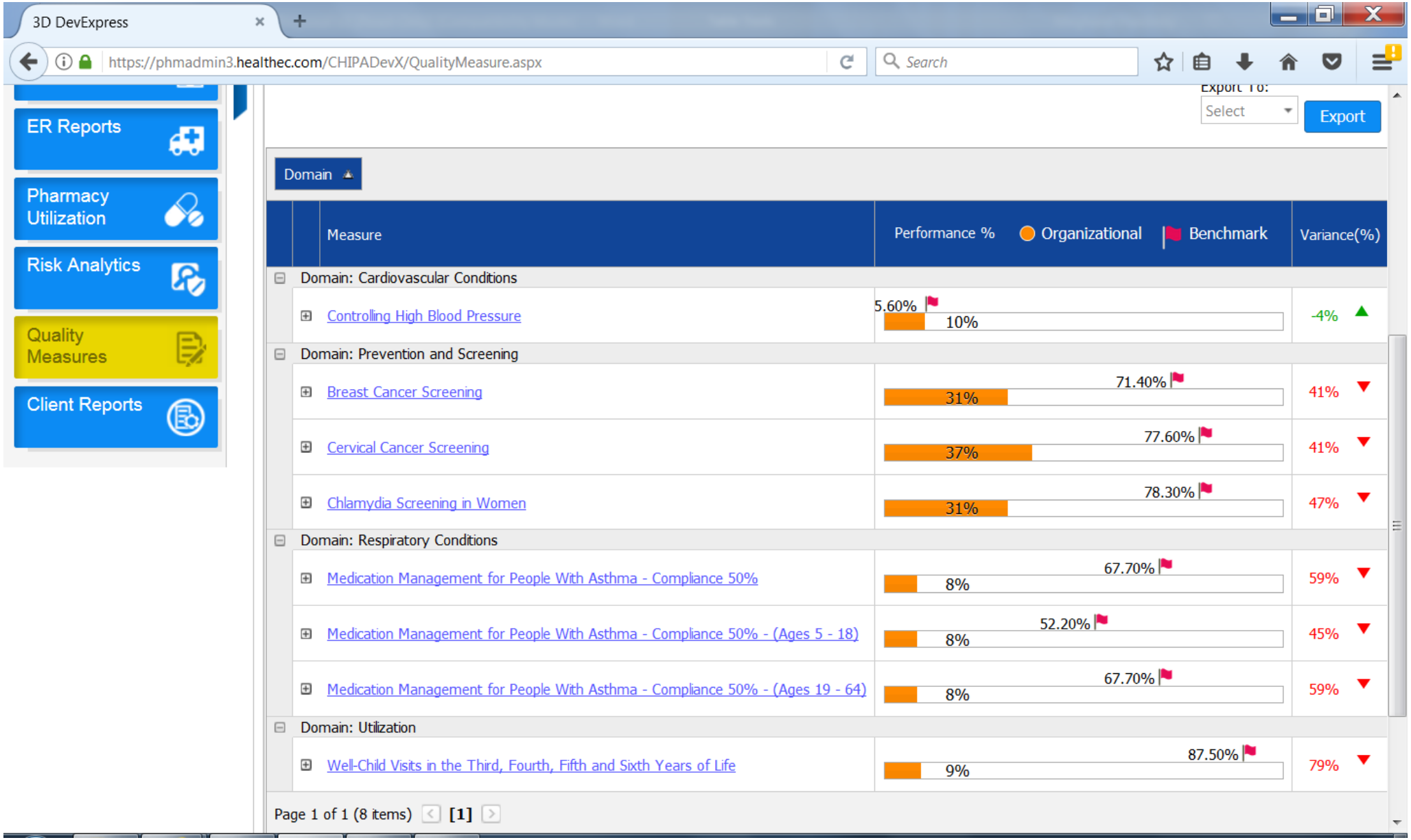
Improvement Quality Measures (2)	Improvement Target			2015 Performance (as example)		
	5%	4%	3%	Denominator	Numerator	Rate of Completion
Breast Cancer Screening	71.4%	70.4%	69.4%	759	504	66.4%
Controlling High Blood Pressure	5.6%	4.6%	3.6%	1017	16	1.6%

KPI Measures - Utilization

KPI Measures (3)	Expected Target in Measurement Year (using 2015 as example)	2015 Performance (as example)
PPV (potentially preventable ER-visits)	425.3 or below (PKPY)	575.9
PPA (potentially preventable admissions)	15.5 or below (PKPY)	3.8
PPR (potentially preventable re-admissions)	11.3 or below (PKPY)	22.6

Managing Performance on Measures

- Population health management platform was a key piece of infrastructure
- Aggregates claims data & EHR data across all FQHCs and also incorporates our specific contract terms and benchmarks
- Provides a CHIPA-level view of performance, with drill down capability to the FQHC, provider, and patient level


3D DevExpress
https://phmadmin3.healthec.com/CHIPADevX/QualityMeasure.aspx
Search
ER Reports
Pharmacy Utilization
Risk Analytics
Quality Measures
Client Reports
Export To:
Select
Export
Domain
Measure
Performance %
Organizational
Benchmark
Variance(%)
Domain: Cardiovascular Conditions
Controlling High Blood Pressure
5.60%
10%
-4%
Domain: Prevention and Screening
Breast Cancer Screening
71.40%
31%
41%
Cervical Cancer Screening
77.60%
37%
41%
Chlamydia Screening in Women
78.30%
31%
47%
Domain: Respiratory Conditions
Medication Management for People With Asthma - Compliance 50%
67.70%
8%
59%
Medication Management for People With Asthma - Compliance 50% - (Ages 5 - 18)
52.20%
8%
45%
Medication Management for People With Asthma - Compliance 50% - (Ages 19 - 64)
67.70%
8%
59%
Domain: Utilization
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
87.50%
9%
79%
Page 1 of 1 (8 items)
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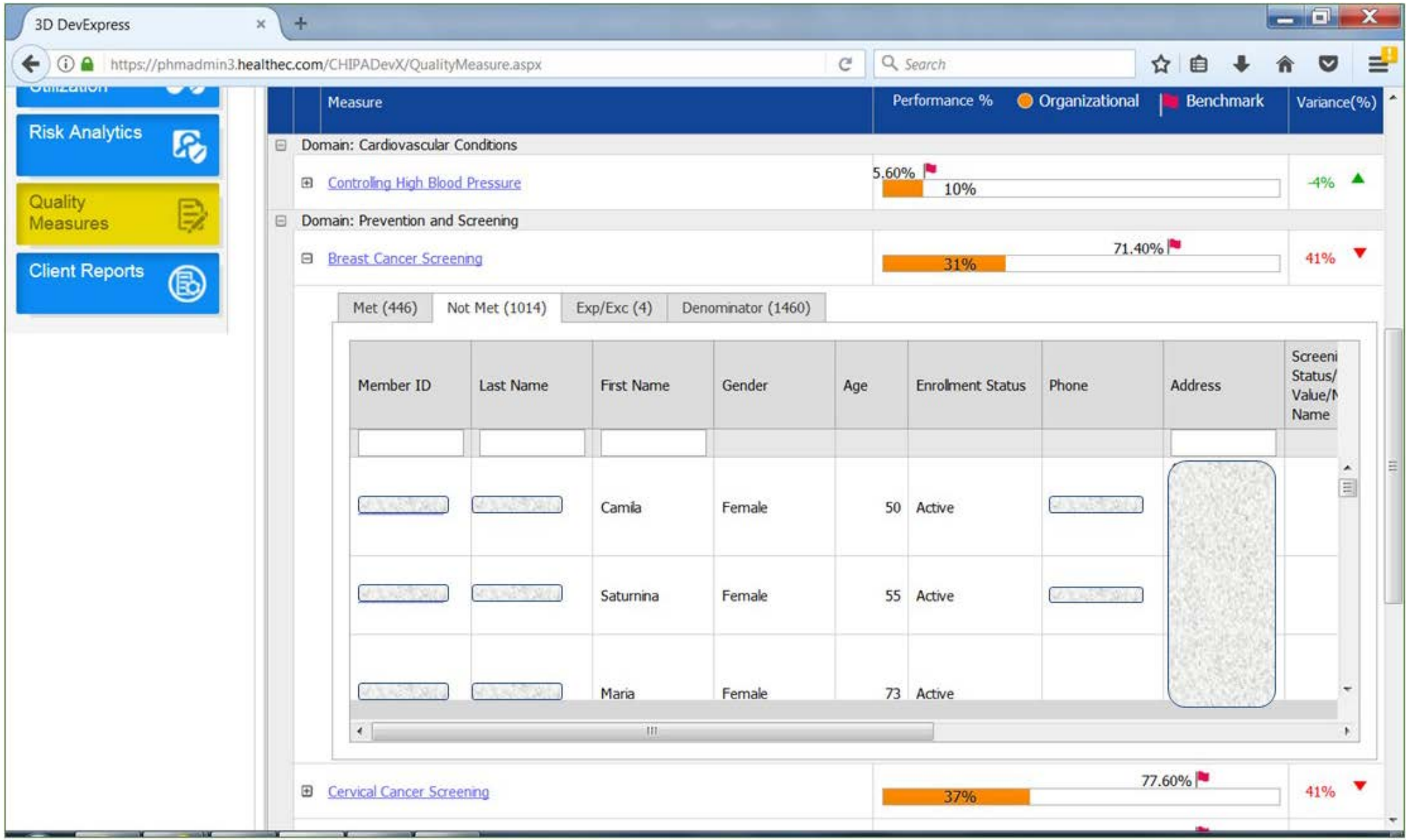
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https://phmadmin3.healthec.com/CHIPADevX/QualityMeasure.aspx
Search
Risk Analytics
Quality Measures
Client Reports
Measure
Performance %
Organizational
Benchmark
Variance(%)
Domain: Cardiovascular Conditions
Controlling High Blood Pressure
5.60%
10%
-4%
Domain: Prevention and Screening
Breast Cancer Screening
71.40%
31%
41%
Met (446)
Not Met (1014)
Exp/Exc (4)
Denominator (1460)
Member ID
Last Name
First Name
Gender
Age
Enrollment Status
Phone
Address
Screeni Status/ Value/N Name
Camila
Female
50
Active
Saturnina
Female
55
Active
Maria
Female
73
Active
Cervical Cancer Screening
77.60%
37%
41%

CHIPA Quality and Performance Management Committee

- Bi-monthly meeting of a cross-section of CMOs, Quality staff, population health staff from all 6 participating health centers
- Review performance data, identify areas for improvement, and action steps
- Support and guidance from our vendor in interpreting the data
- Supplemented with individual calls with each health center.

Discussion

Contact

mhardesty@chipany.com

Website

https://www.communityhealthipa.com/

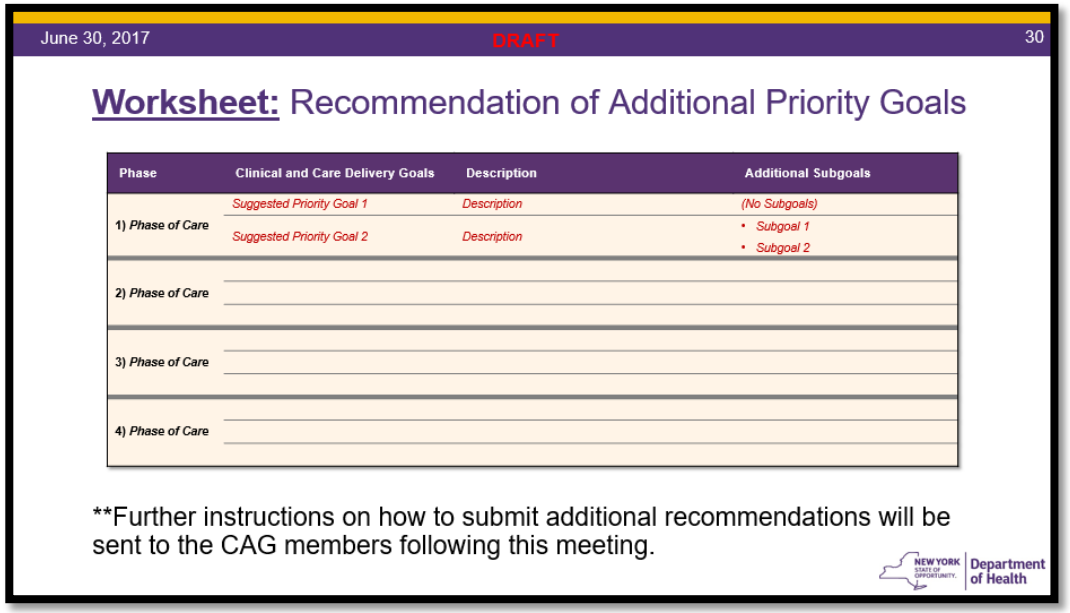
Section 7: MY 2018 Priority Clinical and Care Delivery Goals

Recap of 2017 CAG Feedback
Next Steps

2017 Clinical Advisory Group Feedback Process

Work to Date

- The initial set of Priority Clinical and Care Delivery Goals presented to the CAGs in July 2017 was based on a review of the CAG and Integrated Care Workgroup (ICWG) Measure Set recommendations
- Following the July 2017 CAG meetings, members were asked to submit their feedback on the priority clinical and care delivery goals and sub-goals for each arrangement's measure set.
- Responses were aggregated and used to update the goals and sub-goals targeted by each arrangement.



June 30, 2017 DRAFT 30

Worksheet: Recommendation of Additional Priority Goals

Phase	Clinical and Care Delivery Goals	Description	Additional Subgoals
1) *Phase of Care*	*Suggested Priority Goal 1*	*Description*	*(No Subgoals)*
	Suggested Priority Goal 2	*Description*	• *Subgoal 1* • *Subgoal 2*
2) *Phase of Care*			
3) *Phase of Care*			
4) *Phase of Care*			

**Further instructions on how to submit additional recommendations will be sent to the CAG members following this meeting.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Summary of Feedback

Clinical and Care Delivery Goals

Recommendations for updates and modification of the four Clinical and Care Delivery Goal tables were extracted from both the July 2017 CAG meeting member discussion and the worksheets subsequently submitted to the Department of Health (DOH).

Feedback was analyzed to create a summary of key themes and incorporate recommendations into the existing priority clinical and care delivery goals.

Key Themes

1 General Primary and Secondary Prevention	Recommendations fell into two core themes related to the addition of clinical and care delivery goals addressing control of modifiable risk factors to prevent the occurrence of chronic disease and the addition of goals focused on screening and early detection of disease.
2 Diabetes	Feedback included emphasis on the importance of goals for patient self-management, optimal health behaviors, and psychosocial health, including depression and stress management, supporting optimal diabetes management and prevention of diabetes-related complications
3 Chronic Heart Disease	Recommendations for additional goals related to psychosocial health and optimal lifestyle/health behaviors supporting self-management of chronic heart disease, slow disease progression, and prevent acute cardiovascular events.
4 Chronic Pulmonary Disease	Recommendations supporting the addition of goals related to assessment of environmental exposures, self-management of asthma, and obesity screening/weight management for patients with chronic pulmonary disease.

Clinical and Care Delivery Goals

General Primary and Secondary Prevention

Based on feedback received, the Clinical and Care Delivery Goals table for General Primary and Secondary Prevention has been modified to include:

- Goals focusing on prevention and early detection of chronic diseases including diabetes, cardiovascular disease, and obesity.
- Additional goals for optimal health behaviors and psychosocial health including goals related to physical activity and stress management.
- Additional reproductive and sexual health goals related to HIV risk assessment and screening based on recommendations from the HIV/AIDS CAG.

Care Focus	Priority Clinical and Care Delivery Goals	
1) Immunizations/ Vaccinations	**Childhood Immunizations**	**Prevention and Control of Seasonal Influenza with Vaccinations**
2) Optimal Health Behaviors/ Lifestyle	**Active Living / Regular Physical Activity** **Healthy Weight** **Nutrition**	**Screening and Prevention of Drug Abuse and Excessive Alcohol Use** **Tobacco Avoidance and Cessation**
3) Prevention and Early Detection of Disease	**Cancer Screening** − *Breast Cancer* − *Cervical Cancer* − *Colorectal Cancer* **Chronic Disease Screening** − *Pre-Diabetes* − *Cardiovascular Risk Assessment* − *Hypertension* − *Dyslipidemia* − *Obesity*	**Medication Management** − *Daily Aspirin use as cardiovascular prophylaxis for those at elevated risk for cardiovascular disease/events ^*
4) Psychosocial Health	**Depression Screening** − Early Identification, Initiation of Treatment, and Management	**Psychosocial Stress Management**
5) Reproductive and Sexual Health	**Sexually Transmitted Infection Prevention** − *HIV Risk Assessment (Identification of at-risk patients)* − *HIV Pre-Exposure Prophylaxis (PrEP)*	**Sexually Transmitted Infection Early Detection** − *Hep B Screening* − *Chlamydia Screening* − *HIV Screening* − *HIV Re-screening for at-risk patients (high-risk negatives)*

Red text indicates goals that were added based on feedback

^ Source: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer

Clinical and Care Delivery Goals

Diabetes

Based on feedback received, the Clinical and Care Delivery Goals table for Diabetes has been modified to include:

- Incorporation of diabetes self-management.
- Inclusion of regular physical activity and exercise for diabetes management and prevention of cardiovascular comorbidities.
- Assessment and management of depression and psychosocial stressors in patients with diabetes.

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management	**Access to Care** **Care Coordination** **Glycemic Control** **Cardiovascular Disease** **Diabetes Self-Management** **Eye Care** **Foot Care** **Kidney Disease** **Medication Management**	**Optimal Health Behaviors/Lifestyle** – *Weight Management** – *Nutrition** – *Active Living/Regular Physical Activity** – *Tobacco Avoidance and Cessation** **Psychosocial Health** – *Depression Screening and Management** – *Psychosocial Stress Management**
2) Exacerbation and Complex Treatment	**Access to Care** **Care Coordination**	**Clinical Outcomes**

Red text indicates goals that were added based on feedback.
** Goals also included in General Primary and Secondary Prevention tables.*

Clinical and Care Delivery Goals

Chronic Heart Disease

Based on feedback received, the Clinical and Care Delivery Goals table for Chronic Heart Disease has been modified to include:

- Assessment and management of depression and psychosocial stress in patients with chronic heart disease.
- Inclusion of regular physical activity and exercise as part of the chronic heart disease management plan.

Care Focus	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	**Access to Care** **Blood Pressure Control** **Cardiovascular Function (Ejection Fraction)** **Care Coordination** **Functional Status Assessment** **Lipid Control** **Medication Management** **Stroke Risk Assessment**	**Optimal Health Behaviours/ Lifestyle** – *Weight Management** – *Nutrition** – *Active Living/Regular Physical Activity** – *Tobacco Avoidance and Cessation** **Psychosocial Health** – *Depression Screen and Management** – *Psychosocial Stress Management**
2) Acute / Hospitalization	**Care Coordination** **Mortality**	**Outcomes**
3) Post Acute / Rehab	**Access to Care**	**Care Coordination**
4) Cardiac Procedures	**Cardiac Catheterization**	

Red text indicates goals that were added based on feedback.
** Goals also included in General Primary and Secondary Prevention tables.*

Clinical and Care Delivery Goals

Chronic Pulmonary Disease

Based on feedback received, the Clinical and Care Delivery Goals table for Chronic Pulmonary Disease has been modified to include:

- Assessment of environmental exposures including indoor allergens and outdoor air pollution.
- Influenza and Pneumococcal vaccinations for chronic pulmonary disease patients at increased risk.
- Tobacco use assessment and cessation for patients with chronic pulmonary disease.
- Screening/management of obesity and weight management to support improvements in levels of pulmonary function and asthma control.

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	**Access to Care** **Asthma Severity Assessment and Monitoring** **Asthma Self-Management** – *Management of Asthma Triggers* **Care Coordination** **Environmental Exposure** – *Assessment of Environmental Exposures: Air Quality (indoor allergens; outdoor air pollution)*	**Immunizations/ Vaccinations** – *Influenza* – *Pneumococcal* **Medication Management** **Optimal Health Behaviors/ Lifestyle** – *Weight Management** – *Tobacco Avoidance and Cessation** **Obesity- Screening and Management** **Pulmonary Function**
2) Acute / Hospitalization	**Asthma Self-Management** **Mortality**	**Outcomes** – *Utilization of Controller Medications*
3) Post Acute / Rehab	**Functional Status Assessment**	**Health Related Quality of Life**

Red text indicates goals that were added based on feedback.
** Goals also included in General Primary and Secondary Prevention tables.*

Children's Health CAG

Priority Clinical and Care Delivery Goals – Maternity

The Children's Health CAG met between October 2016 and July 2017. During deliberations the committee discussed maternity care and its impact on the newborn child. As a result, some of the clinical and care delivery goals underpinning the Maternity Quality Measure Set were also recommended for inclusion in Total Care for the General Population (TCGP).

All clinical and care delivery goals put forward by the Children's Health CAG are in alignment with the Maternity CAG goals.

Question: Do you agree that these clinical and care delivery goals (see table) should be included in TCGP arrangements?

Phase of Care	Priority Clinical and Care Delivery Goals	
1) **Prenatal Care**	***Access to Care*** – *Timely initiation of prenatal care* **Modifiable Risk Factors** – *Nutrition* – *Weight* – *Tobacco Avoidance and Cessation* – *Physical Activity/Exercise*	**Psychosocial Risk Assessment and Intervention** – *Depression, anxiety, and other mental illness* – *Drug and/or alcohol use* – *Stress management* – *Interpersonal violence* **Outcomes of Maternity Care** – *Low Birth Weight*
2) **Labor and Delivery**	**Breast Feeding Support** **Full Term Pregnancy**	
3) **Postpartum Care**	**Access to Care** – *Timely postpartum follow up*	**Postpartum Counseling/Education** – *Counseling on safe pregnancy spacing and family planning*

HOMEWORK: Priority Clinical and Care Delivery Goals Analysis

- The *MY 2018 Measure Sets* have been reviewed against the priority clinical and care delivery goals identified by the CAGs through the MY 2018 Annual Update Cycle.
- The resulting report, *Measurement Year (MY) 2018 Priority Clinical and Care Delivery Goals: Supporting Measure and Gap Analysis,* aims to:

1. Aid the State in evaluating the degree to which the *MY 2018 Measure Sets* align with the priority goals identified by the CAGs through the Annual Update Cycle
2. Identify gap areas where measures may not be available or inadequately address quality of care relating to the goal
3. Support decision making regarding measure selection and phasing strategies in the next round of annual updates to the Measure Sets

- The CAG is asked to review this document in advance of the next CAG meeting in late summer

HOMEWORK: Children's Health CAG Recommendations

- The Children's Health CAG was tasked with selecting child-focused quality measures for inclusion in VBP arrangements beginning in 2018.
- A group of maternity measures were recommended based on their relevance to child health quality.
- These are applicable to TCGP as well as the Maternity arrangement, given Maternity is part of TCGP.
- The TCGP/IPC CAG is asked to review these measures (see table below) and consider which (if any) measures should be added to the TCGP/IPC measure set.
  - It is suggested that that 'timeliness and frequency of prenatal and postpartum care visits' may be most appropriate to include. *Do you agree?*

Recommended Measure	Description	Category	Classification	Measure Steward	NQF Endorsed?
Infants exclusively fed with breast milk in hospital	The number of newborns exclusively fed with breast milk during the newborn´s entire hospitalization.	Cat 1	P4R	The Joint Commission	Y
Live births less than 2500 grams	The adjusted rate for live infants weighing less than 2500 grams among all deliveries by women continuously enrolled in a plan for 10 or more months.	Cat 1	P4R	Agency for Healthcare Research and Quality	Y
Timeliness and frequency of prenatal and postpartum care visits	**Prenatal Care: The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.** **Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.**	**Cat 1**	**P4P**	**National Center for Quality Assurance**	**N**
Women provided most or moderately effective methods of contraceptive care within 3 to 60 days of delivery	Among women aged 15-21 who had a live birth, the percentage that is provided a most effective (sterilization, contraceptive implants, intrauterine devices or systems (IUD/IUS)) or moderately (injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery.	Cat 1	P4R	Office of Population Affairs	Y
Behavioral risk assessment for pregnant women	Percentage of women who gave birth during a 12-month period who were seen at least once for prenatal care and who were screened for depression, alcohol use, tobacco use, drug use, and intimate partner violence.	Cat 2	N/A	No Current Steward	N

Thank you!

Please send questions and feedback to:

vbp@health.ny.gov